

The Medical Protective Company
Allied Health Care Providers
Professional Liability Insurance Application

Policy Number _____
Company Use Only

I. GENERAL INFORMATION

A.

LAST NAME FIRST NAME MIDDLE NAME DEGREE

DATE OF BIRTH (M/D/Y) SOCIAL SECURITY NUMBER

B. CURRENT EMPLOYMENT (Information for which you require Medical Protective coverage. List principal location first.)

1. SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY % OF PRACTICE # HRS WORKED

BUSINESS PHONE BUSINESS FAX E-MAIL ADDRESS

II. PROFESSIONAL INFORMATION

A. Specialty: _____

GRADUATE SCHOOL STATE COUNTY TYPE COMPLETED YEAR OF GRADUATION

B. List states where you practice. (If your specialty does not require a license, attach a copy of your Specialty Certification/Degree).

1. State License # 2. State License #

C. Will you be carrying other professional liability coverage? Yes No
If **Yes**, list the practice description and location (name, city, state):

Name of Carrier and effective date of policy: _____

D. Please fully explain a "yes" answer on a separate page:

1. Have you 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 your privileges or license revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Yes No

2. Have you had any professional liability insurance refused, canceled or non-renewed? Yes No

E. PRACTICE ORGANIZATION: Please check the boxes that best describes your practice affiliation(s): ("X" applicable boxes).

Employment status:

- Employee of _____
- Shareholder/Partner of _____
- Independent Contractor

F. Please check any of the following functions performed as part of your professional activities.

- Limited "scrub nurse" functions such as holding retractors, suction, tying sutures, handing and counting of instruments.
- Casting and splinting.
- Directly assisting as a non-physician first assistant in surgical procedures.

G. If you practice as a dental hygienist, do you administer any form of analgesic or anesthesia? Yes No

H. If you are a podiatrist, do you perform surgery? Yes No

I. Do you independently prescribe/order drugs without same day authorization from your supervising physician? Yes No

V. COVERAGE INFORMATION

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS. LIST CURRENT INSURER FIRST.

1. _____
 OCCURRENCE
 CLAIMS-MADE _____ / _____ / _____ TO _____ / _____ / _____
INSURER

2. _____
 OCCURRENCE
 CLAIMS-MADE _____ / _____ / _____ TO _____ / _____ / _____
INSURER

B. COVERAGE DESIRED

- Occurrence
- Claims-Made Coverage

If requesting prior acts coverage, please indicate your retroactive date below.
If you have purchased a reporting endorsement (tail coverage), please attach a copy with your application.

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

This date cannot be earlier than the expiration date of your current policy.

From: _____ / _____ / _____ 12:01 a.m.
MONTH DAY YEAR

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

To: _____ / _____ / _____ 12:01 a.m.
MONTH DAY YEAR

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS

This date cannot be greater than the retroactive date shown on your current policy.

_____ / _____ / _____ 12:01 a.m.
MONTH DAY YEAR

E. IF YOU PRACTICE IN A FUND STATE, PLEASE INDICATE YOUR CURRENT FUND RETROACTIVE DATE IF DIFFERENT THAN THE RETROACTIVE DATE STATED ABOVE: _____ / _____ / _____ 12:01 a.m.

MONTH DAY YEAR

Are you aware of any gaps in your Fund coverage? Yes No

If yes, please provide the exact dates and a written explanation: _____

F. LIMITS DESIRED _____ / _____
per occurrence annual aggregate

VI. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer or other third party _____
Name and Address

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer or other third party has paid the premium (e.g. termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to The Medical Protective Company's Home Office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

VII. 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

VIII. 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 specialty, 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 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.

Date Signed: _____

Signature: _____

Printed Name: _____

REMINDER: If you answered "yes," to questions in the Loss Information Section, you must complete a Claim Information Form for **EACH** claim or suit.

