



805 East Broward Boulevard, Suite 303 Fort Lauderdale, FL 33301
www.sabalinsurance.com

Please Fax Your Completed Application to:

Monica Gomez at **FAX 800 915 3922**. Thank you!

First Name: _____ Last Name: _____

Mailing Address: _____
(street) (city) (state) (zip code)

Phone: _____ Email address: _____ License Number: _____ State of Licensure: _____

- o Has your license ever been suspended or revoked? Have you ever been the subject of an ethics investigation by a state or professional licensing agency?
 Yes No
If yes please attach a separate document with your explanation
- o Have you ever been treated for substance abuse? Yes No
If yes please attach a separate document with your explanation
- o Have you ever had a claim made against you or do you currently have reason to believe a claim might be made against you? Yes No
If yes please attach a separate document with your explanation
- o Has your professional liability insurance ever been cancelled or non-renewed? Yes No
If yes please attach a separate document with your explanation

I am a

Aide	<input type="checkbox"/>	Licensed Practical Nurse	<input type="checkbox"/>
Licensed Vocational Nurse	<input type="checkbox"/>	Registered Nurse	<input type="checkbox"/>
Certified Nurse Specialist	<input type="checkbox"/>	Physicians Assistant	<input type="checkbox"/>
Nurse Practitioner	<input type="checkbox"/>	Advanced Practice Nurse	<input type="checkbox"/>
Nurse Midwife	<input type="checkbox"/>	Nurse Anesthetist	<input type="checkbox"/>

- o If you are a Registered Nurse or a Certified Nurse Specialist which area do you primarily work in? Obstetrics Other
- o If you are a Physician's Assistant, Nurse Practitioner or an Advanced Practice Nurse which area do you primarily work in?
Obstetrics Psychiatry Pediatrics Surgical Other

If you are a Nurse Midwife

- o Do you work under the auspices of an Obstetrician who carries Professional Liability Limits of at least \$250,000/\$75,000? OR Is your Obstetrician board certified with hospital privileges? Yes No
- o Do you deliver exclusively in a hospital or other institutional setting? Yes No
- o Are you ACNM Certified? Yes No

Policy and Coverage Information

- o What coverage do you desire? Claims Made Occurrence
- o What limits do you desire? \$100,000/\$300,000 \$250,000/\$750,000
- o Desired policy effective date? ____/____/____
- o Do you currently have professional liability coverage? Yes No
- o If you have coverage, what is the expiration date of the policy? ____/____/____
- o If you currently have professional liability coverage, is it: Claims Made Occurrence
- o If your current coverage is Claims Made what is the retro date of the policy? ____/____/____
- o If your current coverage is Claims Made do you desire Nose Coverage? Yes No
- o If located in Florida, what part of the state is the majority of your practice in? Broward/Dade Remainder of State
- o Do you work part time (20 or fewer hours per week)? Yes No
- o Are you a member of The Florida Nurses Association (Members receive a 10% credit)? Yes No
- o Are you a member of your state's nurses association? Yes No If so, what state? _____

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

I understand that by checking the box below that I am attesting that the above statements are true and accurate and that they will be the basis for the insurance of a professional liability contract. I Agree

I understand that by checking the box below that I am attesting that I have the read the Subscription Agreement and Investor Letter. I Agree

_____ Print your name _____ Signature _____ Date