POSITIVE PHYSICIANS INSURANCE COMPANY

PHYSICIAN GROUP PROFESSIONAL LIABILITY INSURANCE APPLICATION

Application Definitions and Instructions

A. As used in this Application, the word Group means the entity or corporation as well as all Group Members unless otherwise indicated below. Group Members means any Group shareholder, owner, employee or independent contractor.

B. If additional space is needed, please complete **Section VII. Supplemental Information** with a reference to the relevant question.

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

I. Group Information

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

Group Name(s): _____

Group DBA, Fictitious Name, etc.: _____

___ — _____ Federal Tax I.D. Number

_____ National Provider Identifier Number (Corporate NPI 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 Group does business under any other name, please list all additional names (including clinic names).

Group Name(s): _____

___ — _____ Federal Tax I.D. Number

_____ National Provider Identifier Number (Corporate NPI Number)

Date Entity Formed: ____ / _____ MM YYYY

If there is more than one Group Name, please add the information above to the Supplemental Information section at the end of the application.

C. If the Group has 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 Corporation
- ☐ Not for Profit Corporation
- ☐ 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
- ☐ In Vitro Fertilization
- ☐ Laboratory
- ☐ Liposuction
- ☐ Managed Care Organization/ Managed Services Organization
- ☐ Medi-Spa
- ☐ MRI/X-Ray/Imaging
- ☐ Nursing Home
- ☐ Obstetrics
- ☐ Osteopathic Manipulation Therapy
- ☐ Pain Medicine
- ☐ Pathology
- ☐ Pharmacy
- ☐ Physical Therapy Center
- ☐ Plastic Surgery
- ☐ Primary Care
- ☐ 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): _____

F. Was this Group a previous Positive Physicians Insurance Company insured? ☐ Yes ☐ No

If yes, please provide the Individual, Corporation, or Partnership policy and/or group number if known.

Policy#: _____ Group#: _____ Sub-Group#: _____

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I. Group Information (continued)

G. Practice Location(s): (Please list primary location first. Combined percentage of practice for all locations must total 100%. If you need more space for additional locations, please use Section VII. Supplemental Information.)

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 Group authorized to do business?

State of Incorporation: _____ Authorized states: _____, _____, _____, _____, _____, _____, _____, _____

II. General Information

A. Has the Group or any Group Member:

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

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

3. Ever had any professional liability insurance refused, declined, canceled or non-renewed by the insurance company? ☐ Yes ☐ No

4. Ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

5. Ever incurred or become aware of having a condition that impairs a Group Member's ability to practice his or her 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) and date(s) and identify the Group Member's treating physician(s) in the space provided below. In the event of any such impairment, **a statement from the Group Member's physician attesting to his or her fitness to practice his or her specialty must accompany this application.**

6. Have any physicians incurred any gaps in coverage in the last 10 years? ☐ Yes ☐ No

If the answer was yes to any of the above, please identify the Group Member(s) involved, date(s) and provide an explanation.

Group Member(s): _____ Date: _____ / _____ MM YYYY

Explanation: _____

_____

_____

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

If yes, is the laboratory providing services solely for the Group's patients? ☐ Yes ☐ No

If no, please explain: _____

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II. General Information (continued)

C. Will any of the Group's members be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, state practice name, location and insurer name. If you need more space, please use Section VII Supplemental Information.

Practice Name: _____

Location: _____

Name of Insurer: _____

D. Does the Group participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? ☐ Yes ☐ No

If yes, does it include an indemnification agreement provided by the pharmaceutical company? ☐ Yes ☐ No

E. Please include estimated annual amounts regarding the following:

Clinic visits: _____

Surgeries performed: _____

Gross Revenue: $ _____ , _____ , _____

F. In the last 5 years:

1. Has the Group discontinued major surgical procedures, performance of obstetrics, or any other medical activity? ☐ Yes ☐ No

   If yes, list such discontinued procedures/activities, reason for discontinuing, and date discontinued. Date: ____ / ____ (MM / YYYY)

   _____

   _____

2. Has the Group performed weight-control surgery or prescribed anorectic drugs? ☐ 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

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III. Roster of Staffing

A. Please identify all owners, employed and contracted individuals within your Group, and provide information concerning each Group Member in each category listed in the following table. Please also identify any group members who will not be insured by Positive Physicians

Insurance Company : Note: Include all Group Members.

For Status column below: (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor

Last Name, First Name, Middle, Designation (i.e. Smith, Jane G. MD)	DOB	License Number	Status (S) (P) (E) (IC)	State	County	Specialty ISO	Surgery Type (No) (Minor) (Major)	Gradua-tion Date	Date First Started in Practice	Retro Date	Coverage Type	Limits	Hours per Week (avg)

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III. Roster of Staffing (continued)

B. If any of the following are to be provided shared limits, please list below.

Classifications	Number Employed
Nurse Midwife	
Nurse Anesthetist	
Nurse Practitioner	
Optometrist	
Physician Assistant	
Surgical Assistant	
Total Personnel	

**Employee means any person employed by, or under contract with, and acting within the direct control or supervision of the insured physician, or his or her solo corporation, at the time of the health care event.*

IV. Loss Information

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below in which the Group's or any of its members policy was triggered and 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 the Group or any of its members even if you believe the claim or suit would be without merit.

A. In the last ten years, is the Group or any of its members now involved, 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 current or previous claims/suits have arisen? _____ ☐ None

B. Is the Group or any of its members 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 the Group or any of its members received a written request from an attorney for treatment records concerning any current or former patient(s) that might reasonably result in a claim or suit?

If **yes**, how many? _____ ☐ None

D. Have all claims, suits, written requests and incidents that would qualify under A, B & C above been reported to the Group's current insurer?

☐ Yes ☐ No

V. 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 the Group's 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".**
2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage Desired: (Please check all that apply)

☐ Claims-Made coverage without Prior Acts coverage ☐ Occurrence coverage ☐ Occurrence Plus
☐ Claims-Made coverage with Prior Acts coverage ☐ Occurrence coverage with Prior Acts coverage ☐ Occurrence Plus 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 the Group's current Claims-Made policy is: ____ / ____ / _____
(This date is required for Occurrence with prior acts, Occurrence Plus with prior acts or Claims-Made with Prior Acts.) MM DD YYYY

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V. Coverage Information (continued)

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

E. 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 been and will not be purchased. (Note: If this selection is chosen, the accompanying box must be initialed.)

The Group **will not** purchase tail coverage (i.e. extended reporting endorsement) from its current carrier where the Group is insured under a Claims-Made policy. The Group realizes that failure to purchase such coverage from the current carrier will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by our current carrier's policy. The Group understands that the policy, which is being applied for from Positive Physicians Insurance Company, will not provide Prior Acts coverage.

Initial Here

VI. Notices and Agreements

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

The Group hereby declares 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 the Group's initial or renewal application, are true and that neither the Group nor any Group Member has knowingly suppressed or misstated any material facts, whether on behalf of the Group or the Group Member, and the Group and each Group Member agrees that this application, and any **Attachments**, shall be the basis of the contract with the Company. The Group agrees 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 professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

The Group understands that any material misrepresentation or omission made 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, neither the Group nor any Group Member is relying upon any oral or written representation that coverage has or will be extended to the Group or that a policy of insurance will be issued.

The Group further understands and agrees that the Group has no right to demand or expect coverage until Positive Physicians Insurance Company has: (1) received the Group's completed application; (2) offered the Group a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if Positive Physicians Insurance Company has agreed to finance the premium, the first installment due. In addition, the Group understands that if it pays the Group's premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by Positive Physicians Insurance Company until it has been honored by the bank.

The Group agrees that if the Group or any Group Member fails to comply with these terms the Group or Group Member will have no coverage for any claim under any policy of insurance for which the Group is applying.

The Group and each Group Member also understands that Positive Physicians Insurance Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding the Group and Group Member's credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, the Group and all Group Members hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to Positive Physicians Insurance Company any information regarding the Group, or any Group Members which Positive Physicians Insurance Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder. The Group warrants that the Authorized Representative below is authorized to disclose all information that may be submitted 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 the Group (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), and employed and contracted physicians, the Authorized Representative warrants that he or she is an Officer, Partner, Office Administrator or other Authorized Representative of the Group applying for coverage.

Application must be signed by one of the following:

- **a President, Chief Executive Office, or other Officer of the Group;**
- **Partner, if a PC or PA; or**
- **the Office Administrator or equivalent Authorized Representative on behalf of the Group and all Group Members.**

_____ Date Signed: ____/____/_____

Authorized Representative Signature MM DD YYYY

_____

Print Name

_____

Title

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VII. Supplemental Information

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