Medical Mutual℠
PROTECTING OUR PROFESSION

For office use only:

ALTERNATIVE EXPOSURE UNIT LIABILITY ENTITY APPLICATION

Non-Assessable Claims-Made Coverage

(Please type or print in black ink.)

REQUIRED DOCUMENTS

- **Answer all questions as they pertain to the entity. A separate application must be completed for each joint venture, partnership, or corporation.**
- **If space is insufficient to answer any questions fully, use the additional comments section at the bottom of this form, or attach separate documentation.**
- **List of operations or activities performed that are not otherwise described in the application.**
- **Copy of current insurance policy.**
- **Curi roster of active and terminated locations/providers must accompany this entity application.**

Practice

Legal Name: _____

Web Site Address: _____

Tax ID: _____ NPI Number: _____

Office Manager or Contact

Full Name: _____

E-mail Address: _____ Phone (_____) _____

Practice Mailing Address

Address Line 1	Address Line 2	
City	State	Zip Code

Practice Names

If the Applicant does business under any other name, please list all additional names:

_____

_____

Billing Address (if different from mailing address)

Address Line 1	Address Line 2	
City	State	Zip Code

Coverage

Practice State	Practice County	Desired Effective Date
		_____/_____/_____

Desired Limits (Each Claim/Aggregate)

- ☐ $ 200,000/$600,000 **(TX only)**
- ❑ $ 250,000/$750,000 **(FL only)**
- ❑ $ 500,000/$1,500,000
- ❑ $1,000,000/$3,000,000
- ❑ $2,000,000/$4,000,000
- ❑ $3,000,000/$5,000,000
- ❑ Current Cap Limit (**Available in Virginia only**)
- ❑ Other: Indicate limits desired: _____
  Limits must be approved by Underwriting

Organization

Type of Practice

PLEASE SELECT THE MOST APPROPRIATE AND COMPLETE THE APPLICABLE ROSTER/SUPPLEMENTAL FORM

❑ Emergency Center ❑ Anesthesia Services Practice ❑ Radiology Practice
❑ Certified Trama Center ❑ Urgent Care Center ❑ Other type of Practice

If other, please explain:

_____

_____

Type of Organization (select the one most appropriate)
*Note: Non-Profit Organizations must attach list of Board of Directors and Shareholders along with proof of non-profit status.**

❑ Professional Corporation ❑ Limited Liability Corporation ❑ For Profit Organization:
❑ Joint Venture ❑ Government Agency ❑ Non-profit Organization
❑ Partnership ❑ Multi-Shareholder Corporation ❑ Other: _____

Entity Ownership: (select the one most appropriate)

❑ Physician Owned ❑ Independently Owned
❑ Hospital Owned ❑ Other: _____
(Please explain)

During the next (12) twelve months, are there any plans for mergers or acquisitions, or does the facility plan on adding any additional locations?

If yes, please explain:

_____

_____

Credentialing

1. Prior to employment of staff members does the facility:
   a. Verify education background? ❑ Yes ❑ No
   b. Check all references to include past employers? ❑ Yes ❑ No
   c. Check for active licenses, license suspensions, revocations, or disciplinary actions? ❑ Yes ❑ No
   d. Check criminal history? ❑ Yes ❑ No
   e. Require medical professional liability claim history? ❑ Yes ❑ No
2. Are medical staff credentials reviewed by a medical staff committee and approved prior to granting privileges? ❑ Yes ❑ No
3. Is there a systemic process used for ongoing quality assurance review on all staff members clinical care? ❑ Yes ❑ No
4. Do medical staff by law require each contracted provider working at your facility to maintain medical professional liability insurance? ❑ Yes ❑ No
   If yes, are certificates of insurance obtained annually, coverage verified and kept on file from each individual provider? ❑ Yes ❑ No

Risk Management

1. Is there a formal risk management program? ❑ Yes ❑ No
2. Is there a full-time risk manager? ❑ Yes ❑ No
   If no, how much time is devoted to risk management?_____
3. Is the risk manager responsible for reviewing reported incidents? ❑ Yes ❑ No
4. Is there a policy and procedure in place to assure corrective action is taken assuring compliance and follow up? ❑ Yes ❑ No

5. Is there a continual quality assurance committee in place?
   a. *If yes,* is the risk manager a member of this committee? ❑ Yes ❑ No
   b. Who is the quality assurance committee accountable to? ❑ Yes ❑ No
   c. What quality metrics are monitored? Please provide a list. _____
   _____
   d. Is there an active peer review process as part of the quality assurance program? ❑ Yes ❑ No
   If no, please explain:
   _____

Underwriting Information

1. Who is the medical director of your organization? _____
2. Does the medical director have liability insurance? ❑ Yes ❑ No
3. Does the applicant plan to change any services within the next (12) twelve months? ❑ Yes ❑ No
   If yes, please provide details: _____
   _____
4. Have any services been discontinued in the last (24) twenty-four months? ❑ Yes ❑ No
   If yes, please explain: _____
   _____
5. Does the applicant have policies and procedures in place providing precautions for the treatment of disease along with an isolation area? ❑ Yes ❑ No
6. Do you provide medical services (including opinion or advice), interpret films or slides, prescribe medications, or sell any products or services via telecommunication, video, the internet and/or e-mail or other information systems? ❑ Yes ❑ No
   If yes, explain: _____
7. Does the Applicant provide Emergency Medicine Services? ❑ Yes ❑ No
   a. Has the applicant had any enforcement related to EMTALA violations? ❑ Yes ❑ No
   b. Are all the emergency department support personnel ACLS/PALS certified? ❑ Yes ❑ No
   c. Does the applicant approve Emergency Medical Services (EMS) Protocols? ❑ Yes ❑ No
   If yes, do you have liability insurance for these services? ❑ Yes ❑ No
   d. Does your organization have policies and procedures for the following:
      i. Follow-up radiology discrepancies? ❑ Yes ❑ No
      ii. Providing patients with lab results, cultures, etc., after ED visit? ❑ Yes ❑ No
      iii. A mechanism to handle patients in need of timely outpatient follow-up? ❑ Yes ❑ No
      iv. STEMI/PCI Protocols? ❑ Yes ❑ No
8. Does the applicant provide Urgent Care Services? If yes, please answer the questions below: ❑ Yes ❑ No
   a. Does the applicant have a call-back procedure in place? ❑ Yes ❑ No
   b. Does the applicant provide services other than Urgent Care? (e.g.: MedSpa, IV Infusions, Weight Loss, etc.) ❑ Yes ❑ No
   If yes, please provide details: _____
   c. If Advanced Practice Providers perform and/or interpret radiological studies, are there policies and procedures in place requiring an over-read by a radiologist? ❑ Yes ❑ No
   d. Does the applicant have written procedures in place addressing telephone advice and medication requests? ❑ Yes ❑ No
   e. Is the identity of patients verified by review of two or more forms of patient identification prior to administering medication, testing or treatment? ❑ Yes ❑ No

Insurance History

	Current Carrier	1st Prior Carrier	2nd Prior Carrier	3rd Prior Carrier	4th Prior Carrier
Insurance Company					
Policy Number					
Coverage form	❑ Claims-Made ❑ Occurrence ☐ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ☐ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ☐ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ☐ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ☐ Claims-Made Plus
Dates of Coverage	From:____/___/___ To:_____/___/____	From:___/___/____ To:____/___/_____	From:___/___/____ To:____/___/_____	From:___/___/____ To:____/___/_____	From:___/___/____ To:____/___/_____
Liability Limits					
Deductible	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____
Retroactive Date	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____

Has this medical practice or entity ever had any professional liability insurance refused, cancelled, or non-renewed? ❑ Yes ❑ No
(**The above questions should not be completed for the state of Missouri)**

Prior Acts Coverage

(NOTE: Prior Acts Coverage is optional and subject to underwriting approval. For your protection, do not forfeit your right to purchase extended-reporting period endorsement coverage from your current carrier.)

Do you desire Prior Acts coverage for this practice or entity? ❑ Yes ❑ No

If yes, Retroactive Date used by existing carrier _____/_____/_____

(Must attach current Declaration Page or Certificate of Insurance and a signature is required below)

I certify that I have no knowledge of any professional liability claims which have been asserted against this Applicant, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior or applicable carrier.

I furthermore certify that I have no knowledge of any occurrence, incident or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim, incident or circumstance should be given to your carrier if such notice has not already been provided. <u>This policy will not provide coverage for any such claim, occurrence, incident or circumstance.</u>

I certify that the above is true, complete, and correct to the best of my knowledge, information, and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

Authorized Representative of Applicant_____

Claims History

Attach current Loss Run (No more than (90) ninety-days old) for the previous (10) ten years of practice. (A *loss run* is a document from your previous professional liability carrier(s) verifying claims, suits, or reported incidents.) **Your application will not be processed without this information.**

1. Have any claims or suits been brought against the entity or medical practice, or have any incidents concerning professional services been reported? ❑ Yes ❑ No
2. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against the entity or medical practice? ❑ Yes ❑ No

   If yes, has it been reported to your current carrier? ❑ Yes ❑ No

   If no, report immediately to your current carrier. Our policy will not provide coverage for this incident. Please attach proof of reporting.

If yes to 1 or 2 above, please complete the following for each such circumstance. If you need more space, use comments section or attach additional sheet.

Patient's Name			
Date of Occurrence	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/_____	Date claim closed ____/____/_____	Amount reserved $	Amount paid $
Allegation:			

Patient's Name			
Date of Occurrence	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/_____	Date claim closed ____/____/_____	Amount reserved $	Amount paid $
Allegation:			

Authorization and Release

(This authorization and release must be signed by the Applicant.)

I, the undersigned Applicant, understand that this is an application and is not an insurance binder. **I certify the representations in this application and all supplemental information to be true and complete, and understand that the policy if issued, is conditioned upon the truth of and completeness of the representations in this application and all supplemental information. I further understand that the falsity or incompleteness of any representations made in this application and all supplemental information for insurance could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application and all supplemental information.**

I, the undersigned Applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and the company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

Signature of Applicant or Representative Date

Authorization and Release (continued)

Name and address of broker:

_____

_____

Signature of Broker Date

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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR 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 MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 NEW JERSEY 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 RESIDENTS: 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.
Please return completed application to your broker or to the Company:

Additional Comments

Question #	Comments