AANA Insurance Services is pleased to announce a CHOICE in Carrier for your Professional Liability Insurance coverage. If your State's Insurance Department has approved the coverage forms and rates filed by The Medical Protective Company, we will be offering you coverage and carrier options on behalf of both CNA and The Medical Protective Company.

ALL QUESTIONS ON THE APPLICATION MUST BE COMPLETED OR THE APPLICATION WILL BE RETURNED.

APPLICATIONS MUST BE DATED WITHIN 60 DAYS OF THE EFFECTIVE DATE OF COVERAGE; THEREFORE, APPLICATIONS RECEIVED MORE THAN 60 DAYS BEFORE THE REQUESTED EFFECTIVE DATE OF COVERAGE WILL BE RETURNED. ***EXCEPTION;*** IF YOU ANSWERED "YES" TO ***ANY*** QUESTION IN PART VI, ALLOW ***90 DAYS*** FOR UNDERWRITING.

This application contains five sections. Please note the following:

1. Section one is the general application. Complete all questions in this section. If a particular question does not apply, simply put N/A (for not applicable).

   If you currently have a claims-made policy and would like to consider quotations that include Prior Acts coverage (which means you would not need to purchase a "tail" from your current claims-made insurance company), please provide a copy of the Declarations Page from your current claims-made policy (this is the page that shows your name, address, limits of liability, effective and expiration dates, etc.) as well as a claims history from your current insurance company.

2. Section two is the supplemental application that will provide us with the necessary additional information required to quote options for The Medical Protective Company. The Medical Protective Company has agreed to accept the CNA application together with their supplement. Should you choose to bind coverage with The Medical Protective Company, you will not need to complete their full application.

3. Section three is the Claims Waiver for Claims-Made Coverage. You must complete and return this form as part of the application.

4. Section four is the Patient Compensation Fund Form. Only applicants working in Indiana, Kansas, Louisiana, Nebraska and Wisconsin must complete this form.

5. Section five is the Supplemental Claim Information Form. This form is to be completed by applicants with any previously reported claim(s) even if you were subsequently dismissed.

This page must be signed, dated, and returned with your application. **Any incomplete application will be returned**. Please provide us with a fax number and/or email address where we may contact you.

____________________ Fax Number

____________________ Email Address

____________________ Signature

____________________ Printed Name

____________ Date

NOTE: Completed applications may be faxed to 800-547-2220

Occurrence Coverage vs. Claims-Made Coverage

	What It Means	Benefits
Occurrence Coverage	If a medical malpractice incident occurs during the policy period, the claim would be covered regardless of when the claim is reported. The purchase of an Extended Reporting Period Endorsement, know as a tail, is not necessary as the tail is built into the premium which is what makes occurrence coverage more expensive. Any changes made to the current policy are not retroactive, meaning they do not go back to the start of the policy.	• Simplicity in that there are no retroactive dates to be concerned with • No need to purchase a tail • You get a new set of limits every policy year
Claims-Made Coverage	If a medical malpractice incident occurs during the policy period, the claim would only be covered if it is also reported during the policy period. The purchase of a tail is necessary in order to report incidents once the policy is no longer in force. The cost of the tail is 100% of the expiring premium. Any changes made to the current policy are retroactive and go back to the start of the policy.	• Prior Acts coverage is portable which could be important if your company has financial issues and you need to move to a new carrier • Less record keeping is involved because you only need to keep track of your current policy • The tail is usually free when permanently retiring

NURSE ANESTHETIST
PROFESSIONAL LIABILITY INSURANCE APPLICATION
FOR CLAIMS-MADE OR OCCURRENCE COVERAGE

INSTRUCTIONS: *If you have any questions, please contact* ***AANA Insurance Services at 1-800-343-1368.***

1. Answer all questions completely to avoid a processing delay.
2. Sign and date the application before returning it. (Please keep a copy for your records)
3. Attach a copy of your prior or current Coverage Summary Page.
4. You may fax your completed application to 800-547-2220

PART I. APPLICANT INFORMATION *(All applicants complete this section)*

1. Name of Applicant:	4. AANA Membership #
2. Applicant Business Name or DBA (if applicable):	5. Social Security # XXX-XXX-___________
3. Mailing Address: Street:	6. Date of Birth:
City: State: Zip:	7. County:
8. Phone #: ( ) ☐ Home ☐ Work ☐ Cell ☐ Pager	
9. Alternate #: ( ) ☐ Home ☐ Work ☐ Cell ☐ Pager	
10. Fax #: ( )	
11. E-mail address:	

PART II. CURRENT COVERAGE *(attach a copy of your current **Coverage Summary Page**)*

1. Which of the following best describes your ***current*** professional liability coverage?

☐ I have no current coverage
☐ I am covered by my own policy
☐ I am covered by my employer's policy
☐ I am covered by my employer's & my own policy

2. If you currently have your own policy, you must complete the following information about your current coverage.
*If you do not have your own policy, leave blank and proceed to **Part III**.*

Insurance Carrier		
Policy Period		
Limits of Liability	$ Per Claim	$ Aggregate
Policy Form	☐ Occurrence ☐ Claims-Made	____________ Retroactive Date *(for Claims Made only)*

3. If you are currently insured on a claims-made policy and individually named on such policy and have your own separate set of limits, will you be purchasing an optional extended reporting period endorsement ("tail" coverage) from your current carrier? ☐ Yes ☐ No

PART III. DESIRED COVERAGE & LIMITS OF LIABILITY

1. **Limits of Liability: Each Claim/Aggregate**
(If you currently practice or plan to practice in Florida, Michigan or Texas, the default limit you will be offered is: $250,000/$750,000 in Florida; or $200,000/$600,000 in Michigan or Texas. Higher limits are available in Florida, Michigan or Texas on request, subject to underwriting approval.)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $500,000/$1,000,000
☐ $1,000,000/$3,000,000 ☐ $2,200,000/$6,600,000 *(available in Virginia Only – Statutory limits updated annually)*

2. **Requested Effective Date:** ______________________________
(Effective date may not be earlier than the date AANA Insurance Services receives this application)

3. **Coverage Forms:**
▪ Claims-Made
Claims made coverage applies only to those claims which are the result of medical incidents that happen on or subsequent to the retroactive date stated on the certificate of insurance and which are first made against you while this insurance is in force. It may be necessary to secure an Extended Reporting Period endorsement (also called a "tail") for coverage against claims submitted after your policy has expired.

▪ Occurrence
If a medical incident occurs during the policy period, the claim would be covered regardless of when the claim is reported.

4. Which category best describes **the practice for which you are seeking coverage?**

PRACTICE INFORMATION		PART TIME OR FULL TIME COVERAGE		MOONLIGHTING COVERAGE		
A.	**Coverage you are applying for:**	☐ All facilities and locations where I am practicing as a CRNA (I have no other coverage.)		☐ Only those facilities and locations where coverage is ***not provided*** for my practice. (I have other coverage.)		
B.	Number of **ANNUAL** hours worked **for which you are applying for coverage:**	☐ 1-1000	☐ Over 1000	☐ 1 - 500	☐ 501-1000	☐ Over 1000

PART IV. CREDENTIALS AND PRACTICE

1. CRNA School Graduated: ______________ Date Graduated: Month: ________ Year: ________
2. Year of initial certification ______________
3. Are you currently certified? .... ☐ Yes ☐ No *
4. Has certification been continuous? .... ☐ Yes ☐ No *
5. Are you a member of the American Association of Nurse Anesthetists? .... ☐ Yes ☐ No *
6. Do you abide by the AANA *Scope and Standards of Nurse Anesthesia Practice* and AANA *Guidelines for Clinical Privileges* (as well as the AANA *Standards for Office Based Anesthesia Practice* if in non-hospital settings) when you practice? .... ☐ Yes ☐ No *

* If "No" to any of questions 3-6 above, provide detailed explanation in Part VII. Remarks & Explanations.

PART IV. CREDENTIALS AND PRACTICE *(continued)*

7. Indicate the **number of facilities** where you worked in the **last** 12 months: ___________________

8. Indicate the **number of facilities** where you plan to work in the **next** 12 months: ___________________

9. List **all of the states where you plan to practice the next 12 months.**

State*	County (**Required**)	Municipality **(Kentucky only)**	% of Practice in State *(must total 100%)*	Do you have the appropriate credentials to practice as a CRNA in this State?	I want coverage for this State
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No

*** If you intend to practice in Indiana, Kansas, Louisiana, Nebraska or Wisconsin complete, sign, date and return the attached Patient Compensation Fund Form.**

10. Are you a resident of Kansas? ………………………………………………………………………………………. ☐ Yes ☐ No

11. Do you ever have another CRNA substitute for you in a temporary situation (locum tenens)? ………………… ☐ Yes ☐ No
If yes, you will need to provide dates of substitution in advance for your CNA policy to apply to any substitute. Note: the substitute must either complete an application or provide evidence of coverage elsewhere. Call AANA Insurance Services at 1-800-343-1368 for instructions.

PART V. BUSINESS STRUCTURE

1.

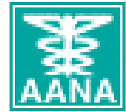
X	POLICY TYPE	BUSINESS	COVERAGE OPTIONS
☐	Individual	None	Self only – no business entity
☐	Individual with Entity *(Self and my business)*	☐ Sole Proprietor ☐ LLC ☐ PC ☐ Corporation	**The business will be included on a shared limits basis for no additional premium**** *(Exceptions: KS residents and WI residents are required to carry a separate limit of liability for their legal Entity-10% Additional Premium.) If you choose to enroll in the IN Patient's Compensation Fund and have an IN business you are required to carry a separate limit of liability for the legal entity-10% Additional Premium)*
☐	Group** *(More than 1 practitioner)*	☐ Partnership ☐ Corporation ☐ Other ______	**The business will be included on a shared limits basis for no additional premium**** *(Exceptions: KS residents and WI residents are required to carry a separate limit of liability for their legal Entity-10% Additional Premium.) If you choose to enroll in the IN Patient's Compensation Fund or the NE Excess Liability Fund and have an IN or NE business you are required to carry a separate limit of liability for the legal entity-10% Additional Premium).*

*******In order to cover the business, you, your partners, and professional employees must be covered together on one policy. A separate application must be completed for each individual covered under the policy.*

2. List all owners, partners, and professional employees of the business: (use Part VII. Remarks & Explanations if additional space is needed)

Name	Title	Profession	Are Professional Medical Services provided by this individual on behalf of the Entity?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

NURSE ANESTHETIST
PROFESSIONAL LIABILITY INSURANCE
KENTUCKY
LOCATION OF PRACTICE SUPPLEMENT



The General Assembly of the Commonwealth of Kentucky has enacted House Bill 524 (HB524). Effective 1/1/2010, the taxes charged by the State of Kentucky are calculated based on the PRIMARY location of practice. The State Surcharge of 1.8% remains and is in addition to this tax.

- In order to correctly calculate the Municipal and County taxes, please complete the following for your primary Kentucky practice.
- We cannot provide you a quotation without this information.
- If you do not have a specific location of practice in Kentucky at this time, we will be unable to offer you coverage in Kentucky until that location can be identified.
- If you are working in multiple locations within the State of Kentucky, you must select a PRIMARY location.
- If you are practicing the same percentage of time in multiple locations, only one location can be identified as your PRIMARY location.

PRIMARY LOCATION OF PRACTICE IN KENTUCKY			
*** ALL FIELDS ARE REQUIRED ***			
Name of Facility:			
Street:			
City:	**County in KY:**	**State:**	**Zip:**

Please Note: If you are working in multiple states, you will only be taxed on the Kentucky portion of your total premium.

Signature: ____ Date: __________________________

3. List all Independent Contractors utilized by you and / or your business in the space below. Include *anticipated* numbers of hours each independent contractor will work on a **monthly** basis for the upcoming policy period. Note: Independent Contractors will not be insured under your policy but you will be protected, subject to the terms and conditions in the policy, for a covered event due to their actions. ***Each Independent Contractor must carry his or her own malpractice coverage.*** The company reserves the right to add a vicarious liability charge, subject to underwriting criteria, if Independent Contractors are used.

Independent Contractor	Monthly Hours	Insurance Carrier *(Required Info)*	Limits *(Required Info)*

4. Do you require that minimum limits of liability insurance be carried by your Independent Contractors? …… ☐ Yes ☐ No

5. If "yes" limits required: ______________________ Do you require proof of such coverage? ☐ Yes ☐ No

PART VI.

Please explain any "Yes" response in Part VII. Remarks & Explanations, using additional sheets as needed:

1. Have you had a professional liability claim or suit brought against you, even if subsequently dismissed? (If yes, complete the enclosed Supplemental Claim Form) .... ☐ Yes ☐ No
2. Are you aware of any facts or circumstances (including a request for records) that might give rise to a claim against you? (Even if you were not named in a suit.) If yes, complete the enclosed Supplemental Claim Form..... ☐ Yes ☐ No
   (If you are applying for replacement of your current claims-made insurance; you must report all claims, suits, and incidents to your current insurer prior to the expiration date of your current insurance.)
3. Have you reported any incident or claim to your Professional Liability Insurance Company or Agent? .... ☐ Yes ☐ No
4. Have you attended any cases that resulted in a formal incident report or investigation by any healthcare facility? .... ☐ Yes ☐ No
5. Have you been involved in a case in any Government facility, Veterans Administration facility, or Indian Reservation where you cannot be held personally liable, and the outcome of the case resulted in a patient's death, neurological injury or any permanent injury? .... ☐ Yes ☐ No
6. Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program?.. ☐ Yes ☐ No
7. Have your privileges been restricted, suspended, revoked, or put on probation by any health care facility? .... ☐ Yes ☐ No
8. Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis? .... ☐ Yes ☐ No
9. Have you ever been convicted or charged with a felony or misdemeanor? .... ☐ Yes ☐ No
10. Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer, or healthcare facility at which you practice(d)? .... ☐ Yes ☐ No
11. Has any insurer canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage (Missouri applicants please leave blank)?........ ☐ Yes ☐ No
12. Have you terminated or had terminated any claims made coverage without purchasing an Extended Reporting Period (Tail) endorsements or prior acts coverage from another insurance carrier? .... ☐ Yes ☐ No
13. Have you provided any professional services without professional liability insurance?........ ☐ Yes ☐ No

PART VII. REMARKS AND EXPLANATIONS (use reverse side if more room is needed)

____

____

____

____

____

PART VIII. APPLICANT'S AFFIDAVIT, AUTHORIZATION, RELEASE, AND SIGNATURE *(each application must be signed and dated.)*

I declare that the information contained in this application is true and that no material facts have been misstated or suppressed. I do authorize the Company to conduct any investigation to substantiate this information and/or any aspect of my professional competency. I hereby authorize the release of claim information or any other relevant information from any prior insurers or professional societies, licensing boards, hospitals, government entities, institutions or persons that may have any record or knowledge concerning any statements or answers contained herein to the Company and its agents responsible for underwriting and claims review. I also authorize the use of claim information for risk management/loss control purposes.

Signing this application does not bind the applicant or the Company to complete the insurance. Approval will not be given before all information has been provided including questions developed from the information contained herein.

PART IX. FRAUD WARNINGS

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 District of Columbia residents only**): 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. (**For Florida residents only**): 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 of the third degree. (**For Kentucky residents only**): 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. (**For Louisiana residents only**): 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. (**For Maine residents only**): 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. (**For New York residents only**): 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 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 Oklahoma residents only**): 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. (**For Pennsylvania residents only**): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000. (**For Tennessee and Washington residents only**): 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. Penalties include imprisonment, fines and denial of insurance benefits. (**For Vermont residents only**): 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 may be a crime and may be subject to civil fines and criminal penalties.

PART X. ASSIGNMENT OF RIGHTS TO CANCEL COVERAGE - ***If you are applying for coverage as part of a GROUP policy and the premium is paid by your Employer or other third party,*** that employer or other third party has the right to cancel the coverage on your behalf. (Copies of all correspondence, notices, and endorsements will be sent to you at the last address on record.)

I have read the above application and to the best of my knowledge and belief, the facts stated herein and in the accompanying materials are a complete statement of such facts and are true.

Signature ____ **Date Signed** __________________________

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company, and is offered through Magaw Healthcare Professionals Purchasing Group Association. Coverage, rates and limits may differ in some states. All products and services are subject to change without notice. CNA is a registered trademark of CNA Financial Corporation. ***Copyright © 2014 CNA. All rights reserved***

Note: Please allow 2-3 weeks for processing your application.

Mail, fax or scan and email completed and signed application to:
AANA Insurance Services
116 South Prospect Avenue
Park Ridge, IL 60068
Telephone: (800) 343-1368
Fax: (800) 547-2220
Email: insuranceinfo@aana.com

HEALTHCARE PROFESSIONAL LIABILITY INSURANCE SUPPLEMENTAL CERTIFIED REGISTERED NURSE ANESTHETISTS

A premium credit of 5% is available on the American Casualty Insurance policy premium quotes **(Please note there are no negative coverage restrictions if you choose not to accept this credit and endorsement on your policy.)**

Are you willing to accept an endorsement which excludes claims if you reuse the same needle or syringe when administering intravenous medications in exchange for a policy premium credit? .... ☐ Yes ☐ No

If yes, to the above question, please complete the following:

☐ I understand I will not be provided coverage for any claims that result from the reuse of the same needle or syringe when administering intravenous medications, arising from services rendered on or after the date below, upon which I accepted this exclusion in writing, on this application for coverage, or the corresponding policy effective date, whichever is later.

SAMPLE OF ENDORSEMENT IS ATTACHED.

Signature: ______________________________ Date: ______________

CERTIFIED REGISTERED NURSE ANESTHETIST PROFESSIONAL LIABILITY COVERAGE PART OCCURRENCE PROHIBITED REUSE EXCLUSION WITH DEFENSE COVERAGE LIMIT

In consideration of the premium paid, it is understood and agreed that this endorsement amends coverage provided under the **CERTIFIED REGISTERED NURSE ANESTHETIST PROFESSIONAL LIABILITY COVERAGE PART OCCURRENCE (G-142837-A)**, the **CERTIFIED REGISTERED NURSE ANESTHETIST PROFESSIONAL LIABILITY INSURANCE COMMON CONDITIONS (G-142836-A)** and the **CERTIFICATE OF INSURANCE (G-142839-A)** as follows:

Solely with respect to **claims** other than **claims:**

a. subject to the Wisconsin Injured Patients and Families Compensation Fund, or any similar fund established for the payment of such **claims**; or
b. subject to the Kansas Healthcare Stabilization Fund, or any similar fund established for the payment of such **claims**; or
c. arising out of an act, error or omission in the rendering of **professional services** in the state of New York,

and in consideration of a premium credit, **Section V. EXCLUSIONS** is amended with the addition of the following:

1. Section **V. EXCLUSIONS**, the **CERTIFIED REGISTERED NURSE ANESTHETIST PROFESSIONAL LIABILITY COVERAGE PART** is amended with the addition of the following exclusion:

Prohibited Reuse

This Policy does not apply to **prohibited reuse claims**, except that we will provide a defense of any such **claims** pursuant to the terms and conditions set forth in paragraphs 2. and 3. of this endorsement below.

2. The **CERTIFIED REGISTERED NURSE ANESTHETIST PROFESSIONAL LIABILITY COVERAGE PART-OCCURRENCE** is amended with the addition of the following:

A. Claims Expenses Prohibited Reuse Aggregate Limit

Subject to the **Claims Expenses Prohibited Reuse Aggregate Limit** set forth in paragraphs 2B. and 3. below, and all other terms and conditions of coverage, we will provide **you** with a defense of any such **prohibited reuse claim** but only until:

(1) such **prohibited reuse** for which **you** are legally liable has been determined to have occurred by any trial verdict, court ruling, regulatory ruling or legal admission, whether appealed or not, or

(2) the **Claims Expenses Prohibited Reuse Aggregate Limit** in the amount set forth in paragraph 3. below, has been exhausted by payment of **claims expenses** related to the investigation or defense of such **prohibited reuse claim**.

B. The **Claims Expenses Prohibited Reuse Aggregate Limit** is the maximum amount we will pay under this Policy for all **claims expenses** related to the investigation and defense of all **prohibited reuse claims**, and such defense will not waive any of our rights under this Policy. We have no duty to pay any **damages** for any **prohibited reuse claim** or suit involving any actual or alleged act of **prohibited reuse**.

3. The **Certificate of Insurance** is amended with the addition of the **Claims Expenses Prohibited Reuse Aggregate Limit** in the amount of $25,000.00.

4. Solely with respect to this endorsement, Section XVII. **DEFINITIONS**, of the **CERTIFIED REGISTERED NURSE ANESTHETIST PROFESSIONAL LIABILITY INSURANCE COMMON POLICY CONDITIONS**, is amended as follows:

The definition of **"claims expenses"** is deleted in its entirety and replaced as follows:

"Claim Expenses" means:

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SAMPLE

1. fees charged by an attorney we designate; and

2. all other fees, costs and expenses, which result from the investigation, adjustment, and defense of a **claim,** or appeal of a **claim**, but only if such appeal is from a judgment, court ruling, or arbitration finding in **your** favor.

These expenses must be incurred by us, or by **you** with our prior written consent.

"Claim Expenses" do not include:

1. salary charges of our regular **employees** or company officials;

2. fees and expenses of independent adjusters;

3. interest on any judgment against **you;** or

4. fees, costs and expenses which result from the appeal of a **claim**, if such appeal is from a judgment, court ruling, or arbitration finding against **you**.

5. Section **IV. ADDITIONAL DEFINITIONS**, is amended with the addition of the following definitions:

- The definition of **"prohibited reuse"** is added as follows:

  "Prohibited reuse" means the reuse of:
  (1) needles, syringes;
  (2) catheters, ports, including implanted ports;
  (3) intravenous solution whether intended for direct intravenous administration or as a source of diluent for medication or any other substance to be administered parenterally;
  (4) intravenous medications intended for direct intravenous administration, including heparin or sodium chloride used for flushing venous access devices;
  (5) lines, including intravenous lines, tubing, and any connectors thereto; or
  (6) any other type of parenteral device or supply used to inject medications or to administer parenteral substances, or to withdraw blood samples,

in contravention of:

(a) the instructions, warnings, or recommendations of the manufacturer of such parenteral device or supply; or
(b) or any standards regarding safe injection practices, intravenous therapy guidelines, infection control, or any other pertinent recommendations or guidelines promulgated by the Center for Disease Control and Prevention or other state or federal agency or governmental authority regulating the use of any such parenteral device or supply.

"Prohibited Reuse" includes:
(aa) the use of any catheter, line, or tubing, including any connectors thereto, on any person after its removal from a person, or after its use for any other purpose wherein it may have become contaminated, or is otherwise no longer sterile; or
(bb) the introduction of any syringe, needle, or any other parenteral device or supply into a multidose vial or intravenous solution after its use.

"Prohibited Reuse" does not include more than one parenteral access of a single patient by means of an implanted port or an indwelling venous access device intended to be used for multiple parenteral access, including but not limited to peripheral venous devices, an arterial device, a central venous device, including tunneled and non-tunneled devices, or a PICC (peripherally inserted central catheter) line provided that any such procedure comports with:
(i) the instructions, warnings, or recommendations of the manufacturer of such parenteral device or supply; or

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SAMPLE

(ii) any standards regarding safe injection practices, intravenous therapy guidelines, infection control, or any other pertinent recommendations or guidelines promulgated by the Center for Disease Control and Prevention; or other state or federal agency or governmental authority regulating the use of any such parenteral device or supply, including any protocol prohibiting reuse of any syringe, needle, or other parenteral device or supply to access such port or device.

- The definition of "**prohibited reuse claim"** is added as follows:

  "Prohibited reuse claim" means a **claim** arising out of or related to an act of **prohibited reuse**.

All other terms and conditions of the Policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the Policy issued by the designated Insurers, takes effect on the effective date of said Policy at the hour stated in said Policy, unless another effective date is shown below, and expires concurrently with said Policy.

SAMPLE

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THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

REUSE PROCEDURE EXCLUSION ENDORSEMENT
HEALTHCARE PROFESSIONAL

In consideration of a modification in premium, if any, the following is added to Section VI. EXCLUSIONS:

Any **claim** arising out of the reuse of the same needle or syringe when administering intravenous medications, based upon **professional services** rendered or which should have been rendered on or after the date **you** accepted this exclusion in writing either in **your** application or renewal application for this policy, or the corresponding policy effective date, whichever is later.

All other terms and conditions of the policy remain unchanged.

SAMPLE

The Medical Protective Co.
Sample Reuse of Needles Exclusion

THE MEDICAL PROTECTIVE COMPANY
HEALTHCARE PROFESSIONAL LIABILITY INSURANCE SUPPLEMENTAL
CERTIFIED REGISTERED NURSE ANESTHETISTS

I. GENERAL INFORMATION – Please print legibly. *Please answer all questions. If a question is not applicable, state "N/A".*

A. Name: AANA #:

II. PRACTICE INFORMATION		PART TIME OR FULL TIME COVERAGE		MOONLIGHTING COVERAGE		
A.	**Coverage you are applying for:**	☐ All facilities and locations where I am practicing as a CRNA (I have no other coverage)		☐ Only those facilities and locations where coverage is not provided for my practice. (I have other coverage)		
B.	Number of **ANNUAL** hours worked **for which you are applying for coverage:**	☐ 1-1000	☐ Over 1000	☐ 1 - 500	☐ 501-1000	☐ Over 1000

C. Indicate the type of facilities you are or will be practicing at in the next 12 months and **for which you are applying for coverage**.

FACILITY DESCRIPTION
☐ **ACCREDITED FACILITIES –** This would include only those facilities that have been accredited by one or more of the following organizations: AAAASF, AAAHC, DNV Healthcare, HFAP, IMQ and The Joint Commission (HAP, CAH, OBS and AMB)
☐ **NON-ACCREDITED**

D. **If you are *only* practicing in Accredited Facilities, you must complete the following:**
I attest that I have verified that each of the Accredited Facilities I have requested coverage for is accredited and that the accreditation is current.

Signature: ______________________ Date: __________

E. A premium credit of 5% is available on your policy if you are willing to accept an endorsement which excludes claims if you reuse the same needle or syringe when administering intravenous medications. **(Please note there are no negative coverage restrictions if you choose not to accept this credit and endorsement on your policy.)**

Are you willing to accept an endorsement which excludes claims if you reuse the same needle or syringe when administering intravenous medications in exchange for a policy premium credit? .... ☐Yes ☐ No

If yes, to the above question, please complete the following:

☐I understand I will not be provided coverage for any claims that result from the reuse of the same needle or syringe when administering intravenous medications, arising from services rendered on or after the date below, upon which I accepted this exclusion in writing, on this application for coverage, or the corresponding policy effective date, whichever is later.

Signature: ______________________ Date: __________

SAMPLE OF ENDORSEMENT ATTACHED.

REPRESENTATIONS

I hereby acknowledge and agree that my CNA application, attached hereto, as completed, signed and dated may be used as my application and the basis of coverage for Medical Protective should a Medical Protective policy be issued in lieu of a CNA policy.

I acknowledge that Medical Protective is relying on the information provided in the attached CNA application to review and price my CRNA professional liability coverage. I am not aware of any material changes to my practice activity, claims or potential claims since the completion of the said application.

I acknowledge that I am not aware of any occurrences or alleged injury having potential for a claim arising out of the rendering or failure to render professional services that have not already been reported to CNA. I also do not have any knowledge of any potential claims, claims, or suits in which I have become involved.

By signature below, I affirm that the representations being made above are true and correct to the best of my knowledge and belief. I agree that any misrepresentations or false statements made by me may be the basis for the termination or revocation of my coverage.

WARNING: Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

____
Printed Name

______________________________ ______________________________
Signature Date

ALL APPLICANTS MUST COMPLETE, SIGN AND DATE THIS FORM

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
CLAIMS WAIVER

Name: ______________________________

RE: Professional Liability Policy

To Whom It May Concern:

Except that which is described below, I the undersigned have no:

- Known losses or claims; and/or
- Knowledge or information relating to the providing or withholding of professional services which might result in a claim; and/or
- Knowledge of any request for medical records which might result in a claim; and/or
- Knowledge or information relating to service on a professional board or committee which may result in a claim; and/or
- Knowledge or information relating to the providing or withholding of past professional services which resulted in a written or verbal complaint to an employer, healthcare facility, professional board, licensing body or association of which I am a member; and/or
- Knowledge or information relating to the providing or withholding of past professional services in a Government facility, Veterans Administration facility or Indian Reservation, where I cannot be held personally liable, that resulted in a patient's death, neurological injury or any permanent injury.
- Knowledge or information relating to the providing or withholding of past professional services that resulted in a patient's death or neurological injury.

I attest that I have not intentionally withheld reporting any incidents to my current insurance carrier, which under reasonable conditions might result in a claim against me. Furthermore, I agree to immediately notify AANA Insurance Services of any future knowledge or information relating to potential incidents or claims that I become aware of prior to the effective date of the policy I am applying for.

Exception(s) if any: (use reverse side if more room is needed) ______________________________

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 District of Columbia residents only**): 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. (**For Florida residents only**): 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 of the third degree. (**For Kentucky residents only**): 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. (**For Louisiana residents only**): 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. (**For Maine residents only**): 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. (**For New York residents only**): 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 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 Oklahoma residents only**): 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. (**For Pennsylvania residents only**): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000. (**For Tennessee and Washington residents only**): 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. Penalties include imprisonment, fines and denial of insurance benefits. (**For Vermont residents only**): 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 may be a crime and may be subject to civil fines and criminal penalties.

Signature: ______________________________ Date: ____________________

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
SUPPLEMENTAL APPLICATION
PATIENT COMPENSATION FUND FORM

LISTED BELOW ARE THE STATES THAT HAVE PATIENT COMPENSATION FUNDS AND THE REQUIREMENTS OR OPTIONS APPLICABLE TO EACH.

( ) **INDIANA**

Enrollment in the IN Patient's Compensation Fund caps liability at $1,250,000.

PARTICIPATION	UNDERLYING LIMITS WITH CNA	SURCHARGE
OPTIONAL	$250,000 / $750,000	Per INPCF Requirements

***NOTE: the use of substitute providers is prohibited if you are enrolled in the IN Patient's Compensation Fund*.**

Do you wish to enroll in the Fund?..( ) **YES*** ( ) **NO****

****IF NO,** your application for coverage through CNA Insurance will be referred to our underwriter for approval.

*** IF YES:**

1. Indiana CRNA License #: (*required info*) _________________________
2. Number of hours you expect to work in Indiana **on average per month**: _______________
3. Are you covering your business on the Professional Liability policy with CNA? ( ) **YES*** ( ) **NO**

   *IF YES, is your business filed with the ***Indiana*** Secretary of State?......................... ( ) **YES*** ( ) **NO****

   *IF YES, you must carry a separate limit of liability for your business for an additional 10% of the CNA premium and we will enroll your business in the IN Patient's Compensation Fund.

   *Indiana FEIN #: (required info) ____

   **IF NO, Coverage for your business, if applicable, for work done in the State of Indiana will be limited to the $250,000/$750,000 provided by CNA.

Include the surcharge amount with your premium payment payable to *AANA Insurance Services*. AANA Insurance Services will complete and submit the appropriate form with the payment to the IN Patient's Compensation Fund.

NOTE: Per the Indiana Department of Insurance (IDOI), **45 days *ADVANCE notice is required*** for any policy change that will result in a refund of all or part of the Indiana PCF Surcharge. This includes, but is not limited to, policy cancellation requests.

SIGNATURE: ____ DATE: ________________

( ) **KANSAS**

RESIDENT: INCLUDE THE SURCHARGE AMOUNT WITH YOUR PREMIUM PAYMENT PAYABLE TO AANA INSURANCE SERVICES. AANA INSURANCE SERVICES WILL COMPLETE AND SUBMIT THE APPROPRIATE FORM WITH THE PAYMENT TO THE FUND.

NON-RESIDENT: BECAUSE YOU HAVE AN ACTIVE KANSAS NURSING LICENSE, YOU ARE REQUIRED TO SELF-ENROLL IN THE KS HEALTH CARE STABILIZATION FUND. PLEASE CONTACT THE FUND DIRECTLY FOR ENROLLMENT: KS HEALTH CARE STABILIZATION FUND, 300 SW 8TH AVE., 2ND FL., TOPEKA, KS 66603-3912 Ph: 785-291-3777

PARTICIPATION	UNDERLYING LIMITS	SURCHARGE
RESIDENT / MANDATORY	$200,000/ $600,000	REFER TO FORM FOR OPTIONS
NON-RESIDENT / MANDATORY	$200,000/ $600,000	CONTACT THE FUND

( ) **I understand that participation in the KS Health Care Stabilization Fund is mandatory**.

NOTE: The use of substitute providers is prohibited.

SIGNATURE: ____ DATE: ________________

( ) LOUISIANA

Enrollment in the LA Patient's Compensation Fund caps liability at $500,000.

PARTICIPATION	UNDERLYING LIMITS	SURCHARGE
OPTIONAL	$100,000 / $300,000	SUBJECT TO UNDERWRITING CRITERIA

NOTE: The use of substitute providers is prohibited if you are enrolled in the LA Patient's Compensation Fund.

Do you wish to enroll in the Fund?..( )YES* ( )NO**
****IF NO,** your application for coverage through CNA Insurance will be referred to our underwriter for approval.
*** IF YES:**

1. Louisiana CRNA License #: (*required info*) ___________________________
2. Number of hours you expect to work in LA **on average per month**: ________________
3. Are you covering your business on the Professional Liability policy with CNA? ....( ) **YES*** ( ) **NO**
   *IF YES, is your business filed with the ***Louisiana*** Secretary of State? ....( ) **YES*** ( ) **NO****
   **IF NO, coverage for your business, if applicable, for work done in the State of Louisiana will be limited to the $100,000/$300,000 provided by CNA.

AANA Insurance Services will send you the form for your signature that will reflect the surcharge amount. *A separate check payable to the LA Patient Compensation Fund* is required along with the signed form. Upon receipt, AANA Insurance Services will submit the form and payment to the Fund.

SIGNATURE: ____ DATE: _________________

( ) NEBRASKA

Enrollment in the NE Excess Liability Fund pays up to and caps liability at $1,750,000.

PARTICIPATION	UNDERLYING LIMITS	SURCHARGE
OPTIONAL	$500,000 / $1,000,000	PER FUND REQUIREMENTS

NOTE: The use of substitute providers is prohibited if you are enrolled in the NE Excess Liability Fund.

Do you wish to enroll in the Fund?..( )YES* ( )NO**
****IF NO,** your application for coverage through CNA Insurance will be referred to our underwriter for approval.
*** IF YES:**

1. Are you covering your business on the Professional Liability policy with CNA?......... ( ) **YES*** ( ) **NO**

   *IF YES, is your business filed with the ***Nebraska*** Secretary of State? .... ( ) **YES*** ( ) **NO****
   *IF YES, you will also need to enroll your business in the NE Excess Liability Fund.
   **IF NO, coverage for your business, if applicable, for work done in the State of Nebraska will be limited to the $500,000/$1,000,000 provided by CNA.

A Certificate of Insurance verifying coverage afforded by CNA Insurance Company along with *a check payable to the Nebraska Excess Liability Fund* must be submitted to the Department of Insurance, State of Nebraska, Terminal Building, 941 "O" Street, Suite 400, Lincoln, NE 68508.

SIGNATURE: ____ DATE: _________________

( ) **WISCONSIN** THE APPROPRIATE FORM IS SUBMITTED TO THE FUND DIRECT BY CNA INSURANCE. YOU WILL RECEIVE A BILL FROM THE FUND FOR THE SURCHARGE.

The WI Patient Compensation Fund provides unlimited coverage excess of $1,000,000/$3,000,000. There is no liability cap in Wisconsin

PARTICIPATION	UNDERLYING LIMITS	SURCHARGE
MANDATORY	$1,000,000/ $3,000,000	PER FUND REQUIREMENTS http://oci.wi.gov/pcf.htm

***NOTE: The use of substitute providers is prohibited*.**

( ) **I understand that participation in the WI Patient Compensation Fund is mandatory.**

1. Wisconsin CRNA License #: (required info) ________________________________
2. Are you covering your business on the Professional Liability policy with CNA?......... ( ) **YES*** ( ) **NO**

   *IF YES, is your business filed with the Wisconsin Secretary of State? .... ( ) **YES*** ( ) **NO****

   *IF YES, Wisconsin FEIN #: (required info) ____

   *IF YES, you must carry a separate limit of liability for your business for an additional 10% of the CNA premium and we will enroll your business in the WI Patient's Compensation Fund.

   **IF NO, your business cannot be covered by the WI Patient's Compensation Fund.

SIGNATURE: ____ DATE: ________________

SUPPLEMENTAL CLAIM INFORMATION FORM

THIS FORM IS TO BE COMPLETED BY AN APPLICANT WITH ANY PREVIOUSLY REPORTED CLAIM(S) (EVEN IF YOU WERE SUBSEQUENTLY DISMISSED) OR TO DISCLOSE AN INCIDENT THAT POTENTIALLY MAY GIVE RISE TO A CLAIM.

PLEASE NOTE, YOUR RESPONSES TO THE QUESTIONS ON THIS FORM ***MUST BE TYPED.*** THESE RESPONSES CAN BE TYPED ON A SEPARATE SHEET RATHER THAN USING THE ENCLOSED FORM, IF YOU PREFER.

THIS FORM WILL NEED TO BE COMPLETED FOR ***EACH*** CLAIM / INCIDENT.

In addition to the completed form, please attach the following:

- A typed narrative providing a detailed description of all preoperative, intraoperative and postoperative events as they relate to your involvement in the claim/incident in question.
- Copies of any records or results ***with the patient's name removed*** (such as the anesthesia record, surgeon's report, autopsy report, expert witness documentation, etc) to clarify the events surrounding the claim/incident in question.
- If the insurance policy that is providing (or provided) coverage for the claim/incident was not purchased through AANA Insurance Services, you will also need to secure a copy of your claims history (also called a "loss run") from the company that is providing (or provided) the coverage.
- Copies of dismissal papers (if applicable)

Unfortunately, the possibility exists that CNA may not be willing to provide coverage through the admitted program. You may want to consider other coverage options. Coverage may be available to you through CNA's ***non-admitted*** company, Columbia Casualty. (Coverage is not available through Columbia Casualty Company for practice in IN, KS, LA, NY, NE, VA and WI) We will provide you with the necessary forms if applicable. The underwriting guidelines of non-admitted are more flexible than that of admitted insurance companies. However, there are significant coverage differences between admitted and non-admitted companies. There was an article in the March, 2007 issue of the AANA News bulletin entitled "Buyer Beware: What You Don't Know About Professional Liability Insurance Can Hurt You" which explains some of the differences between admitted and non-admitted insurance companies. The article is also available in the Insurance section of the AANA website (www.aana.com).

If completing a Supplemental Claim Information Form, **allow 90 days for underwriting**.

________________________________ _______________

Signature Date

SUPPLEMENTAL CLAIM INFORMATION FORM

CLAIM INFORMATION INSTRUCTIONS:

1. This form is to be completed by an applicant with any previously reported claim(s) or to disclose an incident(s) that potentially may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM OR INCIDENT.
2. If space is insufficient to answer any questions fully use reverse side of this page or attach a separate sheet.
3. **Your responses to the questions on this form *must be typed*. These responses can be typed on a separate sheet rather than using this form, if you prefer.**
4. Answer all questions completely

---

1. Full name of Applicant: ____

2. Indicate whether the claimant has initiated a claim/suit or if this is a precautionary incident: ☐ Claim/Suit ☐ Incident
   If an incident, have you submitted written notice to your present insurance carrier? ☐ Yes ☐ No

3. Insurance Company handling your claim: ____ Claim File #: ________________

4. Date(s) of treatment primarily responsible for alleged error or omission: ____

5. Date when you first learned of the claim/suit or became aware that an incident may give rise to a claim: ____________________

6. IF CLAIM IS CLOSED:

Total payment to Claimant: $_______________ Indicate whether: ☐ Court Judgment ☐ Out of Court Settlement

7. IF CLAIM IS PENDING:

Claimant's settlement demand? $___________________

Defendant's offer for settlement, if any? $___________________

Insurer's loss reserve, if any? $___________________

8. What steps or procedures have you adopted to prevent a similar claim:

____

____

____

____

____

____

____

____

____

9. Description of claim, suit, or incident: (Provide enough information to allow evaluation – if needed, additional space is provided below. Do not instruct us to contact a legal representative or the insurance company.)

   A. Alleged act, error or omission upon which Claimant bases claim or basis for which an incident may develop into a claim:

   ____

   ____

   ____

   B. Description of care and events leading to claim/incident:

   ____

   ____

   ____

   C. Description of the type and extent of injury or damage allegedly sustained and location (hospital, office, etc.):

   ____

   ____

   ____

Additional Explanation to the questions designated.

Question	Remarks
_______	____
_______	____
_______	____
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_______	____
_______	____
_______	____
_______	____

I understand information submitted herein becomes part of my Professional Liability Application and is subject to the same warranty and conditions

Signature of Applicant: ____ Date: _________________________