Medical Mutual℠
PROTECTING OUR PROFESSION

For office use only:

MEDICAL PRACTITIONER PROFESSIONAL LIABILITY APPLICATION

Non-Assessable Claims-Made, Claims-Made Plus or Occurrence Coverage

(Please type or print in black ink.)

- **Please answer all questions completely and as they relate to the coverage being applied for.**
- **If space is insufficient to answer any questions fully, use the Additional Comments Section at the bottom of this form, or attach separate documentation.**

Applicant

Full Name _____
(First) (Middle) (Last)

Gender ❑ **Male** ❑ **Female** **NPI Number:**_____

Suffix ❑ Sr. ❑ Jr. ❑ I ❑ II ❑ III ❑ IV **Professional Designation** ❑ MD ❑ DO ☐ DPM

Do you practice or have you practiced under any other name? ☐ **Yes** ☐ **No** **If yes, please list below:**

Name_____
(First) (Middle) (Last)

Social Security Number _____ **Date of Birth** _____/_____/_____

E-mail Address _____ **Fax Number** _____

Office Telephone (_____)_____ **Office Contact**_____

Billing Address (if different from mailing) _____

_____

Coverage

Practice State	Practice County	Desired Effective Date / /

1. Are you applying for coverage in a "slot" position? ❑ Yes ❑ No
   If yes, please complete the application as it relates to the intended slot duties.

2. Are you applying for coverage relating to vicarious liability (VL) for your employer? ❑ Yes ❑ No
   (VL applies when you maintain your own coverage that will remain in force. You must attach a current certificate of insurance.)

3. This application is a ☐ Request to join a physician or group currently insured with Medical Mutual under policy number:_____or
   ☐ New application with Medical Mutual.

Desired Coverage Type:

Claims-Made: ☐ **Claims-Made Plus** (check availability): ☐ **Occurrence** (check availability): ☐

Desired Limits (Each Claim/Aggregate) - Choose One Option

❑ Same As Employer
☐ $ 500,000/$1,500,000 (PA only)
❑ $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 below:
Limits must be approved by Underwriting

_____

Practice Locations (for which you are applying for coverage)

I practice at this location: ❑ Primary Practice Location

Practice Name		% of Practice
Address Line 1	Address Line 2	
City	State / Zip Code	

List Other Locations at which you Practice

Practice Name		% of Practice
Address Line 1	Address Line 2	
City	State / Zip Code	
Practice Name		% of Practice
Address Line 1	Address Line 2	
City	State / Zip Code	

Home Address

Address Line 1	Address Line 2
City	State / Zip Code
Home Phone ( )	

Prior Acts Coverage and Certification (Claims-Made only)

(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.)

Are you requesting Prior Acts coverage? ❑ Yes ❑ No If Yes, Retroactive Date used by existing carrier _____/_____/_____

(Must attach current Declaration Page or Certificate of Insurance)

I certify that I have no knowledge of any professional liability claims which have been asserted against me, 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 further more 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.

If your current professional liability insurance is a claims-made policy, are you obtaining Extended Reporting ("tail") coverage from your current insurance company? If no, please explain: ❑ Yes ❑ No

Education

Medical School		State/Country	From / /	To / /	Completed ❑Y ❑N
Residency 1	**Specialty**	**State/Country**	**From** / /	**To** / /	❑Y ❑N
Residency 2	**Specialty**	**State/Country**	**From** / /	**To** / /	❑Y ❑N
Fellowship	**Specialty**	**State/Country**	**From** / /	**To** / /	❑Y ❑N

Explain any gaps in your education history:

Practice History (for additional space, use Additional Comments section)

Name	City	State	From / /	To / /
Name	**City**	**State**	**From** / /	**To** / /
Name	**City**	**State**	**From** / /	**To** / /
Name	**City**	**State**	**From** / /	**To** / /

Explain any gaps in your practice history:

Date you entered private practice for the first time _____

Do you practice in the District of Columbia (DC)? ❑ Yes ❑ No

If yes, list average hours per week _____

Medical License Information

	State	License Number	Expiration Date	Status	% of Practice
1.			/ /	❑ Active ❑ Inactive	
2.			/ /	❑ Active ❑ Inactive	
3.			/ /	❑ Active ❑ Inactive	
4.			/ /	❑ Active ❑ Inactive	
5.			/ /	❑ Active ❑ Inactive	
6.			/ /	❑ Active ❑ Inactive	

Board Certification and Continuing Education Information

Board Name	Eligible	Certified	Expiration Date
	❑ Yes ❑ No	❑ Yes ❑ No	/ /
	❑ Yes ❑ No	❑ Yes ❑ No	/ /

If not Board Certified, explain what steps are being taken to obtain certification and expected completion date.

Have you ever failed a board certification or recertification examination? ❑ Yes ❑ No

If yes, how many times? _____ (Oral) _____ (Written)

Has your membership in any professional association or society ever been revoked or refused? ❑ Yes ❑ No

Number of hours of continuing education completed within the past two years _____

Board Certification and Continuing Education Information (continued)

Please answer the following:

1. Are you a graduate of a foreign medical school? ❑ Yes ❑ No
   If yes, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? ❑ Yes ❑ No
   Have you passed FLEX or USMLE? ❑ Yes ❑ No
   Name & location of Medical School: _____

2. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked, or restricted in any location? ❑ Yes ❑ No
   If yes, explain:

3. Have you ever been or are you currently under a "consent order" or are you currently under proctored or other supervisory arrangement in your delivery of professional medical services? ❑ Yes ❑ No
   If yes, please explain and/or attach a copy of consent order or proctoring documents.

4. Have you ever been diagnosed with, or treated for alcoholism, drug addiction, mental or physical impairment or anger management? ❑ Yes ❑ No
   If yes, explain and provide dates and locations of all treatment or evaluations as well as names of your supervising and/or monitoring physicians.

5. Have you ever been diagnosed with, or treated for, a medical condition which could affect your ability to render medical professional services? ❑ Yes ❑ No
   If yes, please explain and provide a copy of your treating physician's letter clearing you to practice medicine.

6. Are you currently under contract or enrolled with any Interventional/Rehabilitation Program? ❑ Yes ❑ No
   If yes, explain:

7. Have you ever been charged with any felony criminal activity? ❑ Yes ❑ No
   If yes, explain:

8. Has any claim or suit for alleged sexual misconduct ever been brought against you? ❑ Yes ❑ No
   If yes, explain:

9. Have you ever been questioned, investigated by, or requested to appear before any of the following:
   A state licensing board or equivalent? ❑ Yes ❑ No
   A specialty or medical association? ❑ Yes ❑ No
   A Medicare/Medicaid agency, or other local, State or Federal governmental agency? ❑ Yes ❑ No
   Other_____ ❑ Yes ❑ No
   If yes to any of the above, please explain:

10. Has the applicant or any of its employees self-reported any fact(s), circumstance(s), or occurrence(s) to any local, State, Federal or other governmental agency? ❑ Yes ❑ No
    If yes, explain:

11. Are you aware of any fact(s), circumstance(s), or occurrence(s), which could require self-reporting to or become the target of a formal investigation instituted against you by any local, State, Federal or other governmental agency? ❑ Yes ❑ No
    If yes, explain:

Hospital Privileges

1. Do you have hospital privileges? *(for which you are applying for coverage)* ❑ Yes ❑ No
   If no, please explain:

_____

If yes, list all of your current hospital privileges. *(If "restricted" or "other," explain in the details section)*

Hospital Name	City	State
Type: ❑ Pending ❑ Full ❑ Courtesy ❑ Restricted ❑ Other		
Details:		
Hospital Name	City	State
Type: ❑ Pending ❑ Full ❑ Courtesy ❑ Restricted ❑ Other		
Details:		
Hospital Name	City	State
Type: ❑ Pending ❑ Full ❑ Courtesy ❑ Restricted ❑ Other		
Details:		

2. Have your hospital privileges ever been suspended, denied, revoked, restricted, or otherwise sanctioned? If yes, please explain: ❑ Yes ❑ No

Insurance History

Please list insurance information for the past ten (10) years or back to requested retroactive date, whichever is longer.

	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 Limit					
Deductible	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____
Retroactive Date	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____

Insurance Questions

1. Has your professional liability insurance ever been surcharged, written with a deductible, or written in a non-standard market? ❑ Yes ❑ No
   If yes, explain:

2. Has your professional liability insurance ever been canceled, suspended, non-renewed, or declined: or have you ever voluntarily withdrawn your application for professional liability coverage? ❑ Yes ❑ No
   If yes, explain:

3. Have you previously had professional liability insurance provided by our company? ❑ Yes ❑ No
   If yes, list policy number_____

Medical Specialties

Specialty	% of Practice	Specialty	% of Practice
❑ Allergy and Immunology		❑ Pain Management	
❑ Anesthesiology		❑ Pathology – Anatomic/Clinical	
❑ Colon and Rectal Surgery		❑ Pediatrics	
❑ Dermatology		❑ Physical Medicine and Rehab (Physiatry)	
❑ Emergency Medicine		❑ Plastic Surgery	
❑ Family Medicine		❑ Psychiatry	
❑ General Preventative		❑ Public Health	
❑ Hospitalists		❑ Radiation Oncology	
❑ Internal Medicine		❑ Radiology-Diagnostic	
❑ Neurological Surgery		❑ Radiology-Interventional	
❑ Neurology		❑ Surgery	
❑ Obstetrics and Gynecology		❑ Thoracic Surgery	
❑ Occupational Medicine		❑ Urology	
❑ Ophthalmology		❑ Vascular Surgery	
❑ Orthopaedic Surgery			
❑ Otolaryngology			
If you practice in a sub-specialty, please identify:			**%**

If you practice any of the specialties below, please answer the applicable questions.

❑ **Anesthesiology**

Number of certified registered nurse anesthetists (CRNAs) you employ: _____
Number of CRNAs you supervise at any given time: _____
Number of Anesthesia Assistants (AAs) you employ: _____
Number of AAs you supervise at any given time: _____
Do any of the CRNAs or AAs employed or supervised by you administer anesthesia when you are not physically present on premises? ❑ Yes ❑ No

❑ **General Surgery**

Do you do post-op follow ups or provide coverage for bariatric patients other than your own? ❑ Yes ❑ No
Please explain:

_____

❑ **Obstetrics and Gynecology**

Do you specialize in infertility and/or provide infertility treatment? ❑ Yes ❑ No
If yes, please explain:

_____

If you only practice Gynecology, did you ever practice Obstetrics? ❑ Yes ❑ No
If yes, please explain, including date of last OB patient seen.

❑ **Radiology**

Please check the following invasive diagnostic and/or interventional procedures you perform:

- ☐ Angiography (catheter and visceral)
- ☐ Brachytherapy (includes high dose rate- HDR)
- ☐ Carotid artery revascularization
- ☐ Central venous catheter placement (includes tunneled catheters and implanted chest ports)
- ☐ Cholecystostomy
- ☐ Coil embolization (includes arteriovenous malformation-AVM and vascular embolization)
- ☐ Dialysis access catheters placement
- ☐ Gastrostomy and gastrojejunostomy feeding tube placement
- ☐ Inferior vena cava (IVC) filter placement/retrieval
- ☐ Liver biopsy (transjugular)
- ☐ Nephrostomy, nephroureterostomy and ureteronephrostomy
- ☐ Percutaneous access for stone retrieval
- ☐ Percutaneous treatment of malfunctioning or thrombosed dialysis access
- ☐ Renal artery angioplasty and stenting
- ☐ Sclerotherapy of venous and lymphatic malformations
- ☐ Shunt placement (includes TIPS-transjugular intrahepatic portosystemic shunts)
- ☐ Stent placement (includes ureteral stents and malignant strictures: bile duct, esophageal, tracheobronchial and intestinal)
- ☐ Thermal tumor ablation (percutaneous- cryo or radiofrequency)
- ☐ Uterine fibroid embolization
- ☐ Venous thrombolysis and angioplasty
- ☐ Vertebroplasty
- ☐ Chest tube placement

Medical Specialties (continued)

- ☐ Discogram/discography
- ☐ Image-guided soft tissue and bone biopsy
- ☐ Intraabdominal drainage aspirations
- ☐ Kidney biopsy (percutaneous)
- ☐ Liver biopsy (percutaneous)
- ☐ Myelogram (with neck puncture)
- ☐ Percutaneous drainage of abscesses and fluid collections
- ☐ Suprapubic drainage

List other procedures performed not listed above:

Do you practice teleradiology? ❑ Yes ❑ No
If yes, please explain:

Do you utilize "international teleradiology" type services? ❑ Yes ❑ No
If yes, please explain:

❑ **Ophthalmology**
Indicate the percentage of your practice that is devoted to each of the following:

Cataract Removals	_____%	Corneal transplants	_____%
Detached retinas	_____%	Eye muscle surgery	_____%
Removal of embedded foreign objects	_____%	Vision Correction	%
Intra-ocular surgery	_____%	List procedures:	

Describe:

Please indicate any of the following procedures you currently perform in your practice requiring coverage under this policy:

❑ **Abortions**
Number per month _____
% Elective _____
% Therapeutic _____
❑ **Acupuncture** % of Practice _____
❑ **Anesthesia – Moderate Sedation Only**
❑ **Anesthesia – General/Spinal**
❑ **Anesthesia – Local Only** Describe types:
_____
❑ **Anesthesia – Nerve Block**
❑ **Anesthesia – Pain Management**

Explain procedures: _____
❑ **Assisting in Major Surgery** Please specify:

❑ My patients only ❑ Patients other than my own

❑ **Bronchoscopy**
❑ **Cardiology Procedures**

Diagnostic Cardiac Catheterization	❑ Yes	❑ No
Interventional Cardiology	❑ Yes	❑ No
Stent Placement	❑ Yes	❑ No
Coronary Angioplasty	❑ Yes	❑ No
Permanent Pacemaker Insertion	❑ Yes	❑ No
Implantable Cardioverter Defibrillator	❑ Yes	❑ No
Electrophysiology Procedures	❑ Yes	❑ No

If **yes**, please list: _____
Other Interventional Procedures ❑ Yes ❑ No
If **yes**, please list: _____

❑ **Chemotherapy**
❑ Prescribing using protocol by either the National Comprehensive Cancer Network-NCCN or standard compendium
❑ Experimental Chemotherapy

❑ **Circumcisions**
❑ **Closed Reduction of Minor Fractures**
❑ **Cryosurgery/Cryotherapy** (Other than external lesions)
❑ **Dilation and Curettage (D & C)**
❑ **Endoscopic Procedures**
❑ Flexible Sigmoidoscopy
❑ Colonoscopy
❑ Endoscopy
❑ Endoscopic Retrograde Cholangiopancreatography (ERCP)
❑ Upper GI/ Esophagogastroduodenoscopy (EGD)
❑ Other _____
❑ **Experimental Procedures Explain**:
_____
❑ **Homeopathy/Alternative Medicine**
❑ **Hyperbaric Medicine/Wound Care**
❑ **Moh's Micrographic Surgery**
❑ **Needle Biopsies Specify** area: _____
❑ **Paracentesis/Thoracentesis**
❑ **Prenatal/Obstetrical Care**
❑ Prenatal care only
* Gestational week of baby when care is transferred to an obstetrician? _____
❑ Vaginal deliveries
❑ C-Section deliveries
❑ Non-Hospital based deliveries
❑ **Professional Sports Medicine** Explain:
_____
❑ **Radiation Therapy**
❑ **Spinal Injections**
❑ **Vasectomy**
❑ **Vertrebroplasty and/or Kyphoplasty**
❑ **Weight Loss Management** Explain:_____

Medical Specialties

***Please list any procedures you routinely perform not mentioned above:**

Cosmetic Procedures

Indicate if you or any of your staff perform the following:

	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injection	❑	❑	❑
Chemical Peel (medical grade)	❑	❑	❑
Collagen Injection/Dermal Fillers	❑	❑	❑
Cosmetic Tattooing/Tattoo Removal	❑	❑	❑
Hair Transplants	❑	❑	❑
Intense Pulsed Light (IPL)	❑	❑	❑
Laser Hair Removal	❑	❑	❑
Laser Skin Treatment	❑	❑	❑
Leg Vein Therapy	❑	❑	❑
Liposuction or other similar type of Procedure (e.g, Lipodissolve/Cool Sculpting). Please specify type and area of body treated:	❑	❑	❑
Microdermabrasion(medical grade)	❑	❑	❑
Permanent Make-up	❑	❑	❑
Other Please specify:	❑	❑	❑

<u>SURGICAL SPECIALTIES</u>: If you are a surgeon, indicate the percentage of your surgical practice that is devoted to the following surgical activities:

Plastic Surgery _____%
- Reconstruction only _____%
- Cosmetic _____%

*Please describe in detail any cosmetic surgery performed not mentioned above:

Bariatric Surgery _____%
*Please describe the types of procedures performed:

Vascular Surgery _____ %
Thoracic/Cardiac Surgery _____ %
ENT _____ %
Neurosurgery _____ %
Obstetrical Surgery _____ %
Gynecological Surgery _____ %
Trauma Surgery _____ %
Pediatric Surgery _____ %

Urological Surgery _____ %
Orthopaedic Surgery _____ %
- Excluding Spine _____ %
- Including Spine _____ %
- Hand and/or Foot _____ %

Ophthalmological Surgery _____ %
General Surgery _____ %
Dermatologic Surgery _____ %

Underwriting Questions

1. Are you a member of an IPA, PHO, MSO, or ACO, etc.? ❑ Yes ❑ No
   If yes, please list all networks:

2. Have you discontinued major surgical procedures? ❑ Yes ❑ No ❑ N/A
   If yes, list procedures and when last performed:

3. Has your medical specialty changed within the past 5 years? ❑ Yes ❑ No
   If yes, explain:

4. Do you moonlight at an Urgent Care Center, Trauma Center, ER or any other facility in addition to your primary practice? ❑ Yes ❑ No
   % of practice _____ Hours per month _____
   Name of facility _____

5. Do you have any medically related duties that are insured by another company or for which you do not desire coverage by the company? ❑ Yes ❑ No
   If yes, explain:

6. Are you under contract to serve as a medical director for an entity <u>not</u> covered by this policy? ❑ Yes ❑ No
   If yes, explain and give name of entity:

   If yes, do you have coverage elsewhere for your Medical Director duties? ❑ Yes ❑ No
   If no coverage elsewhere, are you requesting coverage under this policy? **(If yes, must attach contract)** ❑ Yes ❑ No

7. Are you currently under contract or have plans to conduct clinical trials? ❑ Yes ❑ No
   If yes, explain:

   Are the clinical trials FDA or IRB compliant? ❑ Yes ❑ No

8. Do you provide medical professional services at correctional institutions? ❑ Yes ❑ No
   If yes, please check type facility: ☐ Federal ☐ State ☐ County Jail ☐ Youth Detention ☐ Other
   Name of facility _____

9. Average number of patients treated weekly: _____

10. Average number of patients treated weekly by you in nursing homes: _____
    a. What percentage of these patients are not your regular patients? _____%

11. 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:

    Do you provide these services to patients in states outside your primary practice location? If yes, list states. ❑ Yes ❑ No

    (For telemedicine you must be licensed in the state in which the patient is located. Check with the appropriate state licensing board.)

    Does your practice utilize the services of any type of international teleradiology service? ❑ Yes ❑ No
    If yes, explain:

12. Do you volunteer your medical services in any capacity? ❑ Yes ❑ No
    If yes, explain:

13. Who covers your night, weekend, and/or vacation call? _____

14. Do you dispense medications to patients (other than samples) within your office? ❑ Yes ❑ No
    If yes, explain:

Underwriting Questions (continued)

15. Are you using any Non-FDA approved devices? ❑ Yes ❑ No
    If yes, when and under what circumstances?

16. Do you prescribe Coumadin (Warfarin), or other anti-coagulant medications? ❑ Yes ❑ No
    If yes, answer the following questions:
    Do you have patient safety protocols in place for monitoring these patients? ❑ Yes ❑ No
    Do you utilize a specific informed consent for use of these medications? ❑ Yes ❑ No

17. Do you or do you plan in the next year to participate in a state certification program for medical cannabis (medical marijuana)? ❑ Yes ❑ No
    If yes, answer the following questions:
    What percentage of your patient population would be involved in this treatment?
    ☐ Less than 10% ☐ 10% to 30% ☐ 30% to 50% ☐ Over 50%
    Have you completed training in the use and side effects of medical cannabis? ❑ Yes ❑ No
    Do you provide patients with educational materials regarding the use and potential risks and complications of medical cannabis? ❑ Yes ❑ No
    Do you require a signed medical cannabis informed consent? ❑ Yes ❑ No
    Do you have a medical cannabis diversion agreement for patients using medical cannabis, which requires them to agree to avoid over-medication or diversion of the cannabis? ❑ Yes ❑ No

Part-time Practice

Are you requesting coverage for a part-time practice? ❑ Yes ❑ No
What date did you begin your part-time practice? _____/_____/_____
Part-time situation:

- ❑ Semi-retired due to age
- ❑ Semi-retired due to health: Health condition: _____
- ❑ Practice full-time, but applying for partial coverage
  - Activities for which coverage is not required under this policy. (Please attach a valid Certificate of Insurance evidencing coverage for these activities)
    - ❑ Residency or Fellowship Program
    - ❑ Military service or Federal Government agency
    - ❑ Other: _____
      Program Name Service/Agency Please explain:
- ❑ Other part-time situation not described above
  Please explain, including name of employer and location:

Indicate the average number of hours per week of your part-time practice devoted to each of the following for which the company is to provide coverage: *(include charting and on-call hours):*

Office Practice _____ Emergency Room _____ Hospital Practice _____
Scheduled or rotating call _____ Medical Director (if covered)_____
Other: (please describe) _____

Employment

I am a(n):

- ❑ Employee of a partnership/corporation
- ❑ Employee of an industrial organization
- ❑ Independent contractor
- ❑ Employee of a hospital or clinic
- ❑ Employee of a government agency
- ❑ Solo unincorporated
- ❑ Partner in a partnership or shareholder in a professional corporation or association
- ❑ Other: _____

Share or Lease Office Space

Do you share or lease office space? ❑ Yes ❑ No
If yes, explain:

Solo Professional Corporation (PC)/Solo Professional Association (PA)

Do you have a Solo Professional Corporation (PC) or Solo Professional Association (PA)? ❑ Yes ❑ No
Solo PC or Solo PA will share in the physician's individual limit at no additional charge (shared limits not available in PA)
Name of organization: _____
Date PA or PC was formed: _____/_____/_____
Have there been any settlements/judgments made on behalf of your PA or PC, or any claims pending? ❑ Yes ❑ No
If yes, please complete the Claims History section of this application.

Medical Staff

1. Provide the number of non-physician personnel employed by you.

Nurses	_____	Physical Therapists	_____	Lab Techs	_____
CMA's	_____	X-Ray Techs	_____	Other	_____

2. Do you contract, supervise or employ any of the professionals listed below? ❑ Yes ❑ No
If yes, complete the following including role and individual:

	Role	Individual		Role	Individual
Physicians	❑ Contract ❑ Supervise ❑ Employ		**Psychotherapists**	❑ Contract ❑ Supervise ❑ Employ	
Physician's Assistant	❑ Contract ❑ Supervise ❑ Employ		**Licensed Clinical Social Worker**	❑ Contract ❑ Supervise ❑ Employ	
Nurse Practitioner	❑ Contract ❑ Supervise ❑ Employ		**Podiatrist**	❑ Contract ❑ Supervise ❑ Employ	
CRNA	❑ Contract ❑ Supervise ❑ Employ		**Chiropractor**	❑ Contract ❑ Supervise ❑ Employ	
Nurse Midwife	❑ Contract ❑ Supervise ❑ Employ		**Dentist**	❑ Contract ❑ Supervise ❑ Employ	
Residents/ Fellows	❑ Contract ❑ Supervise ❑ Employ		**Anesthesia Assistant**	❑ Contract ❑ Supervise ❑ Employ	

Note: The above individuals present an additional exposure to the physician/practice and are not automatically covered by our policy. They must complete a separate application for coverage.

Claims History

Attach current Loss Run (No more than 90 days old) for previous 10 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 you, or have you reported any incidents concerning your professional services? ❑ 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 you? ❑ 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 you answered **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 on back.

Patient's Name			
Date of Occurrence / /	Insurance Carrier		
Location of Occurrence			
Date claim reported ___/___/_____	Date claim closed ___/___/_____	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Patient's Name			
Date of Occurrence / /	Insurance Carrier		
Location of Occurrence			
Date claim reported ___/___/_____	Date claim closed ___/___/_____	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Patient's Name			
Date of Occurrence / /	Insurance Carrier		
Location of Occurrence			
Date claim reported ___/___/_____	Date claim closed ___/___/_____	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

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 to be true and complete, and understand that the policy if issued, is conditioned upon the truth and completeness of the representations in this application. I further understand that the falsity or incompleteness of any representations made in this application 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**.

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 Date

Name and address of agent:

/ /

Signature of agent 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 TENNESSEE & 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 agent or to the Company.

Additional Comments

Question #	Comments