



## **Malpractice Insurance For Clinical Research Professionals**

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- 1) Please print a copy of this application to your desktop printer.
- 2) Complete this hard copy by hand, answering all questions
- 3) Sign, date and either:
  - a. Mail your completed application providing your credit card information OR with check payable to:  
**CM&F Group, Inc., 99 Hudson Street, 12th Floor,  
New York, NY 10013**
  - OR
  - b. Fax your signed and completed application providing your credit card information (per the application) to CM&F Group, Inc. at (212) 608.4378
- 4) Once your application is processed & approved, your policy will be mailed within 5-7 business days. Your payment — whether by check or credit card — will NOT be processed until your coverage has been approved.



5. Corporate Entity Coverage Options - In addition to coverage for individuals, there is an option for adding additional coverage for your corporation. Please check the limit option you are requesting.
- Do not add this entity to my policy
  - Add this entity to my policy, with single set of limits of liability
  - Add an additional set of limits of liability to my policy for this entity for an additional premium

**III. UNDERWRITING PROFILE**

1. Has your professional liability insurance ever been canceled, declined, non-renewed, or accepted only on special terms?  
**NOTE: MISSOURI APPLICANTS DO NOT RESPOND.**  Yes  No If yes, please provide details: \_\_\_\_\_
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2. Have you ever had any professional license suspended, revoked, voluntarily surrendered, or subject to probation in any state?  Yes  No  
 If yes, please provide details: \_\_\_\_\_
3. Have you ever been accused or engaged in behavior defined as sexual misconduct with any of your current or former patients or any current or former patients' spouse or any person with a direct relationship to the patient or former patient (for example a guardian, a blood relative of the patient or spouse or any person sharing the patient's domicile)?  
 Yes  No If yes, please provide details: \_\_\_\_\_
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4. Have you ever had any licensing board or professional ethics body ever require you to surrender your license or found you guilty of violations of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?  Yes  No If yes, please provide details: \_\_\_\_\_
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5. Please list professional designations and/or licenses you currently hold. \_\_\_\_\_
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6. Have you ever:
- a. Been convicted for violation of any law or ordinance other than minor traffic offenses?  Yes  No
  - b. Been treated for alcoholism or drug addiction?  Yes  No
  - c. Had any chronic illness or physical defect that affected your ability to practice professionally?  Yes  No

**If you answered "Yes" to any of the above questions, please explain on a separate sheet.**

**IV. PRACTICE PROFILE**

1. Practice Specialty - If you are practicing as a sole practitioner, please indicate your specialty. If there are other full time employees or independent contractors working for you, please indicate the number and type of specialty (including yourself). Please indicate if they are working for you on a full time employee or independent contractor basis. Please include the number of each professional/non-professional.

	Full Time	Independent Contractor
Clinical Research Associate (CRA)/Clinical Research Monitor	_____	_____
Clinical Research Associate (CRA) (with CCRA accreditation)	_____	_____
Clinical Research Coordinator (CRC)	_____	_____
Clinical Research Coordinator (CRC) (with CCRA accreditation)	_____	_____
Quality/Regulatory Compliance (QC)	_____	_____
Data Management	_____	_____
Medical Writing	_____	_____
Statistical Management	_____	_____
Quality Assurance (QA)	_____	_____
Other _____	_____	_____
<b>Professional Total</b>	_____	_____
<b>Non-professional Total</b> , i.e. Clerical, Receptionist, Bookkeeper	_____	_____

2. Please provide percentages of the types of services you are providing:
- Clinical Research Associate (CRA)/Clinical Research Monitor \_\_\_\_\_
  - Clinical Research Coordinator (CRC) \_\_\_\_\_
  - Quality/Regulatory Compliance (QC) \_\_\_\_\_
  - Data Management \_\_\_\_\_
  - Medical Writing \_\_\_\_\_
  - Statistical Management \_\_\_\_\_
  - Quality Assurance (QA) \_\_\_\_\_
  - Other \_\_\_\_\_
- Total** \_\_\_\_\_

3. Supervision: Please check one:  
Are you acting as an  independent contractor  employed professional
4. Do you have direct patient contact?  Yes  No
5. Please provide an estimate of your annual revenues: This year \_\_\_\_\_ Last year \_\_\_\_\_
6. Do you have any independent contractors working for you? (Indicated in Question 1 of Section IV Practice Profile)  Yes  No  
If yes, please provide a copy of a sample contract.
7. Are certificates of insurance obtained from all contracted providers?  Yes  No
8. Do you provide services to others on a contractual agreement?  Yes  No If yes, please describe services provided and include a copy of the contract: \_\_\_\_\_
9. a. Have you agreed to hold harmless or indemnify others under contract?  Yes  No  
b. Does the sponsor indemnify or agree to hold you harmless?  Yes  No  
If yes to a or b, please describe and include a copy of the contract. \_\_\_\_\_
10. Are you currently in practice?  Full Time  Part Time If Part Time, please describe: \_\_\_\_\_

11. List of last 5 jobs: (Attach separate sheet if necessary)

**Sponsor/Clinical Research Organization/Other**

**Description of Clinical Trial**

Sponsor/Clinical Research Organization/Other	Description of Clinical Trial
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## V. GENERAL LIABILITY

1. Do you render professional services to your client on your premises?  Yes  No
2. Description of your office space (please check applicable descriptions):  
a. Does the applicant?  Rent  Own the premises  
b. Location:  Home Office  Leased Office Space
3. In what practice setting do you provide your services. Please check all that apply:  Your Home  Outpatient Clinic  Doctors Office  
 Hospital  Medical Center  Research Site  Other \_\_\_\_\_
4. Are you providing any direct patient care?  Yes  No  
If yes, are you providing services:  On an outpatient basis?;  As an owner/manager of an overnight bed and board facility?

## VI. CLAIMS HISTORY

1. Has any professional liability claim or suit ever been made against you, your predecessors in business or against any past or present partner(s)?  
 Yes  No If yes, please provide details on the claim supplemental form attached. Use separate form for each claim.
2. Are there any circumstances of which you are aware that may result in any professional liability claim or suit being made against you, your predecessors in business or against any past or present partner(s)?  Yes  No If yes, please provide details on a separate sheet. Please use one sheet for each incident.
3. Have any professional or general liability claims or suits been made or brought against any of your employees or any member, stockholder or partner of your professional association, professional corporation, limited liability company or partnership?  Yes  No  
If yes, provide details: \_\_\_\_\_

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

**THE EARLIEST EFFECTIVE DATE IN WHICH A POLICY CAN BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.**

**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 ILLINOIS APPLICANTS:** THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

**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 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.

Applicant's Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Agent: \_\_\_\_\_ Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Florida Agent License #: \_\_\_\_\_ California Agent License #: \_\_\_\_\_

72359 (12/98)

**PREPAYMENT REQUIRED**

Check or money order enclosed.

Charge premium to credit card.

I authorize CM&F Group, Inc. to charge the premium to my:

VISA  MASTERCARD

Credit Card Account Number: \_\_\_\_\_ Expiration Month and Year: \_\_\_\_\_

Print name exactly as it appears on card: \_\_\_\_\_

**THIRD PARTY CREDIT CARD AUTHORIZATION**

Please complete the following (if payer other than applicant):

CHARGE TO:  VISA  MASTERCARD

Credit Card Account Number: \_\_\_\_\_ Expiration Month and Year: \_\_\_\_\_

Card Member Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**MAIL TO: CM&F Group, Inc.**

99 Hudson Street, 12th Floor, New York, NY 10013

212.233.8940 1.800.221.4904 FAX: 212.608.4378

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**Florida Applicants:**

Richard J.J. Sullivan, Jr. Non Resident License #A257825

**California Applicants:**

CMF Group, Inc. Non Resident CA License #OC3688713