



Connecticut Medical Insurance Company

Somerset Square
80 Glastonbury Boulevard
P O Box 71
Glastonbury, CT 06033
860.633.7788
(CT only) 800.228.0287
Fax: 860.633.8237
(CT only) 800.403.3580
www.cmic.biz

Two empty rectangular boxes for stamp or signature.

Application for Physicians Professional Liability Insurance - Claims Made (Please type or print in ink)

Empty rectangular box for stamp or signature.

A. PERSONAL INFORMATION

- 1. Applicant Name (First, Middle, Last, Professional Designation)
2. Business Mailing Address (Street)
3. Home Address (Street)
4. Office Manager Name
5. Office Telephone No.
6. Office Fax No.
7. Home Telephone No.
8. E-mail
9. Date of Birth
10. Social Security No.
11. Sex M F
12. Names of business(es) which you own or for whom you work - include names under which you are doing business (DBA)
13. Have you ever applied to or been insured by CMIC in the past? Yes No

B. CURRENT PRACTICE INFORMATION

- 1. Connecticut Medical License No. Expiration Date
2. DEA License No.
3. Connecticut Controlled Substance No.
4. Business Organization (check each of the following that applies to your practice)
5. Name of corporation, solo corporation, partnership, DBA or employer, if applicable.
6. As a sole shareholder, is coverage for your entity or business organization desired? Yes No Entity will share your limits. Attach incorporation documents.

Two empty rectangular boxes for stamp or signature.

7. Are you a member in good standing of the Connecticut State Medical Society? Yes No Pending
8. Desired Effective Date ____/____/____ (Effective date of coverage must be subsequent to the date this application is received by CMIC)
9. Do you practice in whole or in part outside the state of Connecticut or read or interpret diagnostic tests that were performed outside the state of Connecticut? Yes No

If Yes, where? State _____ County _____

- a. How many hours per week do you practice out-of-state? _____
- b. How many patients per week do you see out-of-state? _____
- c. How many diagnostic tests do you read or interpret each week that were performed out-of-state? _____
- d. What percentage of your total practice is out-of-state? _____%

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10. a. Please list below all hospitals where you hold or are applying for privileges and the percentage of hospital time worked at each. Percentages should add up to 100%.
 10. b. Please send Certificate(s) of Insurance to the following entities:

Name	%	Name

11. How many of the following health care professionals* are employed by you or your solo corporation?

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)
<input type="checkbox"/> Student Registered Nurse Anesthetist (SRNA)
<input type="checkbox"/> Registered Nurse Midwife
<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Advanced Practice Registered Nurse/
Nurse Practitioner | <input type="checkbox"/> Physical Therapist
<input type="checkbox"/> Optician
<input type="checkbox"/> Podiatrist
<input type="checkbox"/> Other _____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|

*CMIC can provide a separate policy and limits of liability. A separate application for coverage is required.

12. Are you in compliance with all State Regulations related to collaboration with or supervision of the health care professionals you employ? Yes No
13. Do you employ or contract services with any physicians? Yes No
 If Yes, please attach a copy of his/her current professional liability Declarations Page (facesheet) and complete below.

Name	Specialty	
		Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" style="display: inline-table; width: 50px; height: 20px; vertical-align: middle;"></table>
		Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" style="display: inline-table; width: 50px; height: 20px; vertical-align: middle;"></table>

14. Do you properly maintain and/or operate all computer hardware, computer software, related computer products or computerized data that you own, lease, license or process? Yes No

C. EDUCATION

Complete this section or attach a copy of your Curriculum Vitae

1. Name and Location of Medical School _____

Year Graduated _____

If foreign medical school graduate, are you certified by the Educational Council for Foreign Medical Graduates?

Yes No —If No, explain _____

2. Subject and location of medical residency(s) and fellowship(s) served

_____ From ____/____/____ To ____/____/____

_____ From ____/____/____ To ____/____/____

Date residency completed ____/____/____ Date fellowship completed ____/____/____

3. Name all the places where you have practiced (excluding residency or fellowship training)

_____ From ____/____/____ To ____/____/____

_____ From ____/____/____ To ____/____/____

D. COVERAGE INFORMATION

1. Medical Specialty _____ 2. Sub-Specialty _____

Board Certified Yes No

Board Certified Yes No

Name of Specialty Board _____

Name of Specialty Board _____

Date of Certification ____/____/____

Date of Certification ____/____/____

Date of recertification (if applicable) ____/____/____

Date of recertification (if applicable) ____/____/____

3. List all professional liability insurance companies that have provided coverage for you in the past five years.

_____ From ____/____/____ To ____/____/____

_____ From ____/____/____ To ____/____/____

4. Current professional liability insurance company _____

5. Current form of insurance: Occurrence Claims Made Attach a copy of your current Declarations page (facesheet).

- When changing insurance carriers, it is not always necessary to buy an "Extended Reporting Period Endorsement" ("tail" coverage) from your existing carrier. Under many circumstances, purchasing "Prior Acts" coverage from your new carrier can be as effective and substantially less expensive than purchasing "tail" coverage. If you are currently insured for professional liability for a practice in Connecticut under an individual claims made policy, you may be eligible for Prior Acts coverage through CMIC. If you are interested in purchasing Prior Acts coverage, please talk to a CMIC representative.

*Prior Acts coverage provides coverage for claims first made and first reported after the cancellation date of your coverage with your current carrier and the commencement of your policy with CMIC arising out of treatment rendered since the retroactive or prior acts date of your current policy. CMIC Prior Acts coverage does not cover claims or suits of which you are aware or have reason to be aware prior to the effective date of your coverage with CMIC. Nor does Prior Acts coverage include coverage for potential claims or suits arising out of acts or omissions that you knew or had reason to know, prior to the effective date of your coverage with CMIC, might reasonably lead to a claim or suit. These matters must be reported to your current carrier prior to the effective date of your coverage.

F. CLAIMS INFORMATION

TO BE COMPLETED BY ALL APPLICANTS

1. Are you aware of **ANY** circumstances, including but not limited to the following, that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:
 - a. Patient or attorney request for records for reasons other than workers' compensation or accident claims;..... Yes No
 - b. A letter from an attorney regarding your medical treatment of a patient;..... Yes No
 - c. Intra-operative complications or other complications resulting in death, paralysis or other disabilities; Yes No
 - d. Patient or family member has expressed significant dissatisfaction with the medical care you provided;..... Yes No
 - e. You are currently or were treating a patient who is suing another physician or hospital for the same treatment at issue; Yes No
 - f. Patient or family member has filed a complaint against you with the Department of Public Health or other agency; Yes No
 - g. Any other circumstance that might reasonably lead to a claim or suit?..... Yes No
2. Has **any** claim or suit for alleged malpractice **EVER** been brought against you Yes No

If any Yes answers to the above questions, complete the following sections. / _____

Patient's Name	Age of Patient	Sex
Insurance Provider	Date of Occurrence	
Allegations _____		

Status of claim, suit or incident	Amount of settlement (or if pending, amount in reserve by carrier) \$	

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Insurance Provider	Date of Occurrence	
Allegations _____		

Status of claim, suit or incident	Amount of settlement (or if pending, amount in reserve by carrier) \$	

3. If you answered yes to questions 1 or 2, have all potential claims, claims or suits (regardless of merit) been reported to your current or a prior professional liability company?..... Yes No

G. UNDERWRITING INFORMATION

Please explain, on a separate sheet, any Yes answers.

- 1. Has **any** hospital or other health care facility **ever** denied, suspended, non-renewed, revoked, declined or in any way restricted your privileges or has probation **ever** been invoked?..... Yes No
- 2. Have you **ever** voluntarily agreed to surrender your hospital or other health care facility privileges?..... Yes No
- 3. Have you **ever** voluntarily agreed to modify your hospital or other health care facility privileges?..... Yes No
- 4. Has your medical license **ever** been suspended, revoked, voluntarily surrendered or has probation or any limitations **ever** been invoked? Yes No
- 5. Has your narcotics license **ever** been suspended, revoked, voluntarily surrendered or has probation or any limitations **ever** been invoked? Yes No
- 6. Have you **ever** signed a consent order or consent agreement with a state health department, state licensing board or other governmental body? Yes No
- 7. Have you **ever** been investigated by a state health department, state licensing board or other governmental body? Yes No
- 8. Have any complaints **ever** been registered against you with any employer, medical association/society, specialty board, hospital or other health care facility or state licensing authority or other governmental body? Yes No
- 9. Have you **ever** been denied certification by a specialty board?..... Yes No
- 10. Has any insurance company **ever** cancelled, non-renewed, denied you professional liability insurance or offered you professional liability insurance only on special or restricted terms? Yes No
- 11. Have you **ever** been arrested for any criminal offense in the past ten years, **excluding** misdemeanors?..... Yes No
- 12. Are any of the action in Items 1-11 above currently under investigation?..... Yes No
- 13. Do you now or have you **ever** had any defect, illness or disorder, whether physical, mental or emotional, that limits or impairs, has limited or impaired or **COULD** limit or impair your ability to practice to any degree? Yes No
- 14. Do you now or have you **ever** had a drug or alcohol addiction or dependency?..... Yes No

H. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to Connecticut Medical Insurance Company, P.O. Box 71, Glastonbury, CT 06033

Initial Here

Please read the following carefully, then sign and date the application in the space provided below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. **I AGREE** to notify the Connecticut Medical Insurance Company (the "Company") promptly of any material changes in the information I have provided herein. **I UNDERSTAND** that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes herein between the Company and any and all hospitals where I have privileges or any other entity to which the Company provides a Certificate of Insurance. This authorization does not create any obligation for the Company to release or exchange such information.

DISCLOSURE AUTHORIZATION

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record of knowledge concerning any of the statements and answers made by me herein to release such information the Connecticut Medical Insurance Company ("Company") and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues. **I AUTHORIZE** the Company and such representatives to use a copy of this authorization in place of the original.

This authorization shall be valid for the period during which I am insured by or am seeking insurance from the Company. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

Signature of Applicant

Date

Underwriting Manager Approval

Date