Physician Group Professional Liability Application
New Business

Required Documents - In addition to this application, the following information is required:

1. ☐ Loss runs, dated within 60 days of submission, covering the past ten years
2. ☐ Financials
3. ☐ Organizational chart showing corporate structure with legal entities and DBAs
4. ☐ Listing of locations with description of operations for each location
5. ☐ Risk Management Program and/or Quality Improvement Plan
6. ☐ List of all Physicians and Healthcare Providers to be scheduled individually for coverage including 1) Full Name 2) Medical Specialty 3) Retroactive Date (if claims-made) 4) Date of Birth 5) Social Security Number

A. Applicant Information

Agency Name	Producer
Legal Entity Name	Tax ID Number
Principle Business Address (Street, City, State, Zip Code)	County

Business phone	Fax	Email	Web Site

Administrator	Telephone	Email
Risk Manager	Telephone	Email
Mailing/Billing Address (If different from principle business address listed above)		County

Type of Legal Entity:
☐ Corporation
☐ Partnership
☐ Limited Liability Company
☐ Joint Venture (indicate parties in venture and percentage ownership in Comments section)
☐ Other (specify):

Is Applicant or employees currently enrolled in a Patient's Compensation Fund (PCF)? ☐Yes ☐No
If yes, indicate name of fund:
If yes, has Applicant (including all eligible employees), at all times subsequent to the retroactive date, been continually qualified/covered by the state fund? ☐Yes ☐No

B. Current Coverage

Existing Form of Insurance: ☐ Occurrence ☐Claims-made

Specify below insurance coverage for the past 5 years:

Carrier name	Policy #	Coverage Dates	Limits	Retroactive Date

C. Requested Coverage

Effective Date:

Primary Limits of Liability: Excess Limits of Liability:

Deductible/Self Insured Retention: ☐ None ☐ Indemnity Only ☐ Indemnity and Expense

If there is a self-insured retention: Is there an Actuarial Funding Study? ☐ Yes ☐ No

Is there a Trust Document? ☐ Yes ☐ No

Retroactive Date: _____

If current coverage is claims-made and Applicant is **not** requesting prior acts coverage from UMIA, was a reporting endorsement purchased from the current carrier? ☐ Yes ☐ No

If yes, attach a copy of the reporting endorsement. If no, explain:

D. Practice Information

1. Provide a description of operations:

The definition of "owners" includes shareholders, partners and members.

2. Specify the number of owners of the Applicant: ____
3. Are all owners that are health care providers applying for coverage? ☐ Yes ☐ No
4. Are there any subsidiaries of the Applicant? ☐ Yes ☐ No If yes, specify the following:

Subsidiary	Description of Operations	% of Ownership	Date Acquired	Current Carrier	Coverage Desired?

If a subsidiary is not 100% owned by the Applicant, specify owners and percentage of ownership in the Comments section.

5. List all states in which the Applicant provides professional services, including the percentage of practice for each state:

6. Does the Applicant or any of its owners or employed or contracted physicians supervise any residents or interns? ☐ Yes ☐ No

If yes, specify medical school, resident specialty and number supervised:

7. Does the Applicant or any of its owners or employed or contracted physicians supervise any healthcare providers other than those employed or contracted at the Applicant's practice? ☐ Yes ☐ No

If yes, specify facility, specialty and number supervised:

8. Specify total number of **employees** for each type:

_____ Physicians
_____ Physician Assistants/Nurse Practitioners
_____ Other types of healthcare professionals
_____ Non-health care employees
_____ Total number of employees

Specify total number of **contractors** for each type:

_____ Physicians
_____ Physician Assistants/Nurse Practitioners
_____ Other types of healthcare professionals
_____ Non-health care contractors
_____ Total number of contractors

E. Corporate Underwriting Questions

9. Does the Applicant have an ongoing quality assessment and/or improvement plan?	☐ Yes ☐ No
10. Does the Applicant have an ongoing risk management plan? If yes, how often is it updated? _____	☐ Yes ☐ No
11. Are credentials for physicians and allied healthcare professionals checked and approved prior to joining the group? a) Is there a probationary period? b) Are new practitioners proctored?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
12. Does the entity own, operate, or control any specialized, medically related unit, such as a pharmacy, laboratory, physical therapy center, free-standing surgery center, office based surgical suite? If yes, please provide details in the Comments section.	☐ Yes ☐ No
13. Do physicians/individuals not affiliated with your organization use your facilities and/or equipment?	☐ Yes ☐ No
14. Has your group ever been investigated or audited by a governmental or regulatory agency? If yes, please provide details in the Comments section.	☐ Yes ☐ No
15. Has any physician, patient, or insurance plan filed a complaint of any kind against your group with a medical society, foundation or state/federal agency? If yes, please provide details in the Comments section.	☐ Yes ☐ No

F. Provider Underwriting Questions

This section is to be completed on behalf of all physicians and health care professionals (collectively referred to as Providers) that are to be individually scheduled for insurance.

Explain any "yes" answers to the following questions in the Comments section or separate attachment.

17. Are any Providers engaged in moonlighting activities outside of their work for the named insured? If yes, is coverage desired for this moonlighting work?	☐ Yes ☐ No ☐ Yes ☐ No
18. Are any Providers that are eligible for a Patients' Compensation Fund (PCF) not currently enrolled or covered by the fund or has there been a gap in fund coverage?	☐ Yes ☐ No ☐ N/A
19. Are any Providers contracted or employed by any facility as a medical director or similar role?	☐ Yes ☐ No
20. Are any Providers providing diagnostic, consulting or other professional services (including telemedicine) in states other than the Applicant's state of domicile?	☐ Yes ☐ No
21. Do any Providers have an ownership interest in a professional corporation, association, partnership or other health care related entity?	☐ Yes ☐ No
22. Are there any Providers that do not have a valid license to practice in their specific field of medicine?	☐ Yes ☐ No
23. Has any Providers' license to practice been suspended, restricted, revoked or voluntarily surrendered, or has probation been invoked in the past five years?	☐ Yes ☐ No
24. Are you aware of any complaint or investigation with respect to a Providers' license to practice or BNDD/DEA license initiated within the past five years?	☐ Yes ☐ No
25. Are all foreign medical graduates certified by the Educational Council for Foreign Medical School Graduates or have they passed the FLEX?	☐ Yes ☐ No

26. Does any physician or allied healthcare professional have coverage independent of the group? ☐ Yes ☐ No
If yes, are annual certificates of insurance required for proof of Professional liability coverage and are specific limits required? ☐ Yes ☐ No
Limits required: $ _____

G. Claim Information

Explain any "yes" answers to the following questions in the Comments section or separate attachment.

27. Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors arising out of the performance of professional services rendered or which should have been rendered by any person for whose acts or omissions the Applicant is legally responsible for? ☐ Yes ☐ No
If yes, indicate the number of previous and/or pending claims or suits: ____

28. Are you aware of any potential claims including alleged injury, incidents, or circumstances that might reasonably lead to a claim or suit being brought against the Applicant, the Applicant's owners, employees or contractors even if the claim or suit would be without merit? This includes knowledge of any facts that could reasonably lead to a claim or suit? ☐ Yes ☐ No
If yes, please attach copies of your claim notification letters sent to your current or prior professional liability carrier for each potential claim.

29. Are you aware of any claims, suits or potential claims that have not been reported to your current or prior professional liability carrier? ☐ Yes ☐ No

Please provide detailed information for each claim, suit, or potential claim identified above in addition to the loss run.

H. Comments

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another person files an application for insurance 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 the person to criminal and civil penalties.

UMIA FRAUD STATEMENT: Signing this application does not bind UMIA Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If UMIA Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If this policy is issued on a claims-made basis, the policy will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to UMIA Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: The Applicant authorizes access by and release to UMIA Insurance, Inc. of any and all information pertaining to underwriting the undersigned Applicant and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

PRIVACY STATEMENT: UMIA Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of UMIA Insurance, Inc. to discuss any such information within its committees and boards.

APPLICANT ACKNOWLEDGEMENT: The Applicant hereby certifies the foregoing information is true and correct and that any and all claims or potential claims have been reported to the current carrier. The Applicant understands that, if granted prior acts coverage by UMIA Insurance, Inc., no insurance will be provided for any claim, suit or potential claim known at the effective date that has or has not been reported to another insurance carrier.

Signature	Title	Date

Print Name