



# Radiologist Assistant Individual Professional Liability Insurance Application – Claims-Made Form

**Yes, I want Registered Radiologist Assistant (R.R.A.) Individual Professional Liability Insurance, based on the limits of liability I have selected. I understand that the limits of liability issued will be commensurate with those of my supervising radiologist, and I need to document this by enclosing a copy of my supervising radiologist’s current Declarations Page. Absent this documentation, my limits of liability will be subject to state maximums as defined by the Program.**

## A. GENERAL INFORMATION

RRA – R5WW9WA

Please answer ALL questions and SIGN and DATE this form. Incomplete applications cannot be processed.

1. Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY  
 City: \_\_\_\_\_ Day Telephone #: (\_\_\_\_\_) \_\_\_\_\_  
Area Code  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Night Telephone #: (\_\_\_\_\_) \_\_\_\_\_  
Area Code  
 County: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
 E-Mail \_\_\_\_\_

## B. PRACTICE INFORMATION

### 2a. I primarily work at a (an) (choose one):

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Comm. Health Facility (02) | <input type="checkbox"/> Hospital – In-Patient Unit (31) | <input type="checkbox"/> Outpatient Facility (16)        | <input type="checkbox"/> Surgicenter (13)   |
| <input type="checkbox"/> Emergency Unit (27)        | <input type="checkbox"/> Hospital – Operating Room (30)  | <input type="checkbox"/> Primary Physician Clinic (32)   | <input type="checkbox"/> Trauma Center (29) |
| <input type="checkbox"/> Hospice (06)               | <input type="checkbox"/> Nursing Home/LTC (08)           | <input type="checkbox"/> Specialty Physician Clinic (33) | <input type="checkbox"/> Other (15) _____   |

### 2b. Employment Status:

- Employed**, defined as providing services on behalf of an entity you do not own, and receiving a W-2 Form from your employer.  
 If employed, name of your employer: \_\_\_\_\_
- Self-employed**, defined as providing services as an independent contractor and paying self-employment taxes using a 1099 Form.  
 If you are incorporated with or without employees, please call **1-888-288-3534**.  
**Self-employed R.R.A.s** must include a copy of their supervising radiologist’s Declarations Page with this application in order to be considered for coverage. If you are an R.R.A. reporting to multiple radiologists, or cannot otherwise provide the required Declarations Page, please call 1-866-216-8166 for assistance with your application.

- 2c.  Full-time R.A. (check only if total hours worked is greater than 24 hours per week)  
 Part-time R.A. (check only if total hours worked does not exceed 24 hours per week; eligible for 35% discount off the full-time rate)  
 Student R.A.

2d. Are you a member of the American Society of Radiologic Technologists (ASRT)?.....  Yes  No  
*You must be a member of ASRT in order to be eligible for coverage; sign up at [www.asrt.org](http://www.asrt.org) or call (800) 444-2778, then press 5*

2e. Did you pass the ARRT post primary certification test for the Registered Radiology Assistant? .....  Yes  No

### 3. Please check the coverage limits you would like (Per Claim/Aggregate). For limits other than \$1,000,000/\$3,000,000, please call 1-866-216-8166 for your rate.

- a.  \$100,000/\$300,000    b.  \$200,000/\$600,000    c.  \$250,000/\$750,000    d.  \$500,000/\$1,000,000  
 e.  \$1,000,000/\$3,000,000

To qualify for the highest possible limits you must enclose a copy of your supervising radiologist’s current Declarations Page with your application. Without it, your limits of liability will be subject to state maximums as defined by the Program.

If you practice in Indiana or Louisiana, you must participate in the Patient’s Compensation Fund, and you will be subject to \$250,000/\$750,000 and \$100,000/\$300,000 limits, respectively.

**C. COVERAGE INFORMATION**

4. Do you need Prior Acts Coverage? (If so, you must provide the Retro Date of your current policy, found on the Declarations Page. For important details on Retro Date, see "Important Notice About Claims-Made Coverage" on page 4 of this application.)  
If requesting prior acts, please include a copy of your claim loss data from your previous insurance carrier.

Yes, I need Prior Acts Coverage. My Retro Date is \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

(If requesting Prior Acts, please include a copy of your Declarations Page and a copy of your claim loss data from your current insurance carrier.)

No, I do not need Prior Acts Coverage. I have read and understand "Important Notice About Claims-Made Coverage" on Page 4.

5. Enter your annual premium. \$ \_\_\_\_\_ Refer to Page 3 for instructions.

6. Requested Effective Date of Coverage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

(Must be within 60 days from the date we receive your application. If date indicated is prior to receipt date or if not filled out, the effective date will be the receipt date.)

7. Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than for non-payment of premium? (Not applicable for MO residents) .....  Yes  No

8. Has any claim or lawsuit for malpractice ever been brought against you or are you aware of any incidents that may result in a claim or lawsuit? .....  Yes  No

9. Within the last 5 years, have you been the subject of complaints, charges, or disciplinary action against you for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of your profession? .....  Yes  No

(If you have answered "yes" to questions 7, 8, or 9, please provide complete details on a separate sheet of paper and attach to application.)

**Insurance Agent: Michael J. Loughran Iowa License #IA241616; Florida License #A158896**

**PAYMENT OPTIONS:**

Enclosed is my check.\* (Payable to: HPSO) | Charge my credit card.  AMEX  Discover  MasterCard  Visa  
 Bill me for the annual premium. |  Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_ / \_\_\_\_  
MM YYYY

\* To pay by check, residents of NJ, WV and FL must first add a state mandated surcharge to your base premium (NJ: 1.4%, WV: 0.55%, FL: 2.51%). All applicants must add a Healthcare Providers Service Organization Purchasing Group Membership Fee (\$1.00 for Professionals/\$.50 for Students). To calculate your total amount due, please add your base premium, state surcharge (if applicable) and membership fee. If you are paying by credit card, your card will be charged as detailed above.

I have answered these questions to the best of my knowledge. I certify that I hold the highest credentials or standards appropriate for the healthcare profession for which I have applied as mandated by my state guidelines. I have not withheld any information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I understand that a state mandated surcharge will be added to my annual premium if I am a resident of NJ (1.4%), WV (0.55%) or FL (2.51%). I have read and consent to the compensation terms on page 4.

**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 New York residents only: 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 Pennsylvania Residents only: and subjects such a person to criminal or civil penalties.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

**Applicant Signature X** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

**This application must be fully completed, signed and dated in ink. We will issue your certificate of insurance upon approval. You may fax the completed application to 800-701-1986 or mail it to HPSO, 159 E. County Line Road, Hatboro PA 19040-1218.**

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company and is offered through the Healthcare Providers Service Organization Purchasing Group.

All products and services may not be available in all states and may be subject to change without notice. CNA is a service mark and trade name registered with the U.S. Patent and Trademark Office.

Healthcare Providers Service Organization is a division of Affinity Insurance Services, Inc.; in CA (License #0795465), MN & OK, AIS Affinity Insurance Agency, Inc.; and in NY, AIS Affinity Insurance Agency.

Please see page 4 of this application for compensation disclosure information.



# Registered Radiologist Assistant Individual Professional Liability Insurance Application—Claims-Made Form

## COVERAGE

Up to \$1,000,000 per claim / up to \$3,000,000 aggregate claims-made professional liability insurance.  
For more information on how claims-made coverage protects you, visit [www.hpsso.com/ra](http://www.hpsso.com/ra).

## ANNUAL RATES

The rates below are Class A rates. Territories not listed are not available for coverage at this time.

<b>Tier 1:</b> AL, AR, IA, ID, IN, ME, MN, MT, NC, ND, NE, NH, OK, OR, RI, SC, SD, TN, VA, VT, WA, WI					
	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Mature</b>
<b>Professional (Full-time)</b>	\$1,131	\$2,015	\$2,722	\$2,969	\$3,500
<b>Professional (Part-time<sup>1</sup>)</b>	\$735	\$1,310	\$1,769	\$1,930	\$2,275
<b>Student<sup>2</sup>:</b>	N/A	N/A	N/A	N/A	\$150

<b>Tier 2:</b> AK, AZ, CA (all but Los Angeles, Orange, San Bernardino and Riverside Counties), CO, DC, DE, FL (all but Dade, Broward, Palm Beach, Brevard, Orange, Hillsborough and Pinellas Counties), GA (all but Fulton County), IL (all but Cook, Madison, St. Clair and DuPage Counties), KS, KY, MA, MD, MI (all but Macomb, Wayne, Oakland and Monroe Counties), MO, MS, NV (all but Clark County), OH (all but Cuyahoga, Geauga, Lake, Lorain, Medina, Montgomery and Summit Counties), PA (all but Bucks, Chester, Delaware, Montgomery, Philadelphia and Allegheny Counties), Texas (all but Brazoria, Cameron, Harris, Hidalgo, Jefferson, Nueces, San Patricio, Starr and Webb Counties), UT and WY					
	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Mature</b>
<b>Professional (Full-time)</b>	\$1,228	\$2,188	\$2,955	\$3,224	\$3,800
<b>Professional (Part-time<sup>1</sup>)</b>	\$798	\$1,422	\$1,921	\$2,096	\$2,470
<b>Student<sup>2</sup>:</b>	N/A	N/A	N/A	N/A	\$150

Rates shown are for \$1,000,000/\$3,000,000 limits of liability. For lower limits, please call 1-866-216-8166 for your rate.

<sup>1</sup>Part-time R.A.s are eligible for a 35% discount off the full-time rate.

<sup>2</sup>Student R.A.s should complete this application but will be insured under an occurrence-form policy and pay the mature annual rate of \$150 for fixed limits of liability of up to \$1,000,000 per claim / up to \$3,000,000 aggregate.

## DETERMINING YOUR RATES

Rates for a claims-made policy increase automatically over a number of years to reflect accumulating risk, until they reach a maximum or "maturity." **If you are newly licensed or you are currently insured under an occurrence policy,** you would pay the premium listed under the "Year 1" column in the chart above. Please enter this premium on Page 2 of the application where indicated. You do not need to enter a Retro Date because it will be the same as your effective date.

**If you have been insured under a claims-made policy and wish to continue your coverage without interruption** you must include a copy of your current Declarations Page with this application. Please enter the Retro Date of your current policy (found on the Declarations Page), and the requested effective date of your new policy, on this application where indicated. To determine the appropriate rate, first note the number of years that have elapsed between the dates you provided above. Fractional years of six months or more are rounded UP; less than six months rounded to the next lower year. Once you have calculated the correct number of years, add 1 to this total to represent the current year, and this number is the basis for your coverage. If the total is 5 years or more, you would pay the "Mature" rate listed on the chart above. Totals of less than 5 years pay the appropriate premium listed in the matching column. Please enter the total premium you have selected on Page 2 of this application where indicated.

If you do not require Prior Acts coverage, please check the appropriate box on question 4 of this application. If you have any questions or need help with this application, or if you would like information on Prior Acts coverage for services performed before the effective date of this policy, please call 1-866-216-8166 for assistance.

## AN IMPORTANT NOTICE ABOUT CLAIMS-MADE COVERAGE – PLEASE READ

If you are currently insured under a claims-made policy, it is important that you continue your coverage without interruption when moving to a new policy. By providing HPSO with the Retroactive Date or “Retro Date” of your expiring policy, upon approval of your application, your new policy will provide you with continuous coverage. This means that any medical incident that might occur on or after your Retro Date may be covered under your new policy.

If you do not provide your current Retro Date on this application, and do not elect to purchase Extended Reporting Period coverage from your former insurer (“tail coverage”), your previous claims-made coverage will lapse. It will no longer respond to any claims that may arise for that original policy period – and neither will your new policy. This could leave you completely unprotected or “bare”.

### COMPENSATION and OTHER DISCLOSURE INFORMATION

Healthcare Providers Service Organization (HPSO), a division of Affinity Insurance Services, Inc., exclusively offers the HPSO Program as an agent of CNA and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 20% of your paid premium as commission for marketing the program and 20% for underwriting, policy management, billing, risk management, and client services. In addition, Affinity receives \$0.48 annually per paid policy as commission for claim handling for the License Protection coverage extension of the professional liability insurance policy. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer. However, Affinity may charge a Healthcare Providers Service Organization Purchasing Group Membership Fee.

Your signature on your application, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Affinity.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at [http://www.aon.com/market\\_relationships](http://www.aon.com/market_relationships) for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

### Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit [http://www.aon.com/market\\_relationships](http://www.aon.com/market_relationships) for more detail on these agreements.