NATIONAL ORGANIZATION OF AMERICAN MOHALIM/OT (NOAM)

Application For Individual Medical Practitioners
Professional Liability Insurance

Desired Effective Date: _____

APPLICANT INFORMATION

1.

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

b. Principal business premise address: _____
(Street)

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

Phone No. _____ Email Address: _____

c. Date business established/began practicing profession: _____.

d. Are you an active member of NOAM? ..... ☐Yes ☐No

e. Are you NOAM certified as a mohel? ..... ☐Yes ☐No

f. When did you become certified? Date:_____

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

h. Are you also licensed as an MD? ..... ☐Yes ☐No

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: _____
Are you a U.S. citizen? ..... ☐Yes ☐No
If No, your status and date of entry into U.S.A.: _____

k. Educational Institutions that you have attended:

Name and City, State	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

j. Have you ever failed any professional licensing or specialty organization examination? ..... ☐Yes ☐No
If Yes, please provide details: _____

FOR MORE INFORMATION, CONTACT:
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2. APPLICANT PRACTICE

a. Please describe in detail the professional services you render:_____

_____

b. How are medical instruments sterilized? _____

_____

c. What type of anesthesia is used? _____

_____

d. What techniques do you use to perform the procedure? _____

_____

e. Please list all states and any foreign countries where you provide service: _____

_____

f. Are you entered into any written indemnification agreements holding any other party harmless?..... ☐ Yes ☐ No

g. Do you advertise your professional services in any manner (other than simply a listing in a telephone directory)?..... ☐ Yes ☐ No
If Yes, attach a copy of ALL of your advertisements.

h. Annual Gross Revenues: Last 12 months Estimated next 12 months

(include all sources) _____ _____

i. Annual Number of Ceremonies: Last 12 months Estimated next 12 months

_____ _____

j. Do you anticipate any changes in your practice in the next year?..... ☐ Yes ☐ No
If Yes, please explain: _____

3. SERVICES

a. Please give the approximate percentage of total service time spent in the following locations:

_____% Client's Home _____ % Outpatient Clinic
_____ % Surgery Center _____ % Operating Room
_____ % Operating Room _____ % Physician Office (specify specialty): _____
_____ % Laboratory _____ % Hospital Ward
_____ % Other (specify): _____

4. CLAIMS/HISTORY

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

a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? ..... ☐ Yes ☐ No

b. Have you been the subject of any license suspension or revocation or been placed under probation?..... ☐ Yes ☐ No

c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or general liability insurance? ..... ☐ Yes ☐ No

d. Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... ☐ Yes ☐ No

e. Have you been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? ☐ Yes ☐ No

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? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

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.

AMSkier INSURANCE

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