

Physicians Professional Liability Retroactive Coverage Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE AND REPORTED COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

For purposes of this Application, "Retroactive Period" means the period of time requested in question 9 of this Application, during which a "professional services wrongful act" must be committed or allegedly committed.

ACCOUNT INFORMATION

1. Applicant Name	
Other Names Used	
Degree / Title	
Birth Date (MM/DD/YYYY)	
Federal DEA # National Practitioner ID Number (if available)	
2. Home Address	Street:
	City: State: Zip:
	County: Email:
	Phone: Fax:
3. Principal Office Address	Street:
	City: State: Zip:
	County: Website
	Phone: Fax:
	Email:

4. Other Office Address(s)	Street: _____		
	City: _____	State: _____	Zip: _____
	County: _____	Website: _____	
	Phone: _____	Fax: _____	

5. List all locations where the Applicant practiced during the requested "Retroactive Period:" (please attach a separate sheet for additional locations)

a) Practice Name: _____ Period: _____
Practice Street Address: _____
City: _____ State: _____ County: _____ Zip: _____
Website Address: _____
Telephone Number: _____ Email Address: _____

b) Practice Name: _____ Period: _____
Practice Street Address: _____
City: _____ State: _____ County: _____ Zip: _____
Website Address: _____
Telephone Number: _____ Email Address: _____

c) Practice Name: _____ Period: _____
Practice Street Address: _____
City: _____ State: _____ County: _____ Zip: _____
Website Address: _____
Telephone Number: _____ Email Address: _____

6. Type of Practice (check all that apply during the requested "Retroactive Period"):

Individual (solo) Partnership Professional Corporation

Member of Multi-Person Corporation or Association Employee of: _____

Other (describe): _____ Independent Contractor of: _____

7. **Training**

Medical School: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Internship: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Type of Residency: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Fellowship Training Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Additional Medical Specialty training: _____ Dates: _____
 _____ Dates: _____
 _____ Dates: _____
 _____ Dates: _____

8. Is the Applicant a foreign medical school graduate? Yes No

If "Yes," please provide all information pertinent to the Applicant's ECFMG certification:

CURRENT AND REQUESTED COVERAGE

9. Retroactive Period: From: _____ To: _____

10. Briefly describe the reason(s) why the requested coverage is needed:

11. Requested effective date of coverage: _____

12. Duration of coverage: 1 Year 3 Years 5 Years 7 Years Unlimited Other: _____

13. Limits requested: Each claim: _____ Aggregate: _____

14. Limit Structure Requested:

Limits for insured physician only
 Separate limits for insured physician and separate limits for insured entity (if applicable)
 Shared limits for insured physician and insured entity (if applicable)

Note: In all cases, any non-physician insureds share in the insured physician or insured entity limits, as applicable, unless otherwise scheduled.

Separate limits may be subject to a policy maximum aggregate limit.

15. Retention requested: Each claim: _____ Aggregate: _____

16. MISSOURI RESIDENTS - do not answer this question.

Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? Yes No

If "Yes," please provide details:

17. Does the Applicant's current medical professional liability policy allow the Applicant to report known facts, circumstances, situations, transactions, events, acts, errors or omissions that could give rise to a claim that would fall within the scope of the proposed insurance? Yes No

18. List current and previous medical professional liability policies for the past seven (7) years:

Insurance Carrier	Policy Period MM/DD/YY - MM/DD/YY	Limits	Ded/SIR	Retroactive Date	Premium

FINANCIAL AND EXPOSURE DETAILS

19. List all states where the Applicant is licensed:

State: _____ License #: _____ Active Inactive

State: _____ License #: _____ Active Inactive

State: _____ License #: _____ Active Inactive

20. Medical Specialty: _____ % of Practice: _____
If Applicant's specialty is Pain Management, Neurosurgery or Bariatric Surgery Applicant will need to complete an additional procedure questionnaire.

Sub -Specialty: _____ % of Practice: _____
If Applicant's specialty is Pain Management, Neurosurgery or Bariatric Surgery Applicant will need to complete an additional procedure questionnaire.

21. Is the Applicant American board certified or board eligible? Yes No

If "Yes," Name of Specialty Board(s): _____

Date of Certification: _____ / _____ / _____

22. Did the Applicant's specialty and/or types of procedures performed change during the requested "Retroactive Period?" Yes No

If "Yes," please explain:

23. Did the Applicant perform any procedure that is outside the practice of his/her specialty or sub-specialty during the requested "Retroactive Period?" Yes No

If "Yes," please explain:

OPERATIONS AND ADMINISTRATION

24. Has the Applicant or any individual or entity proposed for coverage under this insurance:
- a) Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? Yes No
 - b) Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? Yes No
 - c) Been treated for any alcohol, narcotics or substance abuse? Yes No
 - d) Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? Yes No
 - e) Had hospital privileges reduced, suspended or revoked? Yes No
 - f) Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? Yes No

If "Yes" to any of the above, please explain:

25. During the requested "Retroactive Period," did the Applicant work part-time? Yes No

If "Yes," please explain:

26. Did the Applicant's practice during the requested "Retroactive Period" include the following?
- a. No surgery Yes No
 - b. Minor surgery (including minor invasive procedures) Yes No
 - c. Major surgery Yes No

27. Did the Applicant's practice during the requested "Retroactive Period" include any of the following?
- a. Obstetrics? Yes No
 - b. Weight loss/bariatric surgery? Yes No
 - c. Pediatrics? Yes No
 - d. Cosmetic surgery? Yes No
 - e. Services for any professional sports organizations? Yes No

If "Yes" to any of the above, please explain, and include the percent of practice:

28. Within the requested "Retroactive Period," did the Applicant use any locum tenens physicians? Yes No

If "Yes," please explain:

29. During the requested "Retroactive Period," did the Applicant own, operate or control any specialized medically related unit including, but not limited to, a pharmacy, laboratory, physical therapy center or surgery center? Yes No

If "Yes," please explain:

30. Allied Health Care Providers:

Please provide the number of healthcare professionals described below who were employed by or worked under the control of the Applicant during the requested "Retroactive Period:"

- | | |
|---|---|
| _____ Certified registered nurse anesthetists | _____ Surgical assistants |
| _____ Physician assistants | _____ Psychologists |
| _____ Nurse practitioners | _____ Registered nurses / licensed practical nurses |
| _____ Physical / occupational therapists | _____ Other (describe): |

CLAIMS HISTORY

31. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? Yes No

If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed):

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 31 IS EXCLUDED FROM THE PROPOSED INSURANCE.

32. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? Yes No

If "Yes," please provide details:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 32 IS EXCLUDED FROM THE PROPOSED INSURANCE.

FRAUD WARNINGS

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, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Maryland: 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.

Michigan: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a category D felony.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Pennsylvania: 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.

Puerto Rico: 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.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: 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.

Washington: 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.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy. The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)			
Insurance Agency			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:
Email Address			

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.