

National Organization Of American Mohalim/OT (NOAM)

Application For Individual Medical Practitioners Professional Liability Insurance

Desired Effective Date: _____

APPLICANT INFORMATION

1. Full name of applicant (including professional degree): _____

a. Principal business premise address: _____
(Street)

(City) (State) (Zip) (County)

Phone No. _____ Email Address: _____

b. Date business established/began practicing profession: _____

c. Are you an active member of NOAM? Yes No

d. Are you NOAM certified as a mohel? Yes No

e. When did you become certified? Date: _____

f. Are you a full-time or part-time mohel? FT PT

g. Are you also licensed as an MD? Yes No

h. or Certified Nurse Midwife? Yes No

i. Do you own or operate any business other than that shown above? Yes No

If Yes, please provide details: _____

j. Date of Birth: _____ Place of Birth: _____

k. Are you a U.S. citizen? Yes No

l. If No, your status and date of entry into U.S.A.: _____

m. Educational Institutions that you have attended:

<u>Name and City, State</u>	<u>Years of Training</u>	<u>Degree or Certification Attained</u>
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_____	From _____ To _____	_____
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_____	From _____ To _____	_____
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_____	From _____ To _____	_____
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n. Have you ever failed any professional licensing or specialty organization examination? Yes No

If Yes, please provide details: _____



For More information, contact:

Suzanne Capurso | suzannec@amskier.com | (570) 226-4571

- f. Has any professional liability claim or suit been brought against you and/or any of your employees? Yes No
 If Yes, please provide all dates and details of any incidents or payments: _____
- g. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you and/or any of your employees? Yes No
 If Yes, attach an explanation.
- h. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.
- | Insurance Company | Policy Number | Limits of Liability | Deductible | Premium | Expiration Mo./Day/Yr. | Was this a Claims Made Policy Form? | | Retro Date |
|-------------------|---------------|---------------------|------------|---------|------------------------|-------------------------------------|--------------------------|------------|
| | | | | | | Yes | No | |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
- i. Does current policy cover sexual misconduct? Yes No
 If Yes, please state sub-limits, if applicable: _____

ADDITIONAL ATTACHMENTS

1. Currently-valued Professional loss experience for past five years.
2. Copies of contracts utilized for your services.
3. Copy of your resume.

*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of claim information from any prior insurer.**

 Name of Applicant

 Signature of Applicant

 Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued. If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify us, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

