If previously covered with Medical Protective, please enter the policy number: _____

THE MEDICAL PROTECTIVE COMPANY

PHYSICIAN ENTITY (CORPORATION/PARTNERSHIP) PROFESSIONAL LIABILITY INSURANCE APPLICATION

For faster service, please enter your application online at WWW.MEDPRO.COM

Application Instructions

A. If additional space is needed, please complete Section VIII. Supplemental Information with a reference to the question.

B. 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. ***Additional documentation pertaining to the entity's existence and operations may be requested by the company as necessary.*** For example: Articles of Incorporation, Declaration Page, copy of your most recent entity professional liability policy (including all endorsements), etc.

C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

I. Organization Information

A. Names: (As stated in the Articles of Incorporation and all formal entity/clinic names. Please provide Articles of Incorporation to ensure accurate coverage.)

Entity Name(s):

DBA, Fictitious Name, etc.:

___ - _____ Federal Tax I.D. Number

National Provider Identifier Number

Date Entity Formed: ___ / _____ MM YYYY

Contact's Last Name: Contact's First Name:

Contact's Title:

Email address:

Business Phone: ___ - ___ - ____ Business Fax: ___ - ___ - ____

B. If the above entity does business under any other name, please list all additional entity/clinic names.

Entity Name(s):

___ - _____ Federal Tax I.D. Number

National Provider Identifier Number

Date Entity Formed: ___ / _____ MM YYYY

C. If you have a web address, please provide the website address (URL): _____

D. Type of Legal Entity: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- ☐ Professional Corporation - sole shareholder
- ☐ Professional Corporation - multiple shareholders
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Company (LLC) or Limited Liability Partnership (LLP)
- ☐ General Business Corporation
- ☐ For Profit
- ☐ Not for Profit
- ☐ Other (please explain): _____

E. Type of Organization/Business Practices: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- ☐ Abortions
  - ☐ Therapeutic - Number Per Year: ____
  - ☐ Elective - Number Per Year: ____
- ☐ AIDS/ARC
- ☐ Alternative Medicine (Integrative/Complimentary)
- ☐ Anesthesia
- ☐ Bariatrics
- ☐ Behavioral Health Facility/Psychiatric Facility
- ☐ Blood Banks
- ☐ Cancer Treatment Center
- ☐ Clinical Trials
- ☐ Community Based Health Center
- ☐ Cosmetic Surgery
- ☐ Dental
- ☐ Dialysis Center
- ☐ Emergency
- ☐ Experimental Surgery
- ☐ General Hospital
- ☐ Home Health Care
- ☐ Hospice
- ☐ Hospital - Industrial
- ☐ In Vitro Fertilization
- ☐ Laboratory
- ☐ Liposuction
- ☐ Managed Care Organization/ Managed Services Organization
- ☐ Medi-Spa
- ☐ MRI/X-Ray/Imaging
- ☐ Nursing Home
- ☐ Obstetrics
- ☐ Osteopathic Manipulation Therapy
- ☐ Pathology
- ☐ Pharmacy
- ☐ Physical Therapy Center
- ☐ Plastic Surgery
- ☐ Radiation Therapy
- ☐ Sports Medicine
- ☐ Standard Medical Practice
- ☐ State/County Health Department
- ☐ Substance Abuse Center
- ☐ Surgical Center
- ☐ Telemedicine
- ☐ University/Teaching Facility
- ☐ Urgent Care
- ☐ Weight Reduction
- ☐ Wound Care
- ☐ Other (please explain): _____

I. Organization Information (continued)

F. 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#:

G. Practice Location(s): (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. % of practice
Number & Street
Suite City State Zip Code -
County

2. % of practice
Number & Street
Suite City State Zip Code -
County

3. % of practice
Number & Street
Suite City State Zip Code -
County

H. Billing and Correspondence Address:

☐ Location # (from Question G above): ☐ Other (Please enter below)

Number & Street Suite

City State Zip Code -

I. In which state(s) is this entity authorized to do business?

State of Incorporation: Certificate(s) of Authority: , , , , , , ,

II. General Information

A. Has your entity 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 provide individual(s) involved, date and explanation.
   Individual(s): _____ Date: 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 provide individual(s) involved, date and explanation.
   Individual(s): _____ Date: MM / YYYY
   Explanation: _____
3. Ever had any professional liability insurance refused, declined, canceled or non-renewed by the insurance company? ☐ Yes ☐ No
   If yes, please provide individual(s) involved, date and explanation.
   Individual(s): _____ Date: MM / YYYY
   Explanation: _____

II. General Information (continued)

B. Does the entity own or operate any laboratory? ☐ Yes ☐ No

If yes, is the laboratory providing services solely for your patients? ☐ Yes ☐ No

If no, please explain: _____

C. Will the entity be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

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

Practice Name: _____

Location: _____

Name of Insurer: _____

D. 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, Veteran's Administration, university, military or indigent care, etc.? ☐ Yes ☐ No

If yes, please explain: _____

_____

E. Please include estimated annual numbers:

Clinic visits: ☐☐☐☐☐☐

Surgeries: ☐☐☐☐☐☐

Gross Revenue: $ ☐☐☐ , ☐☐☐ , ☐☐☐

F. In the last 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, reason for discontinuing, and date discontinued. Date: ☐☐ / ☐☐☐☐ (MM / YYYY)

   _____

   _____

   _____

2. 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% ☐ Never prescribed anorectic drugs

   b. If yes, what percentage of the practice (% of patient care) was devoted to performing weight control surgery?
   ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ > 50% ☐ Never performed weight control surgery

G. Does the entity or any of the physicians have ownership or financial interests in a weight control clinic? ☐ Yes ☐ No

If yes, what is the name of the weight control clinic with which the entity or physicians are affiliated? _____

_____

III. Anesthesia Information

A. As defined below, please enter an "X" if a shareholder/partner, employee or independent contractor treats patients under:

☐ **Conscious Sedation (excluding Nitrous Oxide)** utilizing 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 (to include deep sedation)** utilizing a controlled state of depressed consciousness or unconsciousness, accompanied by partial or completed 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.

If Conscious Sedation or General Anesthesia was checked, please complete the Anesthesia Supplement.

B. ☐ 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 IV.

IV. Roster of Staffing

A. Please identify all owners, employed and contracted individuals within your organization, and provide information concerning each member in each category listed in the following table:

Note: Include all applicant(s), all healthcare provider(s), and non-healthcare owner(s).

Individual Status: (Column 5)

A. Requesting Individual Medical Protective coverage.

B. Current Individual Medical Protective insured.

C. Applying for coverage elsewhere or covered elsewhere.

D. Shared Limit Coverage with entity for Healthcare Professionals, other than physicians or dentists, with Medical Protective.

E. Other.

	1. Last name first, then first and middle initials (i.e. Smith, J. G.)	2. Degree	3. Specialty (Write In)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status- A,B,C, D, or E (See key above)	6. Medical Protective Policy Number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

B. Please provide an explanation as to why coverage is not requested for any individuals where Individual Status is C on Roster.

Number from Roster:	Explanation:

V. Loss Information

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below in which the entity's policy was triggered and has **NOT** been covered by a Medical Protective policy.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters 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. Is your entity involved now or has it ever been involved in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? ☐☐☐ None ☐

B. Is your entity aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes, but is not limited to, the following:

► Amputation ► Death ► Loss of major organ function ► Loss of vision ► Permanent neurological injury

If **yes**, how many? ☐☐☐ None ☐

C. In the last 12 months, has your entity received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit?

If **yes**, how many? ☐☐☐ None ☐

VI. Coverage Information

Notes:

1. **Claims-Made coverage is generally limited 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 "extension contract" or "tail coverage".**

2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage Desired:

☐ Claims-Made coverage without Prior Acts coverage
☐ Claims-Made coverage with Prior Acts coverage
☐ Occurrence coverage
☐ Occurrence coverage with Prior Acts coverage

B. Requested Coverage Period (12:01 am): **From:** ☐☐ / ☐☐ / ☐☐☐☐ **To:** ☐☐ / ☐☐ / ☐☐☐☐
Annual policy term will begin and end on the same month and day. MM DD YYYY MM DD YYYY

C. The retroactive date shown on your current Claims-Made policy is: ☐☐ / ☐☐ / ☐☐☐☐
(This date is required for Occurrence with prior acts or Claims-Made with Prior Acts.) MM DD YYYY

D. Desired Limits: Per Occurrence/Per Claim Filed ☐☐☐ , ☐☐☐ , ☐☐☐ Annual Aggregate ☐☐☐ , ☐☐☐ , ☐☐☐

E. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer: _____

☐ Occurrence ☐ Claims Made From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY MM DD YYYY

2. Previous Insurer: _____

☐ Occurrence ☐ Claims Made From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY MM DD YYYY

3. Previous Insurer: _____

☐ Occurrence ☐ Claims Made From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY MM DD YYYY

F. If "Occurrence" or "Claims-Made Without Prior Acts" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.
☐ 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 a 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

VII. Notices and Agreements

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments **(hereinafter "Attachments")** for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with The Medical Protective Company (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, 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 void and without effect or provide the Company 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 my 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 me, 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 Office, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

_____ Date Signed: __ / __ / ____
Authorized Representative Signature MM DD YYYY

_____
Print Name

If application is being signed by the applicant's agent: By my signature, I hereby represent that the applicant has granted me full authority to execute this application on his or her behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that applicant understands and agrees that such representations are binding upon him or her, even though I am executing this application on the applicant's behalf. I further acknowledge that any material misrepresentation or omission made on this application may form the basis for the company terminate my agency agreement with cause.

_____ Date Signed: __ / __ / ____
Agent's Signature MM DD YYYY

_____
Print Name

VIII. Supplemental Information

The Medical Protective Company

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

A. Is the matter related to: **A** ☐ **B** ☐ **C** ☐ **from the Loss Information section? (Check only one)**

A. Current or prior claim.

B. Complication, incident, or adverse outcome.

C. Written request for records.

B. Patient/Claimant Information:

Last Name _____ First Name _____ Age _____

C. Date of treatment and/or surgery which led, or could lead, to allegations against you. ☐☐ / ☐☐☐☐
MM YYYY

D. Date of notice received, if applicable. ☐☐ / ☐☐☐☐
MM YYYY

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer: ☐☐ / ☐☐☐☐
MM YYYY

Current or former insurer name: _____

If no, please explain: _____

_____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

_____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ _____

If closed:

1. Date of closing: ☐☐ / ☐☐☐☐
MM YYYY

2. Was a payment made? ☐ Yes ☐ No

a. If yes, did you consent to the settlement? ☐ Yes ☐ No

b. Total amount of settlement or award: $ _____

c. Total amount of settlement or award paid on your behalf: $ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

_____

_____

_____

_____

_____

The Medical Protective Company

Anesthesia Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

A. Number of: **Anesthesiologists** ☐☐ **CRNAs** ☐☐

B. Other than Anesthesiologists or CRNAs, list anyone who administers anesthesia or conscious sedation:

_____

_____

_____

C. Are all the CRNAs supervised on site by an anesthesiologist? ☐ Yes ☐ No

D. Is the anesthesia provider currently licensed in your state? ☐ Yes ☐ No

If no, please explain: _____

E. Are all individuals who administer the sedation certified in one or more of the following? ☐ Yes ☐ No

☐ CPR ☐ ACLS ☐ ATLS ☐ PALS

If no, please explain: _____

F. Are all Anesthesiologists required to be board-certified/eligible in Anesthesiology? ☐ Yes ☐ No

G. Please indicate who administers conscious sedation?

☐ MD/DO ☐ RN/LPN
☐ AA/NA/CRNA ☐ Other (specify):_____

Where is conscious sedation performed?

☐ Office ☐ Licensed Surgical Center
☐ Hospital ☐ Other (specify):_____

For:

☐ Own Patients
☐ Other than own patients

H. Please indicate who administers general anesthesia?

☐ MD/DO ☐ RN/LPN
☐ AA/NA/CRNA ☐ Other (specify):_____

Where is general anesthesia performed?

☐ Office ☐ Licensed Surgical Center
☐ Hospital ☐ Other (specify):_____

For:

☐ Own Patients
☐ Other than own patients

I. Is the office certified for general anesthesia by a state organization? ☐ Yes ☐ No

If administered outside of a hospital or a licensed surgery center, please answer Questions J through P.

J. How often does your staff participate in simulated emergency training?

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

K. What American Society of Anesthesiology (ASA) categories are treated? _____

L. How often does your practice update health histories?

☐ Every _____ Month(s) ☐ Every patient visit ☐ Anytime invasive procedures are performed

M. Is a pre-anesthesia evaluation done by an anesthesiologist? ☐ Yes ☐ No

N. Is there a separate informed consent for anesthesia? ☐ Yes ☐ No

O. Please place an "X" next to the equipment utilized.

☐ Fail safe mechanisms on anesthesia machines
☐ Basic Airway Equipment
- ☐ Face Mask Resuscitator
- ☐ Oral and Nasopharyngeal Airways
- ☐ Endotrachael Tubes (Adult/Child size)
- ☐ Laryngoscopes

☐ Sphygmomanometer/Stethoscope
☐ Electrocardiographic Monitoring Equipment
☐ Pulse Oximeter
☐ CO2 Detector
☐ Internal/External Temperature Monitor
☐ Tracheostomy/Crycothyrotomy Equipment

☐ Portable Suction
☐ Capnography
☐ Auxiliary Lighting
☐ Emergency Pharmaceutical Kit
☐ Cardiac Defibrillator
☐ Emergency Tube Thoracostomy Equipment

If you do not utilize any of the above equipment, please explain: _____

_____

1. Who owns and maintains the oxygen equipment? _____
2. Do you monitor the use of reversal agents? ☐ Yes ☐ No

P. Do you treat children? ☐ Yes ☐ No