# NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA

**Psychiatrists’ Professional Liability Insurance Coverage Change Request Form**

**DO YOU NEED TO MAKE A POLICY COVERAGE CHANGE?** Unless otherwise indicated below, all coverage changes should be requested within 30 days of the effective date of the change being made. **Please complete all applicable sections below to ensure that your coverage is updated accurately. Sign, date and return the form to:**

The Psychiatrists’ Program

1515 Wilson Boulevard, Suite 800

Arlington, VA 22209

**Fax:** (703) 276-9530 **Internet Web Site:** [www.psychprogram.com](http://www.psychprogram.com/)

***Please make copies of this form for future use.***

*Please Print:* **I NEW MAILING ADDRESS:**

**Named Insured** Street Address

**Policy Number** City/State/Zip

**Customer Number** Telephone Fax

E-Mail Address

Website:

1. **NEW PRACTICE LOCATION:** *Please attach a separate sheet containing all of the below information for each additional location.*

**1. Entity**

**Name: Street**

**Address: City/State/Zip:**

This location is a:

D Private Office D Nursing Home

D Outpatient Clinic D Office in the Home

**County: Telephone: Fax:**

D Hospital

D Admitting

D Non-Admitting

If non-admitting, please explain:

D Government Hospital (Federal, State, Local)

D *Other (Specify):*

**Beginning Date of Practice: Average weekly practice: (in hours):**

**Average number of patients per week:**

1. Is coverage desired for your work at this location? **If your practice activities at this location will be covered by another professional liability insurance carrier, please provide the name of the carrier:**

D Yes D No

1. Do you want a Certificate of Insurance for this location? D Yes D No
2. Do you serve as the Medical Director or Chief of Neurology at this location? D Yes D No
3. If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization? D Yes D No
4. If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization?

D Yes D No

1. Do you teach at this location? D Yes D No

D Classroom Teaching D Clinical Teaching; Average number of weekly hours spent clinical teaching:

**CHANGE IN PRACTICE STRUCTURE:** *Please indicate all practice situations that now apply to you.*

|  |  |
| --- | --- |
| (a) Unincorporated Solo Private Practice | (e) Employer of other Professionals |
| (b) Independent Contractor to Another Provider, a Hospital or Another Facility | (f) Contractor of the Services of other Professionals |
| (c) Employee of a Hospital or Another Facility, or Another Physician | (g) Professional Corporation with More Than One Shareholder |
| (d) Incorporated Solo Private Practice | (h) Professional Partnership/Association |
|  | (i) Fictitious Name Entity or DBA |

***If you checked Items d, e, f, g, h, or i above AND you are the President, Managing Partner, Employer, or Contractor of others please contact your Underwriter for the appropriate application.***

1. **MEDICAL LICENSE NUMBER:**

*(This is required if the New Practice Location involves a change in state.)*

State/Number

1. **LOCATIONS DELETED/EXPIRED:** *(include date)* a) Date:

b) Date:

1. **COVERAGE CHANGES** *(Complete applicable item(s) only.)*

**Amend Limits of Liability:** *(Limits shown may not be available in all states.)*

***This change will be effective going forward only and requires agreement with the claims disclosure statement shown below.***

$2,000,000/$6,000,000 $250,000/$750,000

$1,300,000/$3,900,000 (NY ONLY) $200,000/$600,000

$1,000,000/$3,000,000 (WI – REQUIRED LIMIT) $100,000/$300,000 (LA – REQUIRED LIMIT)

$500,000/$1,500,000 (PA – REQUIRED LIMIT)

**Claims Disclosure: The applicant declares that as of the date of this application there have been no material change(s) in any fact or circumstance from those set forth in the most recent Application submitted to this Company relating to the insurance to be afforded by this Policy and that the applicant has no knowledge of any circumstance, incident or loss that is reasonably likely to give rise to a claim under this Policy.**

**I AGREE**

**Risk Management Seminar(s):** Have you participated in any Risk Management Seminar(s) of four (4) credit hours or more during the last 12 months? **If Yes**, please attach a copy of the certification and brochure explaining the content of the seminar.

**Scope of practice change:**

Full-time Practice -- **professional activities at all covered locations totaling more than 20 hours per week**.

Part-time Practice -- **LIST EACH LOCATION AND THE CORRESPONDING HOURS OF PRACTICE TIME PER WEEK**.

1 to 10 Hours 11 to 15 Hours 16 to 20 Hours

**Return to APA Member-In-Training (MIT) status:**

APA Member-In-Training’s coverage for “moonlighting” practice confined to psychiatry and totaling 20 hours or less per week. (Must be in an ACGME or RCPS(C) approved Residency Training Program full time and in PGY2 or later.

Name of Training Program/School Specialty

**No longer MIT status:**

First, Second or Third Year of Practice immediately following completion of residency or fellowship. Residency Completion Date (MM/DD/YY)

**Vicarious Liability Employee/Independent Contractor Roster Update: Include on roster: Date of Hire**

* 1. Name Degree Practices As

Insurance Carrier Coverage Limits

If insured with this program, please provide the Customer ID#:

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If insured with this program, please provide the Customer ID#:

**Remove from roster:**

Name: Date: Name: Date:

**OTHER** change not specifically mentioned above:

**NOTICE TO APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO COLORADO APPLICANTS**: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**NOTICE TO LOUISIANA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NOTICE TO NEW JERSEY APPLICANTS**: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**NOTICE TO OHIO APPLICANTS**: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS**: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO VERMONT APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

**Physician’s Signature Date**