



APPLICATION FOR AUTOLOGOUS BLOOD THERAPISTS/AUTOTRANSFUSIONISTS
PROFESSIONAL LIABILITY INSURANCE (Claims Made Basis)

New Applicant: _____ Renewal: _____

1. APPLICANT INFORMATION

- a. Full name of applicant: _____
b. Mailing address: _____ (Street)
(City) (State) (Zip) (County)
Phone No.: _____ Email Address: _____
c. Date of Birth: _____ Social Security No.: _____
d. Are you practicing as an: Autologous Blood Therapist _____ Autotransfusionist _____ Both _____
e. Number of years experience as an: Autologous Blood Therapist _____ Autotransfusionist _____ Both _____
f. Educational Institutions that you have attended for Autologous Blood Therapy/Autotransfusion (or related) Training:
Name and City, State Years of Training Degree or Certification Attained
From _____ To _____
From _____ To _____
g. Estimated annual caseload number in which you are involved: Adult _____ Pediatric _____
h. Your duties are performed under the supervision of (e.g. perfusionist, physician, surgeon, other - describe): _____
i. Please list all states and any foreign countries where you provide service: _____

2. CLAIMS/HISTORY

If "Yes" to any of the questions below, attach a detailed explanation.

- a. Have you been reprimanded or the subject of investigatory or disciplinary actions or proceedings of any kind? _____ Yes No
b. Has any insurance company ever canceled, non-renewed or declined to accept your professional liability insurance? _____ Yes No
c. Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses? _____ Yes No
d. Have you been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? _____ Yes No
e. Has any professional liability claim or suit been brought against you? _____ Yes No
If Yes, please provide all dates and details of any incidents or payments: _____
f. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you? _____ Yes No
If Yes, attach an explanation.
g. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE. (cont. page 2)

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"/>	_____

NOTE: ATTACH YOUR NRABT PROOF OF CURRENT REGISTRY

*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 insurance coverage and deemed incorporated therein, should the Insurer evidence its acceptance of this application by binding insurance.

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 insurance is bound.

Contact: MedPlus, LLC (866) 995 1842 NRABT (601) 824 3943

Payment Terms (if application is accepted):

For \$1,000,000 each claim / \$3,000,000 aggregate limits

\$500.00	If bound July 1 st through December 31 st of Policy Year	\$250.00*	If bound January 1 st through June 30 th of Policy Year
\$ 25.00	Policy Fee	\$ 15.00	Policy Fee
\$ 21.00	MS Surplus Lines Tax	\$ 10.60	MS Surplus Lines Tax
\$ 1.31	Stamping Fee	\$.66	Stamping Fee
\$547.31	Total	\$276.26	Total

*50% reduction in premium when purchasing insurance during the last half of a policy year.

For \$500,000 each claim / \$1,000,000 aggregate limits

\$300.00	If bound July 1 st through December 31 st of Policy Year	\$150.00*	If bound January 1 st through June 30 th of Policy Year
\$ 15.00	Policy Fee	\$ 10.00	Policy Fee
\$ 12.60	MS Surplus Lines Tax	\$ 6.40	MS Surplus Lines Tax
\$.79	Stamping Fee	\$.40	Stamping Fee
\$328.39	Total	\$166.80	Total

*50% reduction in premium when purchasing insurance during the last half of a policy year.

Attach check made payable to MEDPLUS LLC for the Total or Submit credit card information: _____ MC _____ Visa

Account No.: _____ - _____ - _____ - _____ Expiration Mo./Yr.: _____ / _____

Billing Name: _____ Full Billing Address: _____

I authorize charge of \$ _____ to my credit card. _____, Date _____

(signature)