If joining a current Positive Physicians Insurance Company, please enter the policy number: _____

If previously covered with Positive Physicians Insurance Company, please enter the policy number: _____

Positive Physicians Insurance Company

ANCILLARY HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

Application Instructions

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

B. ***Additional documentation may be requested by the company as necessary***. For example: A copy of your most recent professional liability policy, including all endorsements, Declarations Page, etc.

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

I. General Information

A.

Last Name

First Name (Full)

Middle Name Suffix Date of Birth MM/DD/YYYY ☐ Male ☐ Female

Social Security Number (Optional) National Provider Identifier Number

Business Phone Business Fax Residence/Cell Phone

Email address:

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

C. Residence Address:

Number & Street Apartment #

City State Zip Code

County

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

_____ **1. % of practice** ☐ Office ☐ Hospital ☐ Other If other please explain: _____

Practice/Hospital Name

Number & Street

Suite City State Zip Code

County

_____ **2. % of practice** ☐ Office ☐ Hospital ☐ Other If other please explain: _____

Practice/Hospital Name

Number & Street

Suite City State Zip Code

County

I. General Information (continued)

3. % of practice ☐ Office ☐ Hospital ☐ Other If other please explain: _____

Practice/Hospital Name

Number & Street

Suite City State Zip Code

County

E. Billing and Correspondence Address:

☐ Location # (from Question D. above) ☐ Residence ☐ Other (Please enter below)

Number & Street Suite

City State Zip Code

II. Professional Information

Note: All percentages requested below for specialties are of your total practice.

Please enter complete name of specialty/sub-specialty and formal training program. Combined percentages for specialties must equal 100%.

A. What is your present specialty? _____ **% of total practice**

What is your sub-specialty? _____ **% of total practice**

B. Education/Training: _____

Name of School Credentials (CRNA, OD, RN etc.)

State Country

Completed from: _____ (MM YYYY) **To:** _____ (MM YYYY)

C. To which Healthcare Professional Societies or Associations do you belong? _____

D. Are you required to be licensed in the state(s) where you practice? ☐ Yes ☐ No

If yes, states in which you hold a license to practice: (Exclude state abbreviation from license number.)

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

	State	License #	Active	Inactive	Temporary	Pending
1.	_____	_____	☐	☐	☐	☐
2.	_____	_____	☐	☐	☐	☐

E. Have you completed a risk management education course within the last twelve (12) months? ☐ Yes ☐ No

F. Indicate the estimated average hours per week for which you require Positive Physicians Insurance Company coverage. _____ hrs

G. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates. _____ hrs None ☐

H. Indicate the average hours per week devoted to treating non-federal prison inmates. _____ hrs None ☐

II. Professional Information (continued)

I. Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, are you an: ☐ Employee ☐ Independent Contractor

Practice Name: _____

Location: _____

Name of Insurer: _____

J. 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 reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date ___ / ____ (MM / YYYY) _____

K. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date ___ / ____ (MM / YYYY) _____

L. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date ___ / ____ (MM / YYYY) _____

M. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? ☐ Yes ☐ No
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s), date(s) and identify your treating physician(s) 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.**

Type(s) of illness: _____

_____

Date(s) of treatment(s): **From** ___ / ____ (MM / YYYY) **To** ___ / ____ (MM / YYYY) ☐ Currently in treatment

Name of treating physician(s): _____

Address(es): _____

_____

N. Please check the box that best describes your practice affiliation: ☐ Employed ☐ Self Employed

O. Do you work for an entity or employer currently insured with Positive Physicians Insurance Company? ☐ Yes ☐ No

If yes, answer the following:

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other: _____

Employer/Entity name:

_____

Please provide Positive Physicians Insurance Company individual, corporation or partnership policy number or group number:

Policy #: _____ Group #: _____ Sub- _____

III. Loss Information (Important! Please fully complete.)

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below that has **NOT** been covered by a Positive Physicians Insurance Company 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. Are you now, or have you ever been, involved in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? ___ None ☐

III. Loss Information (continued) (Important! Please fully complete.)

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? 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, have you or anyone from your practice 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 against you?

If **yes**, how many? ☐☐☐ None ☐

IV. 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 coverage without Prior Acts coverage" was selected as the desired coverage 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 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 insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying for with Positive Physicians Insurance Company, if offered, will not provide Prior Acts coverage.

Initial Here

V. Notices and Agreements

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.

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 Positive Physicians Insurance 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 understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

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: _____
Applicant's Signature MM DD YYYY

_____
Print Name

VI. Supplemental Information-Physician's Assistants and Nurse Practitioners need to complete the following section

A. 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.

B. Do you independently prescribe/order drugs without physician review? ☐ Yes ☐ No

VII. Supplemental Information-Certified Nurse Midwives and Podiatrists need to complete the following section

Pennsylvania law requires Podiatrists and Certified Nurse Midwives to have full annualized, separate and individual limits and participate in the Medical Care Availability and Reduction of Error Fund ("MCARE").

A. What percentage of your practice (based on the number of patients treated) is in Pennsylvania? ___ %

B. If you are a Podiatrist, do you perform surgery? ☐ Yes ☐ No

If yes, please indicate the type of surgeries you perform. _____

C. Please indicate your MCARE retroactive date if different than the retroactive date stated in Question IV.C. _____
MM DD YYYY

VII. Supplemental Information-Certified Nurse Midwives and Podiatrists need to complete the following section (continued)

D. Have you ever had any application for MCARE abatement declined by MCARE? ☐ Yes ☐ No

If yes, please explain: _____

E. Are you aware of any periods of non-compliance with MCARE? ☐ Yes ☐ No

If yes, please explain: _____

VIII. Supplemental Information