



## **Malpractice Insurance For Registered Nurse/Licensed Practical Nurse**

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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, you will be notified by email within 5-7 business days of confirmation of coverage. Your payment -- whether by check or credit card -- will NOT be processed until your coverage has been approved.

Mail Completed Application To:  
**CM&F Group, Inc.**  
99 Hudson Street, 12th Floor  
New York, New York 10013-2815  
(212)233-8911 (800)221-4904  
Fax (212)608-4378  
info@cmfgroup.com

Underwritten By:  
**Granite State Insurance Company**  
(A Capital Stock Company)  
2704 Commerce Drive, Suite B  
Harrisburg, PA 17110

**GENERAL HEALTHCARE PROVIDER PROFESSIONAL LIABILITY  
Nurse Guard Application**

1. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Apartment No. \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Professional License # \_\_\_\_\_

2. How did you hear about us?  
 Convention  Colleague  Advertisement  Mail  CM&F Group Website  Association (Please List)  Other

3. Please indicate your profession:  RN  LPN/LVN

*\*I understand that if I am a Nurse Anesthetist or Certified Nurse Midwife, I am not covered by this policy.*

4. Please indicate Limits of Liability desired (please check one):  \$500,000/\$1,000,000  \$1,000,000/\$6,000,000  \$2,000,000/\$4,000,000

**Are you an Indiana Resident electing to participate in the Indiana Patient's Compensation Fund?**  Yes  No  
**If yes, your Limit of Liability will be \$250,000/\$750,000**

5. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had your professional privileges suspended by any court or administrative agency or ever been the subject of any ethics investigation at a local, state or national level?  
 Yes  No If yes, please attach a separate sheet with full particulars

6. Has any insurance ever been cancelled or non-renewed?  
**\*NOTE: Missouri Residents Do Not Respond.**  Yes  No

7. Has any malpractice claim or suit ever been brought against you?  Yes  No If yes, please attach a separate sheet with full particulars.

8. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you?  Yes  No  
If yes, please attach a separate sheet with full particulars.

9. Please list your prior professional liability insurance, if any.

INSURANCE CARRIER	POLICY NUMBER	LIMITS	PREMIUM	EFFECTIVE DATES

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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS AND NEW MEXICO 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 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 THERE-TO, 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 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 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 AND VIRGINIA 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

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

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

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

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

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

74833 (1/00)

**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  
nurse@cmfgroup.com

**Florida Applicants:**  
Richard J.J. Sullivan, Jr. Non Resident License #A257825

**California Applicants:**  
CMF Group, Inc. Non Resident CA License #OC3688713