

Fax Completed Application To:
CM&F Group, Inc.
99 Hudson Street, 12th Floor
New York, New York 10013-2815
(212)233-8911 (800)397-3008 Ext.105
Fax (212) 233-8941
rsullivan3@cmfgroup.com OR
csullivan@cmfgroup.com

Coverage provided by
Lexington Insurance Company
Wilmington, Delaware
Administrative Offices: 100 Summer Street,
Boston, MA 02110-2103
(A Capital Stock Insurance Company)
Producer Code _____

PERFUSIONIST PROFESSIONAL LIABILITY APPLICATION

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

INSTRUCTIONS

- 1) Please **type or print** clearly.
- 2) Answer **ALL** questions completely, leaving no blanks (use "N/A" if Not Applicable).
- 3) If you need more space for your responses, continue on a separate sheet and indicate question number.
- 4) This application must be completed, dated and signed by the individual applicant certified Perfusionist.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED

- LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

If you have no claims, initial here: _____

Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? Yes No

If yes, give dates, allegations and disposition of each claim or suit on a separate sheet.

- Copies of most recent American Board of Cardiovascular Perfusion (ABCP) certification and where required by state law licensure.

I. GENERAL INFORMATION

- New Application Renewal Application

Requested effective date: _____

Name: _____

Address: _____ Phone: _____

City: _____ County: _____ Fax: _____

State: _____ Zip Code: _____ Email: _____

How did you hear about us?

- Convention: *Specify* _____
 Colleague: *Identify* _____
 Advertisement: *Specify* _____
 Mailer
 CM&F Group, Inc. Website
 Association: *Specify* _____
 Other: *Specify* _____

II. EDUCATION & TRAINING

1. In chronological order, please list all states where you have practiced since obtaining perfusionist certification. (If more space is required, attach a separate sheet). Include practice state, certification # and license # where required by state law.

State	ABCP Certificate Number & Expiration Date	State License Number & Expiration Date

2. (Check all that applies):

- Bachelor's Degree
- Master's Degree
- Certificate in Perfusion Science
- Medical Assistant
- Nurse
- Paramedic
- Other: *Specify* _____

3. Identify the Perfusionist Program (Circulation Technology) you graduated from and the Year of Graduation: _____

4. List the continuing educational classes you have taken in the last 18 months. _____

5. List Professional Associations of which you are a member: _____

III. COVERAGE INFORMATION

1. Please indicate the type of coverage desired: Claims-Made or Occurrence

If it is Claims-Made Coverage, please provide the Retro Date: ____ / ____ / ____

2. Please list prior professional liability insurance carried for the past 5 years, if any.

Insurance Company	Policy #	Limits of Liability	Premium	Claims Made or Occurrence	Effective Dates

3. Please indicate Limits of Liability desired (Please Check One)*:

- \$200,000/\$600,000
- \$250,000/\$750,000
- \$1,000,000/\$3,000,000

*THE PER ACCIDENT/PER POLICY YEAR LIMIT OF LIABILITY REQUESTED CANNOT BE HIGHER THAN THE LIMITS OF YOUR SUPERVISING PHYSICIAN.

IV. PRACTICE PROFILE

1. Total number of cases projected for the next 12 months:

_____ Adult _____ Pediatric _____ Full Time _____ Part Time

2. List the name(s) and address(es) of hospital/facility where you perform services as a Certified Clinical Perfusionist:

3. Check procedures which you perform and assist in (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Isolated Limb Perfusion | <input type="checkbox"/> Lung, Liver, or Heart Transplantation |
| <input type="checkbox"/> Routine Adult Open Heart Surgery | <input type="checkbox"/> Routine Pediatric Open Heart Surgery |
| <input type="checkbox"/> Platelet Gel/Platelet Rich Plasma | <input type="checkbox"/> Electrophysiological Analysis |
| <input type="checkbox"/> Extracorporeal Membrane Oxygenation | <input type="checkbox"/> Vein Harvesting |
| <input type="checkbox"/> Left/Right Ventricular Procedures | <input type="checkbox"/> Other _____ |

4. Do you work in excess of a twelve hour shift? Yes No

If yes, please explain: _____

5. Which of the following safety devices are used (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Oxygen Saturation Monitoring | <input type="checkbox"/> Cerebral Oximeter |
| <input type="checkbox"/> Arterial Line Filtration | <input type="checkbox"/> Bubble Detector |
| <input type="checkbox"/> In Line PO2 Monitoring | <input type="checkbox"/> Level Sensing Device |
| <input type="checkbox"/> Closed Circuit Systems | <input type="checkbox"/> Other _____ |

6. Type of pump used: Centrifugal _____% Roller _____%

7. Describe your equipment safety and maintenance procedures and quality control procedures. _____

8. Who is responsible for the maintenance of equipment? _____

9. What is the frequency of the maintenance program? _____

10. Are all equipment fitted with the appropriate safety devices as recommended by the manufacturer? Yes No

11. Do you have an emergency back up certified clinical perfusionist in the facility available during procedures? Yes No

12. Does your practice include telemedicine activities, e.g., direct interaction with patients through electronic means (video, computer, or telephone) in order to provide healthcare to patients who are geographically separated from the clinicians involved? Yes No

If yes, what is the percent of your total practice time devoted to this activity? _____%

While being treated, are the patients physically located outside the state where your practice is located? Yes No

If yes, are you currently licensed to practice in the state where the patient is located at the time of treatment? Yes No

Is the jurisdiction outside the U.S.? Yes No

On a separate sheet, please explain the details of the telemedicine arrangement (i.e. the location, equipment, conditions being treated, number of patients, health professionals and/or other resources available to the patient at his/her location, etc.)

13. Do you engage in any clinical and/or pharmaceutical research or research involving medical devices? Yes No

14. Do you teach or provide any training? Yes No

V. CLAIMS HISTORY

1. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency or ever been the subject of any ethics investigation at local, state, or national level? Yes No

If yes, please attach a separate sheet with full particulars.

2. Has any Insurance ever been cancelled or non-renewed? **(Missouri Applicants: Do Not Reply)** Yes No
-

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. 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 FOR WHICH A POLICY MAY 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: _____ Date: _____

Name of Agent: _____

Submitted by: _____ Date: _____

Address: _____

Program Administered By:



CM&F Group, Inc.

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

Ph: (212) 233-8911 or (800) 221-4904 Fax: (212) 962-5422

<http://www.cmfgroup.com>