LOCUM TENENS APPLICATION – Occurrence

- Please answer all questions. Do not leave any blanks.
- Please type or use ink.
- Application must be signed and dated by the Insured and the Locum Tenens.

LOCUM TENENS COVERAGE IS SUBJECT TO PRIOR APPROVAL BY CNA. COVERAGE WILL NOT BE PROVIDED IF THIS APPLICATION IS RECEIVED ON OR AFTER THE INITIAL DATE FOR WHICH COVERAGE IS REQUESTED.

THE FOLLOWING SECTION MUST BE COMPLETED BY THE INSURED.

Last Name _____ First Name _____ Middle Initial _____ Designation _____

Home Address _____ City _____ County _____ State _____ Zip Code _____

E-mail Address: _____ Policy Number: _____

Reason for Locum Tenens Coverage: _____

THE FOLLOWING SECTION MUST BE COMPLETED BY THE LOCUM TENENS.

Last Name _____ First Name _____ Middle Initial _____ Designation _____

Home Address _____ City _____ County _____ State _____ Zip Code _____

E-mail Address _____ License Number _____ Specialty _____

•Have any Professional Liability claims been filed against you during the past ten years? ☐ Yes ☐ No If "Yes", please explain. _____

•Has any Insurer canceled, or declined your Professional Liability Coverage during the past ten years? ☐ Yes ☐ No

If "Yes", please explain. **THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS**

•Number of days coverage is requested: _____ From_____To _____

I hereby request that my application for insurance coverage under the provisions of the Professional Protector Plan ® be submitted for consideration to CNA. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to CNA any and all information requested which may relate to my insurability under the Professional Protector Plan ®. I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize CNA to release the information on this application and associated underwriting information. I understand that my Professional Liability Coverage will be written on an an "Occurrence" form.

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: 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.) (For Tennessee and Washington Residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont Residents only: which may be a crime and may be subject to civil fines and criminal penalties.)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

_____ _____ _____

Signature of Insured Signature of Locum Tenens Date