Requested Effective Date ___ - ___ - ______ 12:01 AM

Previous GEMP Policy Number: ______
Company Use Only

The Medical Protective Company

Physician Individual Professional Liability Insurance Application

For Faster Service, Please Enter Your Application online at WWW.MEDICALPROTECTIVE.COM

I. GENERAL INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

Please print legibly, policy is based on readability of your name. Please answer all questions; if a question is not applicable, state "N/A"

A.

LAST NAME

FIRST NAME (FULL)

MIDDLE NAME | SUFFIX | DEGREE | DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY NUMBER

B. OFFICE LOCATIONS WHERE YOU PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST)

(Combined Percentage of Practice for all Office and Hospital locations must total 100%)

1.

% Of Practice | NUMBER & STREET

SUITE | ADDRESS 2

CITY | STATE | ZIP CODE

COUNTY

2.

% Of Practice | NUMBER & STREET

SUITE | ADDRESS 2

CITY | STATE | ZIP CODE

COUNTY

C. HOSPITALS WHERE YOU PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST)

(Combined Percentage of Practice for all Office and Hospital locations must total 100%)

1.

% Of Practice | HOSPITAL NAME

NUMBER & STREET

SUITE | ADDRESS 2

CITY | STATE | ZIP CODE

COUNTY

☐ ADMITTING ☐ NON-ADMITTING If Non-Admitting, please explain: ______

C. HOSPITALS WHERE YOU PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST) (continued)

(Combined Percentage of Practice for all Office and Hospital locations must total 100%)

2.

% Of Practice HOSPITAL NAME

NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

☐ ADMITTING ☐ NON-ADMITTING If Non-Admitting, please explain: ____________

3.

% Of Practice HOSPITAL NAME

NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

☐ ADMITTING ☐ NON-ADMITTING If Non-Admitting, please explain: ____________

D. HOME ADDRESS

NUMBER & STREET

APARTMENT# ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

E. PREFERRED MAILING/BILLING ADDRESS

☐ OFFICE # (FROM SECTION I.B.) ________ ☐ HOME

☐ HOSPITAL # (FROM SECTION I.C.) ________ ☐ OTHER (PLEASE ENTER BELOW)

NUMBER & STREET

SUITE CITY STATE ZIP CODE -

F. PREFERRED METHOD OF CONTACT

☐ E-MAIL ☐ BUSINESS FAX ☐ BUSINESS PHONE ☐ RESIDENCE PHONE

E-MAIL ADDRESS

BUSINESS FAX - - BUSINESS PHONE - - RESIDENCE PHONE - -

II. EDUCATIONAL BACKGROUND

If Additional Space is Needed, Please Use Supplemental Form

A. MEDICAL SCHOOL

NAME OF SCHOOL

CITY STATE

COUNTRY

DEGREE **COMPLETED FROM** MM - YYYY **TO** MM - YYYY

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM? ☐ YES ☐ NO

If no, please explain: ______________________________

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS. (i.e., Residency Specialty Training, Anesthesia Residency Training, etc.)

If more than one Specialty completed please enter each specific specialty.

1. NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM MM - YYYY ***TO*** MM - YYYY

2. NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM MM - YYYY ***TO*** MM - YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., Fellowship, etc.) ☐ YES ☐ NO

1. NAME OF HOSPITAL/FACILITY

CITY STATE COUNTRY

SPECIALTY TYPE COMPLETED

COMPLETED FROM MM - YYYY ***TO*** MM - YYYY

II. EDUCATIONAL BACKGROUND (continued)

If Additional Space is Needed, Please Use Supplemental Form

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., Fellowship, etc.) (continued)

2. ______________________________
NAME OF HOSPITAL/FACILITY

______________ ____ ______________
CITY STATE COUNTRY

____
SPECIALTY TYPE COMPLETED

COMPLETED FROM __ - ____ ***TO*** __ - ____
MM YYYY MM YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN 6 MONTHS BETWEEN YOUR MEDICAL SCHOOL, RESIDENCY, OTHER TRAINING, OR FIRST TIME IN PRIVATE PRACTICE: ______________________________

E. IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE: __ - __ - ____
MM DD YYYY

(Your Medical Protective Company policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.)

F. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? ☐ YES ☐ NO

G. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS? ☐ YES ☐ NO

If yes, how many category 1 credit hours? ____

H. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE LAST TWELVE (12) MONTHS? ☐ YES ☐ NO

III. PRACTICE INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? ☐ YES ☐ NO
(If this is covered by another professional liability insurance policy, complete question I in section IV.)

IF YES, WHICH STATE(S): ______________________________

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE:
(Exclude state abbreviation)

Please check the appropriate box to indicate the status of your license

	STATE	LICENSE #	*Active*	*Inactive*	*Temporary*	*Pending*
1.			☐	☐	☐	☐
2.			☐	☐	☐	☐
3.			☐	☐	☐	☐
4.			☐	☐	☐	☐

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING

If no previous location(s), please indicate your earliest start date at your current location(s): __ - ____
MM YYYY

1. ______________________________
NAME OF PRACTICE

______________ ____ ______________
CITY STATE COUNTRY

______________ ***FROM*** __ - ____ ***TO*** __ - ____
SPECIALTY MM YYYY MM YYYY

III. PRACTICE INFORMATION (continued) — *If Additional Space Is Needed, Please Use Supplemental Form*

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING *(continued)*

2. NAME OF PRACTICE

CITY | STATE | COUNTRY

SPECIALTY | **FROM** MM - YYYY **TO** MM - YYYY

3. NAME OF PRACTICE

CITY | STATE | COUNTRY

SPECIALTY | **FROM** MM - YYYY **TO** MM - YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN ONE MONTH BETWEEN PRACTICE LOCATIONS: ____________________

E. TO WHICH STATE/LOCAL MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG? ____________________

If none, please explain: ____________________

IV. RATING INFORMATION — *If Additional Space Is Needed, Please Use Supplemental Form*

NOTE: ALL PERCENTAGES REQUESTED BELOW FOR SPECIALTIES, PROCEDURES AND SURGICAL ACTIVITIES ARE OF YOUR TOTAL PRACTICE

*****Please enter complete name of specialty/sub-specialty. *****

A. WHAT IS YOUR PRESENT SPECIALTY? ____________________ % OF TOTAL PRACTICE

What is your sub-specialty? ____________________ % OF TOTAL PRACTICE

MUST EQUAL 100%

Are you permanently retired from the practice of clinical medicine? ☐ YES ☐ NO

B. AMERICAN BOARD CERTIFIED? ☐ YES ☐ NO ____________________ Specialty Board Date Certified: MM - YYYY

If no, are you Board Eligible? ☐ YES ☐ NO

If yes, when do you plan on taking your boards? MM - YYYY

If NO, have you ever taken a specialty board examination and failed to pass? ☐ YES ☐ NO

If YES, please explain: ____________________

C. *INDICATE THE AVERAGE WEEKLY HOURS OR PATIENTS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE.* (If you practice in multiple states, please identify the following information for each state.)

Please provide whole numbers (no ranges i.e., > <). If "none" please enter "0" (zero) in the space provided below.

PATIENTS SEEN PER WEEK ☐☐☐☐ HOURS PER WEEK ☐☐☐ WALK-IN PATIENTS PER WEEK ☐☐

D. *PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:*

- ☐ Abortions
- ☐ Acupuncture
  - ☐ Therapeutic/Local Anesthetic
  - ☐ General Anesthetic
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arthroscopy
- ☐ Arteriography
- ☐ Assisting In Major Surgery
  - ☐ Own Patients Only
  - ☐ Own & Other Than Own Patients
- ☐ Blepharopigmentation
- ☐ Blepharoplasty - Brow Lifts
  - Cosmetic ☐☐☐ % Of Total Practice
  - Reconstruction ☐☐☐ % Of Total Practice
- ☐ Botox ☐☐☐ % Of Total Practice
- ☐ Breast Implants
  - Cosmetic ☐☐☐ % Of Total Practice
  - Reconstruction ☐☐☐ % Of Total Practice
- ☐ Bronchoscopy
- ☐ Bronco-Esophagology
- ☐ Cataract Surgery
- ☐ Cryosurgery (Other Than External Lesions)
- ☐ ERCP
- ☐ D & C
- ☐ Phenol Facial Peels
- ☐ Diagnostic Embolization
- ☐ Anesthesia -General/Spinal/Caudal
  - ☐ Pulse Oximetry
  - ☐ End Tidal CO2 Analyzer
- HairTransplants
  - ☐ Scalp Excision/Transplantations
  - ☐ Plug Technique/Minigraph
- ☐ Laproscopic Cholecystectomy
- ☐ Laproscopy
- ☐ Laser Surgery
- ☐ Liposuction
- ☐ Lymphangiography
- ☐ High Velocity/Low Amplitude (HVLA) on patients 18 years of age or older
- ☐ High Velocity/Low Amplitude (HVLA) on patients younger than 18 years of age
- ☐☐☐ % Osteopathic Manipulation Therapy on patients 18 years of age or older
- ☐☐☐ % Osteopathic Manipulation Therapy on patients younger than 18 years of age

- ☐ Lithotripsy
- ☐ Major Gynecological Surgery
- ☐ Myelography
- ☐ Mammograms
- ☐ Needle Biopsy
- Nerve Blocks
  - ☐ Lumbar Epidural Steroid
  - ☐ Paraspinal
  - ☐ Sciatic
  - ☐ Facet
  - ☐ Paravertebral
  - ☐ Peripheral
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Triggerpoint Injection
  - ☐ Intrathecal Pumps
  - ☐ Spinal Cord Stimulators
- ☐ Phlebography
- ☐ Pnuemoencephalography
- ☐ Radial/laser keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye
  - ☐ Non-Ionic Only
- ☐ Shock Therapy
- Sigmoidoscopy
  - ☐ 60 cm or less
  - ☐ Greater Than 60 cm
- ☐ Colonoscopy
- ☐ Polypectomy
- ☐ Gastrointestinal Endoscopy
- ☐ Biopsy(Endoscopic)
- ☐ Peritoneoscopy
- ☐ Laser Therapy (Endoscopic)
- ☐ Laser Therapy (Non-Endoscopic)
- Pacemakers
  - ☐ Permanent
  - ☐ Temporary

- ☐ Silicone Injections
- ☐ Skin Flaps/Grafts
  - Cosmetic ☐☐☐ % Of Total Practice
  - Reconstruction ☐☐☐ % Of Total Practice
- ☐ Oxidation Therapy
- ☐ Prolotherapy
- ☐ Chelation Therapy
- ☐ Electromagnetic Therapy
- ☐ Rectal Ozone Therapy
- ☐ Swan-Ganz Catheterization
- ☐ Right Heart Catheterization (Other Than CVP Lines)
- ☐ Left Heart Catheterization
- ☐ Tubal Ligations
- Vasectomies
  - ☐ Own Patients Only
  - ☐ Own & Other Than Own Patients
- ☐ Weight Control Therapy/Surgery ☐☐☐ % Of Total Practice
  - ☐ Medication - Weight Control
  - ☐ Gastric Bubble
  - ☐ Gastric Stapling
  - ☐ Other(Type): ______________________
- Prenatal Practice
  - ☐ See Patients During The First & Second Trimester
  - ☐ See Patients To Term But Do Not Perform Delivery
  - ☐ See Patients To Term And Perform Delivery
- ☐ Normal Obstetrical Deliveries
  - How Many Per Year? ______________________
- ☐ Cesarean Sections
  - How Many Per Year? ______________________
- ☐ Other Medical Techniques
  - List Procedures (Do not restate your specialty)
  - ______________________
  - ______________________
  - ______________________

If you devote more than 25% of your practice to OMT, please answer both questions below:

1. Do you have an informed consent discussion with all your patients regarding your choice of OMT? ☐ YES ☐ NO
2. Please describe the use of x-ray or imaging technology used in your practice (i.e., is this required prior to manipulation etc.)

____

____

____

E. INDICATE THE PERCENTAGE OF YOUR TOTAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

☐ % Plastic (reconstruction only)
☐ % Plastic (cosmetic enhancement only)
☐ % Hand
☐ % Traumatic
☐ % Thoracic
☐ % Otorhinolaryngology
☐ % Cardiac
☐ % Vascular
☐ % Neurosurgery
☐ % Obstetrics
☐ % Gynecology
☐ % Orthopedic (including back)
☐ % Orthopedic (not including back)
☐ % Ophthalmology
☐ % Urology
☐ % Other (Describe): ____________

F. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures, performance of Obstetrics, or any other medical activity? ☐ YES ☐ NO
If ***yes***, list procedures/activities, ***date*** discontinued and reason for discontinuing. ____________

Date: ☐☐ - ☐☐☐☐
MM YYYY

2. Have you ever been a representative of a Pedicle Screw Manufacturer? ☐ YES ☐ NO
If yes, please ***attach*** an explanation.

3. Have you performed weight control surgery or prescribed weight control medication? ☐ YES ☐ NO

a. If ***yes***, what percentage of your practice (% of patient care) ***was*** devoted to prescribing anorectic drugs?
☐ < 1 % ☐ 1 % - 10 % ☐ 11 % - 50% ☐ > 50%

b. If ***yes***, what percentage of your practice (% of patient care) ***was*** devoted to performing weight control surgery?
☐ < 1 % ☐ 1 % - 10 % ☐ 11 % - 50% ☐ > 50%

4. Do you have ownership interests in a weight control clinic? ☐ YES ☐ NO

5. If ***yes***, what is the name of the weight control clinic with which you are affiliated: ____________

G. IF YOU USE SILICONE GEL/SALINE BREAST IMPLANTS, DO YOU USE THE MANUFACTURER'S INFORMED CONSENT FORMS IN ADDITION TO YOUR NORMAL INFORMED CONSENT PROCEDURE? ☐ YES ☐ NO

H. DO YOU SERVE IN A HOSPITAL EMERGENCY ROOM FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE? ☐ YES ☐ NO

1. If yes, number of hours per month: ☐☐☐

2. If yes, are the hours you work in the ER the minimum number of hours required to maintain hospital privileges? ☐ YES ☐ NO
If you have emergency room activities which are covered by another professional liability insurance policy, complete question I.

I. WILL YOU BE PERFORMING ACTIVITIES WHICH WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY? ☐ YES ☐ NO

If ***yes***, complete the following: ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice name and location(s): ____________

Name of Carrier: ____________

J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP THE MEDICAL PROTECTIVE COMPANY BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE. ____________

V. ADDITIONAL PROFESSIONAL INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

1. ***Do you perform surgery on professional athletes?*** ☐ YES ☐ NO
   If ***yes***, what percentage of your practice is devoted to performing surgery on professional athletes? ☐☐☐ %
   (If you are covered by other insurance for this activity, please complete Section IV, question I.)
2. ***Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?*** ☐ YES ☐ NO
   If ***yes***, include a copy of the indemnification agreement provided by the pharmaceutical company.
   (If you are covered by other insurance for this activity, please complete Section IV, question I.)
3. ***Do you treat or review treatment of federal prison inmates?*** ☐ YES ☐ NO
   (If you are covered by other insurance for this activity, please complete Section IV, question I.)
4. ***Do you treat non-federal prison inmates?*** ☐ YES ☐ NO
   If ***yes***, what percentage of your practice is devoted to treating non-federal inmates? ☐☐☐ %
   Does this facility have a law library? ☐ YES ☐ NO
   (If you are covered by other insurance for this activity, please complete Section IV, question I.)
5. ***Do you use a collection agency which has the authority to file collection suits without your knowledge?*** ☐ YES ☐ NO
6. ***Do you practice as a Medical Director at a blood bank?*** ☐ YES ☐ NO
   (If you are covered by other insurance for this activity, please complete Section IV, question I.)
7. ***Do you devise or review plant/employer safety standards?*** ☐ YES ☐ NO
   (1) What products are manufactured by the company? ______________________________

   ____

   (2) Company name: ______________________ Location: ______________________
   (If you are covered by other insurance for this activity, please complete Section IV, question I.)
8. ***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 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 explain and indicate the date(s): ______________________ Date: ☐☐ - ☐☐☐☐ (MM - YYYY)

   ____
9. ***Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty?*** ☐ YES ☐ NO
   (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)
   If ***yes***, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

   Type of Illness: ______________________________

   Duration of Illness: ☐☐ - ☐☐☐☐ (MM - YYYY) ***To*** ☐☐ - ☐☐☐☐ (MM - YYYY)

   Treating Physician (Name & Address): ______________________________

VI. PRACTICE ORGANIZATION INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PRACTICE ORGANIZATION:

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1) : TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ ***Solo Unincorporated/Sole Proprietor***

Entity Name: ______________________________

Employment Status

☐ Sole Proprietor ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: ☐☐ - ☐☐☐☐ (MM - YYYY)

If Other, please explain: ______________________________

A. PRACTICE ORGANIZATION: (continued)
Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status
Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ ***Solo Incorporated-No employed or contracted physicians***

Entity Name

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Individual, Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES ☐ NO

If yes, do you have any employed or contracted physicians associated with your practice? ☐ YES *(1)* ☐ NO

If no, do you wish to share your individual policy limits with your solo corporation? ☐ YES ☐ NO

If yes, and you desire to share your individual policy limits, please initial here.

Note: To qualify for shared limit solo corporation coverage, you must have no physician employees or physician independent contractors.

*** If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate entity application for consideration.***

☐ ***Multi-Shareholder Corporation, Partnership, Limited Liability Company***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Hospital*** ☐ ***Industrial*** ☐ ***Government-Branch:*** ______

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

VI. PRACTICE ORGANIZATION INFORMATION (continued) *If Additional Space is Needed, Please Use Supplemental Form*

A. PRACTICE ORGANIZATION: (continued)
Please check the boxes that best describes your practice affiliation(s) and "x" applicable boxes under Employment Status
Note (1) : TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ ***State Licensed Medical Surgical Center*** ☐ ***For Use By Other Physicians*** ☐ ***Your Patients Only***

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______________________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

☐ ***Other-Please Explain:*** ______________________________

Entity Name:

Employment Status

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date Joined/Formed: MM - YYYY

If Other, please explain: ______________________________

Is this entity or employer currently insured with The Medical Protective Company? ☐ YES ☐ NO

If yes, please provide The Medical Protective Company the Individual Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? ☐ YES *(1)* ☐ NO

B. IF THE BUSINESS PURPOSE OF THE ENTITY IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN: ______________________________

VII. LOSS INFORMATION (IMPORTANT PLEASE COMPLETE FULLY) *If Additional Space is Needed, Please Use Supplemental Form*

Please complete the Claim/Suit Information Form, Section VIII, for each claim, potential claim or suit.

A. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ☐ YES ☐ NO

If ***yes***, how many?

If ***yes***, have these been reported to your insurer? ☐ YES ☐ NO

B. Do you have knowledge of any incident or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim? ☐ YES ☐ NO

If ***yes***, how many?

If ***yes***, have these been reported to your insurer? ☐ YES ☐ NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

VIII. CLAIMS/SUIT INFORMATION FORM *(Please make copies if additional forms are needed)*

If making additional copies, please enter applicant's name here: ______

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION

1. Patient/Claimant Information:

LAST NAME

FIRST NAME

AGE: Gender: ☐ Male ☐ Female

2. Date of treatment and/or surgery, which led to the allegations against you. MM - YYYY

3. Date claim/incident notice received MM - YYYY

4. Date claim reported to prior insurer MM - YYYY

5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: ______

6. Disposition or current status of claim or suit: ☐ OPEN ☐ CLOSED

If Closed, Date of Closing/Settlement or award : MM - YYYY

7. Indicate case value established by carrier, if known: $ ___ , ___ , ___

8. Defending Insurance carrier name: ______

CARRIER NAME

9. Claim file number, if known: ______

CLAIM NUMBER

10. Was this matter closed with your consent? ☐ YES ☐ NO

Was a suit filed? ☐ YES ☐ NO

Was payment made? ☐ YES ☐ NO

If no, was claim or suit withdrawn? ☐ YES ☐ NO

If yes, indicate total amount of settlement or award: $ ___ , ___ , ___

Amount paid on your behalf: $ ___ , ___ , ___

11. Nature of allegations in the claim or suit: ______

Condition treated: ______

Treatment provided: ______

Alleged negligence: ______

Alleged injury: ______

12. Please provide a narrative description of the medical facts:
(must include, but not limited to the type of treatment and/or surgery; your involvement): ______

IX. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING. LIST CURRENT INSURER FIRST

1. ______________________ Insurer ☐ Claims Made ☐ Occurrence ___-___-_____ MM DD YYYY ***to*** ___-___-_____ MM DD YYYY

2. ______________________ Insurer ☐ Claims Made ☐ Occurrence ___-___-_____ MM DD YYYY ***to*** ___-___-_____ MM DD YYYY

3. ______________________ Insurer ☐ Claims Made ☐ Occurrence ___-___-_____ MM DD YYYY ***to*** ___-___-_____ MM DD YYYY

Please explain any gaps in coverage back to your start date of practice: ______________________

B. COVERAGE DESIRED

1. ☐ Occurrence

2. ☐ Claims-Made Coverage without Prior Acts Coverage

3. ☐ Claims-Made Coverage with Prior Acts Coverage ***(A copy of current declaration page showing current retroactive date must be attached)***

IF 1 OR 2 ARE SELECTED FROM THE ABOVE AND THE MOST RECENT PRIOR COVERAGE WAS ISSUED ON A CLAIMS MADE BASIS, PLEASE COMPLETE ONE OF THE FOLLOWING:

☐ An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)

☐ 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 result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying for with The Medical Protective Company if offered, will not provide prior acts coverage.

☐ ***Initial Here***

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

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.
This date cannot be earlier than the expiration date of your current policy.

From: ___-___-_____ MM DD YYYY ***12:01 a.m.***

To: ___-___-_____ MM DD YYYY ***12:01 a.m.***

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

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:
(Not required for occurrence policies or Claims-Made without prior acts)

___-___-_____ MM DD YYYY ***12:01 a.m.***

E. LIMITS DESIRED: ___,___,___ ***per occurrence/per claims made***

___,___,___ ***annual aggregate***

Note: Requested limits may not be available from this company

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my: ☐ Employer OR ☐ Named Third Party (Include Name&Address) ______________________

____

____

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer 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 assignment 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 ☐

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

XI. 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 act, which is a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here ☐

XII. 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: __ __ - __ __ - __ __ __ __
MM DD YYYY

____
Signature

____
Print Name

When would you like your quote delivered? __ __ - __ __ - __ __ __ __
MM DD YYYY

____
Agent's or Broker's Name (Print Name)

FOR OFFICE USE ONLY Status: ☐ Individual ☐ Entity Only ☐ Entity & Individual ☐ Group (Not Modular) ☐ CNBC

PRODUCER NAME ______________________ PRODUCER # ______________

PRODUCER CONTACT NAME ______________________ TITLE (CSR, MM, etc) ______________

Preferred Method of Contact ☐ E-MAIL ☐ FAX ☐ PHONE

______________________ E-mail

___ - ___ - ____ Fax

___ - ___ - ____ Phone

Entity Name: ______________________

MedPro Corp. # __________ MedPro Group # __________ MedPro Subgroup # __________ CMS # __________

MedPro Policy # __________ Modular Policy # __________ ☐ New Group Number of Insureds __________

Billing: ☐ With Group ☐ As Individual AT END OF POLICY PERIOD: ☐ Renew ☐ Do Not Renew Why: __________

Comments: ______________________

XIII. SUPPLEMENTAL FORM

(Attach a separate piece of paper if additional space is needed)

XIII. SUPPLEMENTAL FORM (continued)

(Attach a separate piece of paper if additional space is needed)