Requested Coverage Effective Date: __ – __ – ____ 12:01 AM

Policy Number: ____________

The Medical Protective Company

Physician Entity (Corporation/Partnership) Professional Liability Insurance Application

For Faster Service, Please Enter Your Application online at WWW.MEDICALPROTECTIVE.COM

APPLICATION INSTRUCTIONS

If additional space is needed, please use supplemental form

A. For coverage to exist, you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. If the entity is a corporation of any type, please attach a copy of Articles of Incorporation. ***Additional documentation pertaining to the entity's existence and operations may be requested by the company as necessary.***

B. A copy of the entity organizational chart (flowchart) listing any subsidiaries, joint ventures, etc. including a brief description of how they interact and copies of contracts between the entities, may be requested by the company as necessary.

C. A copy of your most recent entity professional liability policy (including all endorsements), may be requested.

D. Answer all questions; if a question is not applicable, state "N/A" NOT APPLICABLE.

E. If space is insufficient to provide your complete answer to any question, please make copies of the page or use the Supplemental Section.

F. Complete Roster of Staffing for all individuals employed by, under contract to or having any type of ownership interest in the entity.

G. Please read and initial the State Statutory Requirement in Section IX. of the application. Applications will not be processed without completion of this statutory requirement.

I. ORGANIZATION INFORMATION

If additional space is needed, please use supplemental form

A1. TYPE OF LEGAL ENTITY (Please put an "X" in the applicable spaces)

- ☐ Professional Corporation - sole shareholder
- ☐ Professional Corporation - multiple shareholders
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Corporation (LLC)
- ☐ General Business Corporation
- ☐ Governmental (State, Local, or Federal including not-for-profit)
- ☐ Other (please explain): ____________

A2. TYPE OF ORGANIZATION (Please put an "X" in the applicable spaces)

- ☐ Community Based Health Center
- ☐ Emergency/Walk-in Center
- ☐ General Hospital
- ☐ Home Health Care
- ☐ Hospital - Industrial
- ☐ Laboratory (Pathology)
- ☐ Managed Care Organization/Managed Services Organization
- ☐ MRI/CT (Fixed/Mobile)
- ☐ Nursing Home
- ☐ Outpatient Surgical Center
- ☐ Physical Fitness Center
- ☐ Physical Therapy Center
- ☐ Psychiatric/Substance Abuse Center
- ☐ Rehabilitation/Chronic Disease
- ☐ Renal Dialysis
- ☐ Standard Medical Practice
- ☐ State/County Health Department
- ☐ University/Teaching Facility
- ☐ Other (please explain): ____________

B. ENTITY NAMES: (As Stated in the Articles of Incorporation and All Formal Entity/Clinic Names. Failure To Provide Complete Names May Void Coverage).

ENTITY NAME

Federal Tax I.D. Number

C. IF THE ABOVE ENTITY DOES BUSINESS UNDER ANY OTHER NAME, PLEASE LIST ALL ADDITIONAL ENTITY/CLINIC NAMES (e.g. DBA, fictitious, etc.):

D. IS THIS ENTITY ASSOCIATED WITH A CURRENT MEDICAL PROTECTIVE INSURED? ☐ YES ☐ NO

If yes, please provide the Individual, Corporation or Partnership policy and group number if known.

Policy#: ______ Group#: ______ Sub-Group#: ______

I. ORGANIZATION INFORMATION (Continued)

If additional space is needed, please use supplemental form

E. OFFICE LOCATIONS OF PRACTICE (LIST PRINCIPAL LOCATIONS FIRST) TOTAL OF ALL LOCATIONS MUST EQUAL 100%

1.

% Of Practice NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

FROM MM - YYYY ***TO*** MM - YYYY

2.

% Of Practice NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

FROM MM - YYYY ***TO*** MM - YYYY

3.

% Of Practice NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

FROM MM - YYYY ***TO*** MM - YYYY

F. IN WHICH STATE(s) IS THIS ENTITY AUTHORIZED TO DO BUSINESS?

State of Incorporation: ______________________

Certificate of Authority: ______________________

G. PREFERRED MAILING/BILLING ADDRESS: ☐ Office# __________ ***(FROM SECTION E)*** ☐ Other ***(PLEASE ENTER BELOW)***

SUITE NUMBER & STREET

CITY STATE ZIP CODE -

H. PREFERRED METHOD OF CONTACT ☐ E-MAIL ☐ BUSINESS FAX ☐ BUSINESS PHONE

CONTACT (OR OFFICE MANAGER)

LAST NAME FIRST NAME

TITLE

E-MAIL ADDRESS

BUSINESS FAX - - BUSINESS PHONE - -

II. GENERAL INFORMATION *If additional space is needed, please use supplemental form*

If additional space is needed for an explanation(s), attach a separate page and reference the related question number with the answer.

A. *DOES THE ENTITY USE A COLLECTION AGENCY THAT HAS THE AUTHORITY TO FILE COLLECTION SUITS WITHOUT YOUR KNOWLEDGE?* ☐ YES ☐ NO ☐ N/A

If yes, please explain: ____________________

B. *HAS YOUR ORGANIZATION OR ANY OF YOUR EMPLOYEES:*

1. Ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association? ☐ YES ☐ NO
   If yes, please explain and include dates and individuals involved:
   Individual(s) ____ From: MM - YYYY To: MM - YYYY Explanation ____

2. Ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ YES ☐ NO
   If yes, please explain and include dates and individuals involved:
   Individual(s) ____ From: MM - YYYY To: MM - YYYY Explanation ____

3. Ever had any professional liability insurance refused, declined, canceled or nonrenewed by the insurance company? ☐ YES ☐ NO
   If yes, please explain and include dates and individuals involved:
   Individual(s) ____ From: MM - YYYY To: MM - YYYY Explanation ____

C. *DOES THE ENTITY OWN OR OPERATE ANY LABORATORY?* ☐ YES ☐ NO

1. Is the laboratory providing services solely for your patients? ☐ YES ☐ NO
   If no, please explain: ____________________

D. *DOES THE ENTITY MAINTAIN CURRENT CERTIFICATES OF INSURANCE ON FILE FOR ALL DOCTORS AND ALLIED HEALTH CARE PROVIDERS EMPLOYED, CONTRACTED OR PRIVILEGED AT THIS FACILITY?* ☐ YES ☐ NO

If no, please explain: ____________________

E. *WILL THE ENTITY BE PERFORMING ACTIVITIES THAT WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY?* ☐ YES ☐ NO

If yes, state practice name, location and carrier name.

Practice Name	Location	Carrier Name

F. *HAS THE ENTITY PERFORMED ANY CONTRACT WORK FOR OR ENTERED INTO ANY CONTRACT OR AGREEMENT (WRITTEN OR ORAL) WITH ANY ENTITY/CITY/COUNTY/STATE/FEDERAL AGENCY/CLINIC INCLUDING PROVIDING CARE AT CORRECTIONAL FACILITIES, PRISONS, MENTAL HEALTH FACILITIES, VETERANS ADMINISTRATION, UNIVERSITY, MILITARY OR INDIGENT CARE, ETC.?* ☐ YES ☐ NO

If yes, please specify and explain: ____________________

G. *IS SCHEDULED PREVENTATIVE MAINTENANCE PERFORMED ON ALL BIOMEDICAL EQUIPMENT EACH YEAR BY A QUALIFIED BIOMEDICAL TECHNICIAN?* ☐ YES ☐ NO ☐ N/A

If no, please explain: ____________________

H. *DOES YOUR ORGANIZATION HAVE A WRITTEN DOCUMENT THAT DEFINES THE SERVICES PROVIDED IN YOUR OFFICE?* ☐ YES ☐ NO

I. *DOES YOUR ORGANIZATION HAVE AN ESTABLISHED PROCESS FOR FOLLOWING-UP ON PATIENT DIAGNOSTIC AND LAB TEST RESULTS?* ☐ YES ☐ NO

If yes, please provide the implementation date: MM - YYYY

If yes, does the process include: (Check all that apply)

1. Results reviewed by the doctor and documented? ☐ YES ☐ NO
   If no, please explain: ____________________
2. Decision on care documented? ☐ YES ☐ NO
   If no, please explain: ____________________
3. Patients notified promptly of test results and noted in file? ☐ YES ☐ NO
   If no, please explain: ____________________
   If no, are you willing to establish a process going forward? ☐ YES ☐ NO

II. GENERAL INFORMATION (Continued) *If additional space is needed, please use supplemental form*

J. *HAVE YOU ADDED ANY NEW SERVICES, PROCEDURES OR TREATMENTS TO YOUR PRACTICE IN THE LAST TWELVE MONTHS?* ☐ YES ☐ NO

If yes, did your practice complete:

1. A risk/benefit analysis prior to implementing? ☐ YES ☐ NO
   If no, please explain: ____________________
2. Appropriate credentialing and training of all staff? ☐ YES ☐ NO
   If no, please explain: ____________________
3. A review of existing policies and procedures for necessary updates? ☐ YES ☐ NO
   If no, please explain: ____________________

K. *DO YOU HAVE A COMPREHENSIVE SYSTEM FOR DOCUMENTING PATIENT CARE?* ☐ YES ☐ NO

If yes, does it include:

1. The clinical rationale for decisions? ☐ YES ☐ NO
   If no, please explain: ____________________
2. Patient education to help the patient make informed decisions about their health care? ☐ YES ☐ NO
   If no, please explain: ____________________
3. Documentation of patient telephone conversations and messages? ☐ YES ☐ NO
   If no, please explain: ____________________

L. *DO YOU HAVE PROCEDURES THAT SCREEN AND TRACK THE RATIONALE FOR REQUESTING HEALTH CARE RECORDS TO ENSURE THAT ONLY THE PERSON LEGALLY AUTHORIZED TO REQUEST A COPY OF RECORDS, ACTUALLY OBTAINS ACCESS TO THEM?* ☐ YES ☐ NO

If no, are you willing to establish a process going forward? ☐ YES ☐ NO

M. *DO YOU HAVE A POLICY AND PROCEDURE MANUAL IN YOUR OFFICE?* ☐ YES ☐ NO

If yes, please check the topics addressed in your manual:

☐ Human Resources	☐ Office Operations	☐ Medication Management	Other(please eplain): ____________
☐ Patient Registration	☐ Patient Care	☐ Appointment Scheduling	____________
☐ Confidentiality	☐ Documentation	☐ Billing & Collections	
☐ Health Care Records	☐ Patient Complaints	☐ Disclosure of Adverse Events	
☐ Facility Management	☐ Terminating Patient Relationship	☐ Informed Consent/Refusal	

If no, are you willing to create a manual going forward? ☐ YES ☐ NO

If yes, indicate estimated implementation date: __ __ - __ __ __ __ (MM - YYYY)

Which topics will be included:

☐ Human Resources	☐ Office Operations	☐ Medication Management	Other(please eplain): ____________
☐ Patient Registration	☐ Patient Care	☐ Appointment Scheduling	____________
☐ Confidentiality	☐ Documentation	☐ Billing & Collections	
☐ Health Care Records	☐ Patient Complaints	☐ Disclosure of Adverse Events	
☐ Facility Management	☐ Terminating Patient Relationship	☐ Informed Consent/Refusal	

N. *IF YOU PROVIDE DIALYSIS SERVICES:*

1. Is the filter changed after each patient? ☐ YES ☐ NO
2. Does all equipment used for dialysis have an automatic shut-off fail safe device to prevent backwash? ☐ YES ☐ NO

If no, for questions ***N.*** 1 or 2, please explain: ____________________

O. *IF YOU PROVIDE OUTPATIENT SURGICAL SERVICES:*

1. Is the facility accredited by either: ☐ JCAHO ☐ AAAHC ☐ YES ☐ NO
2. Do you have a medical services review committee? ☐ YES ☐ NO
3. Does your recovery room provide full time observation by a qualified healthcare provider? ☐ YES ☐ NO

If no, for questions ***O.*** 1, 2 or 3, please explain: ____________________

P. *IF YOU PROVIDE PATHOLOGY SERVICES:*

1. Is this facility approved by the College of American Pathology? ☐ YES ☐ NO
   If no, please explain: ____________________

The Company, as necessary, may request a copy of the latest CAP Test Scores

II. GENERAL INFORMATION (Continued) *If additional space is needed, please use supplemental form*

Q. IF YOU PROVIDE WALK-IN CLINIC SERVICES:

1. Are your services available 24 hours? ☐ YES ☐ NO
2. What is the average number of physician extenders supervised by a physician? ☐☐☐
3. Do any physician extenders have authorization to write prescriptions? ☐ YES ☐ NO
   If yes for questions **Q.** 1 or 3, please explain: ______________________________

R. IF YOU PROVIDE DIAGNOSTIC IMAGING/X-RAY SERVICES:

1. Do you provide any radiation therapy? ☐ YES ☐ NO
2. Who interprets the results of the test performed?

______________________________ ☐ CONTRACTED ☐ EMPLOYED
Name Specialty

______________________________ ☐ CONTRACTED ☐ EMPLOYED
Name Specialty

3. Does your facility interpret results of tests performed at facilities other than those requesting insurance through this application? ☐ YES ☐ NO
   If yes for questions **R.** 1 or 3, please explain: ______________________________

S. PLEASE INCLUDE ANNUAL NUMBERS:

Clinic visits: ☐☐☐☐☐

Surgeries: ☐☐☐☐☐

Gross Revenue: $ ☐☐☐ , ☐☐☐ , ☐☐☐

T. IN THE LAST TEN (10) YEARS,

1. Has the entity or any of the employees discontinued major surgical procedures, performance of Obstetrics, or any other medical activity? ☐ YES ☐ NO
   If yes, list procedures/activities, ***date*** discontinued and reason for discontinuing: ______________________________
2. Has the entity or any of the employees ever been representatives of a Pedicle Screw Manufacturer? ☐ YES ☐ NO
   If yes, please attach an explanation: ______________________________
3. Have any of the employees performed weight control surgery or prescribed weight control medication? ☐ YES ☐ NO
   A. If yes, what percentage of the practice (% of patient care) ***was*** devoted to prescribing anorectic drugs?
   ☐ < 1 % ☐ 1 % - 10 % ☐ 11 % - 50% ☐ > 50%
   B. If yes, what percentage of the practice (% of patient care) ***was*** devoted to performing weight control surgery?
   ☐ < 1 % ☐ 1 % - 10 % ☐ 11 % - 50% ☐ > 50%
4. Does the entity or any of the physicians have ownership interests in a weight control clinic? ☐ YES ☐ NO
   If yes, what is the name of the weight control clinic the entity or physicians are affiliated with? ______________________________

III. BUSINESS PRACTICES *If additional space is needed, please use supplemental form*

ARE ANY OF THE FOLLOWING TYPES OF PATIENT CARE SERVICES RENDERED WITHIN THE FACILITY? (Please put an "X" in the applicable spaces)

- ☐ ***These procedures are not performed***
- ☐ Abortions
  - ☐ Therapeutic-Number Per Year: ☐☐☐☐
  - ☐ Elective-Number Per Year: ☐☐☐☐
- ☐ AIDS/ARC
- ☐ Alcohol/Drug Abuse
- ☐ Alternative (Integrative/Complimentary Medicine)
- ☐ Anesthesia
- ☐ Blood Banks
- ☐ Burn Care
- ☐ Cardiac Intensive Care
- ☐ Cardiovascular Surgery
- ☐ Certified Trauma Center
- ☐ Chiropractic
- ☐ Cosmetic Plastic Surgery
- ☐ Dental
- ☐ Diagnostic Radiology
- ☐ Dialysis
- ☐ Endocrinology
- ☐ Experimental Surgery
- ☐ Genetics
- ☐ Home Health Care
- ☐ InVitro Fertilization
- ☐ Laboratory (Pathology)
- ☐ Liposuction
- ☐ Nuclear Medicine
- ☐ Obstetrics
- ☐ Open Heart Surgery
- ☐ Organ Tissue Transplant
- ☐ Osteopathic Manipulation Therapy
- ☐ Orthopedic
- ☐ Outpatient Surgery
- ☐ Patient Care
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Psychiatric
- ☐ Radiation Therapy
- ☐ Research/Experimental
- ☐ Silicone Injections
- ☐ Sports Medicine
- ☐ Tonsillectomy
- ☐ Weight Reduction

IV. ANESTHESIA INFORMATION

If additional space is needed, please use supplemental form

A. AS DEFINED BELOW, PLEASE "x" IF YOU, A SHAREHOLDER, EMPLOYEE OR INDEPENDENT CONTRACTOR TREAT PATIENTS UNDER:

☐ ***Please "X" here if this section does not apply to you.*** Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar) or nitrous oxide only. Please continue to Section V.

☐ ***Conscious Sedation Utilizing (Excluding Nitrous Oxide)*** A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

☐ Oral ☐ IM/IV

☐ ***General Anesthesia Utilizing (To include deep sedation)*** A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

B. PLEASE INDICATE WHO ADMINISTERS CONSCIOUS SEDATION:

☐ MD/D.O. ☐ RN/LPN

☐ Nurse Anesthetist/CRNA ☐ Other (specify): _______________

WHERE IS CONSCIOUS SEDATION PERFORMED?

☐ In office ☐ Licensed Surgical Center

☐ Hospital ☐ Other (specify): _______________

FOR:

☐ Own Patients

☐ Other Than Own Patients

C. PLEASE INDICATE WHO ADMINISTERS GENERAL ANESTHESIA:

☐ MD/D.O. ☐ RN/LPN

☐ Nurse Anesthetist/CRNA ☐ Other (specify): _______________

WHERE IS GENERAL ANESTHESIA PERFORMED?

☐ In office ☐ Licensed Surgical Center

☐ Hospital ☐ Other (specify): _______________

FOR:

☐ Own Patients

☐ Other Than Own Patients

D. HOW OFTEN DOES YOUR PRACTICE UPDATE HEALTH HISTORIES?

☐ Every_______ Month(s)

☐ Every Patient Visit

☐ Anytime invasive procedures are performed

E. IS THE OFFICE CERTIFIED FOR GENERAL ANESTHESIA BY A STATE ORGANIZATION? ☐ YES ☐ NO

F. IF CONSCIOUS OR GENERAL ANESTHESIA SEDATION IS PERFORMED OUTSIDE OF A HOSPITAL, HOW OFTEN DOES YOUR STAFF PARTICIPATE IN SIMULATED EMERGENCY TRAINING?

Every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other:

G. HAS THE ORGANIZATION CONFIRMED THAT ALL ANESTHESIA PROVIDERS ALLOWED INTO YOUR OFFICE HAVE PROFESSIONAL LIABILITY LIMITS EQUAL TO OR GREATER THAN YOUR LIMITS? ☐ YES ☐ NO

If no, please explain: ____

H. IF A CRNA IS UTILIZED, ARE THEY SUPERVISED ON SITE BY A DOCTOR? ☐ YES ☐ NO

If no, please explain: ____

I. IS THE ANESTHESIA PROVIDER CURRENTLY LICENSED IN YOUR STATE? ☐ YES ☐ NO

If no, please explain: ____

J. ARE INDIVIDUALS ADMINISTERING THE SEDATION CERTIFIED IN ONE OR MORE OF THE FOLLOWING? ☐ YES ☐ NO

If yes, please "x" the boxes that apply: ☐ CPR ☐ ACLS ☐ ATLS ☐ PALS

If no, please explain: ____

K. Is the following equipment utilized? ☐ YES ☐ NO

(If yes, please "x" equipment used)

*Verify that the practice will insure that all Anesthesiologists allowed in your practice will supply the following equipment

(Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital setting)

☐ Fail safe mechanisms on anesthesia machines

☐ Basic Airway Equipment

- ☐ Full Face Mask Resuscitator
- ☐ Oral and Nasopharyngeal Airways
- ☐ Endotracheal Tubes (Adult/Child size)
- ☐ Laryngoscope

☐ Sphygmomanometer/Stethoscope

☐ Electrocardiographic Monitoring Equipment

☐ Pulse Oximeter

☐ CO2 Monitor

☐ Internal/External Temperature Monitor

☐ Tracheostomy/Coniotomy Equipment

☐ Portable Suction

☐ Capnography

☐ Auxiliary Lighting

☐ Emergency Pharmaceutical Kit

☐ Direct Current Defibrillator

If no, please explain: ____

V. ROSTER OF STAFFING

If additional space is needed, please use supplemental form

Please identify all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below.

Use the following Key for Individual Status (column 7).

A. Previous Medical Protective insured requesting Medical Protective Coverage
B. Current Medical Protective insured
C. Requesting Medical Protective coverage
D. Applying for coverage elsewhere or covered elsewhere
E. Other-Including OHCP (Allied Staff) or Office Manager, etc. (requesting to share limits with the Entity)

***** Note Include all applicant(s), all health care providers and non-health care owners.***

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by a Shared Limit Additional Insured Endorsement.

	1. Last name first, then first and middle initials (i.e. Smith, J. G.)	2. Degree	3. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	4. Percentage of ownership (if shareholder or partner) Enter as a Decimal	5. Specialty (Write in)	6. Surgical Category (See Key Below)	7. Individual Status- A,B,C, D or E (See Key Above)	8. Medical Protective Policy#
1.				.				
2.				.				
3.				.				
4.				.				
5.				.				
6.				.				
7.				.				
8.				.				
9.				.				
10.				.				
11.				.				
12.				.				
13.				.				
14.				.				
15.				.				

Surgical Categories (Key): (Please use the number referenced 1-6 in lieu of writing out the specialty).

1. No Surgery.
2. Minor Surgery.
3. Assisting in surgery on your own patients.
4. Major Surgery.
5. Assisting in surgery on other than your own patients.
6. Obstetrics.

V. ROSTER OF STAFFING (Continued) *If additional space is needed, please use supplemental form*

Please provide an explanation for why coverage is not requested for any individuals where Individual Status is ***D*** on Roster.

Number from Roster	*Explanation*

VI. LOSS INFORMATION (IMPORTANT, COMPLETE FULLY) *If additional space is needed, please use supplemental form*

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

A. Has your organization or any of your employees/contractors been involved now or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization? ☐ YES ☐ NO

If yes, how many? ☐☐☐

If yes, have these been reported to your insurer? ☐ YES ☐ NO

B. Does your organization or any of your employees/contractors have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization which may give rise to a claim? ☐ YES ☐ NO

If yes, how many? ☐☐☐

If yes, have these been reported to your insurer? ☐ YES ☐ NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE COPIES OF THE REPORT(S).

VII. CLAIMS/SUIT INFORMATION FORM

(Please make copies if additional forms are needed)

If making additional copies, please enter applicant's name here: ______

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION

1. Patient/Claimant Information:

LAST NAME

FIRST NAME

AGE: Gender: ☐ Male ☐ Female

2. Date of treatment and/or surgery, which led to the allegations against you: MM - YYYY

3. Date claim/incident notice received: MM - YYYY

4. Date claim reported to prior insurer: MM - YYYY

5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: ______

6. Disposition or current status of claim or suit: ☐ OPEN ☐ CLOSED

If Closed, Date of Closing/Settlement or award : MM - YYYY

7. Indicate case value established by carrier, if known: $, ,

8. Defending Insurance carrier name: ______

CARRIER NAME

9. Claim file number, if known: ______

CLAIM NUMBER

10. Was this matter closed with your consent? ☐ YES ☐ NO

Was a suit filed? ☐ YES ☐ NO

Was payment made? ☐ YES ☐ NO

If no, was claim or suit withdrawn? ☐ YES ☐ NO

If yes, indicate total amount of settlement or award: $, ,

Amount paid on your behalf: $, ,

11. Nature of allegations in the claim or suit:

Condition treated: ______

Treatment provided: ______

Alleged negligence: ______

Alleged injury: ______

12. Please provide a narrative description of the medical facts (must include, but not limited to the type of treatment and/or surgery; your involvement): ______

VIII. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. *List all previous professional liability insurers for the entity beginning with the most recent.*

1. ______________________ Current Insurer for the Entity ☐ Claims Made ☐ Occurrence __ - __ - ____ (MM DD YYYY) to __ - __ - ____ (MM DD YYYY) ______ Deductible (if any)

2. ______________________ Insurer for the Entity ☐ Claims Made ☐ Occurrence __ - __ - ____ (MM DD YYYY) to __ - __ - ____ (MM DD YYYY) ______ Deductible (if any)

3. ______________________ Insurer for the Entity ☐ Claims Made ☐ Occurrence __ - __ - ____ (MM DD YYYY) to __ - __ - ____ (MM DD YYYY) ______ Deductible (if any)

B. *COVERAGE DESIRED*

1. ☐ Occurrence
2. ☐ Claims-Made Coverage without Prior Acts Coverage
3. ☐ Claims-Made Coverage with Prior Acts Coverage *(A copy of current declaration page showing current retroactive date must be attached for option 3)*

If 1 or 2 are selected from the above and the most recent prior coverage was issued on a Claims Made basis, please select one of the following:

☐ An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)

☐ An extended reporting endorsement has not and will not be purchased.

I ***will not*** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy.
I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy.
I understand that the policy, which I am applying from The Medical Protective Company, will not provide prior acts coverage.

☐ *Initial Here*

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claims-made and occurrence coverage or the additional expense associated with an "extension contract" or "tail coverage."

C. *REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.*
This date cannot be earlier than the expiration date of your current policy.

Annual policy terms will begin and end on the same month and day.

From: __ - __ - ____ (MM DD YYYY) *12:01 a.m.*

To: __ - __ - ____ (MM DD YYYY) *12:01 a.m.*

D. *THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:*
(Not required for occurrence policies or Claims-Made without prior acts)

__ - __ - ____ (MM DD YYYY) *12:01 a.m.*

E. *LIMITS DESIRED:* __ , ___ , ___ *per occurrence/per claims made*

__ , ___ , ___ *annual aggregate*

Note: Requested limits may not be available from this company

IX. STATE STATUTORY REQUIREMENT

NOTE: All applicants must read and initial the following:
Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

☐ Initial Here

X. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional entity, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS ***I WILL HAVE NO COVERAGE FOR ANY CLAIM*** UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding my organization, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity) I warrant that I am an Officer, Partner, Office Administrator or other Authorized Representative of the entity applying for coverage.

Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

____
Signature

Date Signed: __ __ - __ __ - __ __ __ __
MM DD YYYY

____
Print Name/Title

When would you like your quote delivered? __ __ - __ __ - __ __ __ __
MM DD YYYY

____
E-mail

FOR OFFICE USE ONLY Status: ☐ *Entity* ☐ *Entity Adding to an Existing Group* ☐ *Entity & Individual* ☐ *Groups (Not Modular)* ☐ *CNBC*

PRODUCER NAME ____________________ *PRODUCER #* ____________

PRODUCER CONTACT NAME ____________________ *TITLE (CSR, MM, etc.)* ____________

Preferred Method of Contact ☐ *E-MAIL* ☐ *FAX* ☐ *PHONE*

_______________ *E-mail*
__ __ __ - __ __ __ - __ __ __ __ *Fax*
__ __ __ - __ __ __ - __ __ __ __ *Phone*

Entity Name: ____________________

MedPro Corp. # __________ *MedPro Group #* __________ *MedPro Subgroup #* __________ *CMS #* __________

MedPro Policy # __________ *Modular Policy #* __________ ☐ New Group *Number of Insureds* __________

Billing: ☐ With Group ☐ As Individual *AT END OF POLICY PERIOD:* ☐ Renew ☐ Do Not Renew Why: __________

Comments: ____________________

XI. SUPPLEMENTAL FORM

(Attach a separate piece of paper if additional space is needed)