Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Practice Change

All adjustment requests are subject to underwriting approval. Adjustment changes may incur a change in premium.

Policy #: Policyholder Name: Requested Effective Date:

Please list all practice locations in which you require Medical Protective coverage. *Please note: Total percentage of practice should equal 100%.*
If you have more than 3 locations, please provide the additional information in the comments section below, or attach separate documentation.

Practice Name:
Percentage of Practice: Hours Worked: Phone: Fax: Email:
Address:
City: State: Zip: County:

Practice Name:
Percentage of Practice: Hours Worked: Phone: Fax: Email:
Address:
City: State: Zip: County:

Practice Name:
Percentage of Practice: Hours Worked: Phone: Fax: Email:
Address:
City: State: Zip: County:

Have you added or discontinued any procedures since your last completed application with Medical Protective? ☐ Yes* ☐ No

Do you desire shared or separate entity coverage for any of the above locations? ☐ Yes* ☐ No

Are you adding/changing employer affiliation, corporation/entity coverage, or requesting a change to third party assignment of rights? ☐ Yes* ☐ No

**** If yes, please complete the appropriate supplement(s) at the end of this form.***

Complete only if changing:

Residence Address: City: State: Zip:
Phone: _____ Fax: _____ Email:

Billing Address: City: State: Zip:

License Number: Policy Limits: _____ Per Occurrence / _____ Aggregate

Coverage type:
☐ Claims-Made Coverage with prior acts Coverage
☐ Occurrence Coverage
☐ Claims-Made Coverage without prior acts Coverage
☐ Occurrence Coverage with Prior Acts Coverage

Additional comments:

_____ _____
Insured's Signature Date

If this form is being signed by the insured's agent: By my signature, I hereby represent that the insured has granted me full authority to execute this form on his or her behalf. I also represent that I have reviewed the responses contained in this form with the insured, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this form with the insured and that the insured understands and agrees that such representations are binding upon him or her, even though I am executing this form on the insured's behalf. I further acknowledge that any material misrepresentation or omission made on this form may form the basis for the Company to terminate my Agency Agreement with cause.

_____ _____
Agent's Signature Date

Please read:	**Deliver to:**
Please sign and return.	Fax: 800-398-6726 Postal Mail: P.O. Box 15021 Fort Wayne, Indiana 46885 Email: medproinduction@medpro.com

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Practice Organization Supplement

Policy #:	Policyholder Name:	Requested Effective Date:

Practice Organization Affiliation:

Number of practice organizations of which you are an employee, shareholder/partner, or independent contractor:

(Please provide details below for your primary practice organization. If you indicated more than one organization above, please complete a Practice Organization Supplement form for each one.)

Name of Legal Entity:
Date Joined / Formed (MM/DD/YYYY):

If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.):

Type of Organization:

- ☐ Standard Medical / Dental Practice
- ☐ Hospital
- ☐ Mobile Dentistry
- ☐ Nursing Home
- ☐ State Licensed Surgery Center:
  - ☐ For use by other Doctors
  - ☐ Your patients only
- ☐ Other – Please explain:

Employment Status:

- ☐ Employee
- ☐ Shareholder / Partner
- ☐ Independent Contractor
- ☐ Other – Please explain:

Please indicate the number of doctors and healthcare professionals providing services in your office:

Doctors (please exclude yourself):

Healthcare Professionals:

Type of Legal Entity (Check only one box):

- ☐ Solo Incorporated:
- ☐ Multi-Shareholder Corporation / Partnership / Limited Liability Company:

  If this entity or employer is currently insured by Medical Protective, please provide the following information:

  Policy #: Group #: Sub-Group #: Modular #:

- ☐ Other – Please explain:

Do you desire coverage for this entity? ☐ No ☐ Yes

If yes, please select the type of entity coverage desired: ☐ Shared Policy Limits ☐ Separate Policy Limits

Note: *Shared policy limits are not available in Indiana, Kansas*, and Pennsylvania*. To request Separate Limit Entity Coverage, please contact your agent or a Medical Protective Service Representative to complete an entity application for consideration.* ***(* Excludes Dental Policies)***

5814 Reed Road Fort Wayne, IN 46835 | 800-4MedPro | www.medpro.com

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Practice Organization Supplement – Continued

Third Party Assignment of Rights:

Would you like to assign an employer or third party the right to cancel your coverage and receive any premium refunds? ☐ Yes ☐ No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. 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 faxing a written notice to 1-800-398-6726 or by sending written notice to The Medical Protective Company, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initials:

Third Party Name:

Address:

City: State: Zip:

Additional Comments:

_____ _____
Insured's Signature Date

If this form is being signed by the insured's agent: By my signature, I hereby represent that the insured has granted me full authority to execute this form on his or her behalf. I also represent that I have reviewed the responses contained in this form with the insured, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this form with the insured and that the insured understands and agrees that such representations are binding upon him or her, even though I am executing this form on the insured's behalf. I further acknowledge that any material misrepresentation or omission made on this form may form the basis for the Company to terminate my Agency Agreement with cause.

_____ _____
Agent's Signature Date

Please read:	**Deliver to:**	
○ Please sign and return.	Fax:	800-398-6726
	Email:	medproinduction@medpro.com
	Postal Mail:	P.O. Box 15021 Fort Wayne, Indiana 46885
All adjustment requests are subject to Underwriting approval. Adjustment changes may incur a change in premium coverage.		

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Requested effective date of change: _____ / _____ / _____ 12:01am **Policy number:** _____

MM DD YYYY

THE MEDICAL PROTECTIVE COMPANY

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE/PROCEDURE CHANGE REQUEST FORM

Procedure Change Request Instructions

Please print legibly and answer all questions. If a question is not applicable, state "N/A".

I. Practice Information

A. Indicate the average weekly numbers, under each of the following categories, for which you require Medical Protective coverage. (If you practice in multiple states, please identify the following informatoin for each state.)

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

# of Patients Per Week _____ Hours Per Week _____ Unscheduled New Walk-In Patients Per Week _____

B. What is your present specialty? _____ _____ % of Total Practice

What is your sub-specialty? _____ _____

C. Are you discontinuing any major surgical procedures, performance of obstetrics, or any other medical/activity? ☐ Yes ☐ No

If yes, list procedures/activities, reasons for discontinuing, and date discontinued. _____ Date: _____ / _____

_____

D. Please check any of the following procedures you will perform:

- ☐ Abdominoplasty - Tummy Tuck
- ☐ Abortions - Elective _____% of total practice
- ☐ Abortions - Therapeutic _____% of total practice
- ☐ Acupuncture - Therapeutic/Local Anesthetic
- ☐ Anesthesia General/Spinal/Caudal
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assisting in major surgery - own patients only
- ☐ Assisting in major surgery - own & other than own patients
- ☐ Bariatric Surgery - Laparoscopic
- ☐ Bariatric Surgery - Non-Laparoscopic
- ☐ Biopsy - Endoscopic
- ☐ Blepharopigmentation - _____% of total practice
- ☐ Blepharoplasty - Cosmetic _____% of total practice
- ☐ Blepharoplasty - Reconstruction ___% of total practice
- ☐ Botox _____% of total practice
- ☐ Brachioplasty
- ☐ Breast Implants - Cosmetic _____% of total practice
- ☐ Breast Implants - Reconstruction ___% of total practice
- ☐ Breast Reduction - Cosmetic
- ☐ Bronchoscopy
- ☐ Bronco-esophagology
- ☐ Buttock Implants
- ☐ Calf Implants
- ☐ Cataract Surgery
- ☐ Catheterization - Umbilical Cord
- ☐ Catheterization - Left Heart
- ☐ Catheterization - Right Heart (other than CVP lines) / Swan Ganz
- ☐ Cheek/Chin/Lip Implants
- ☐ Chelation Therapy
- ☐ Chemical Peels - Superficial / Medium
- ☐ Chemical Peels - Deep _____% of total practice
- ☐ Cleft Lip Surgery - Reconstructive
- ☐ Cleft Palate Surgery - Reconstructive
- ☐ Colonoscopy
- ☐ Cryosurgery (Cervical)
- ☐ Cryosurgery (non-external lesions)
- ☐ D & C
- Discectomy
  - ☐ Open
  - ☐ Other Than Open
- ☐ Discograms
- ☐ Electromagnetic Therapy
- ☐ Electroconvulsive/Shock Therapy
- ☐ Embolization
- ☐ Epidural Injections
- ☐ ERCP
- ☐ Face Lifts
- ☐ Face Lifts Mini(done with laser)___% of total practice
- ☐ Gastrointestinal Endoscopy
- ☐ Gynecology - Major Surgery
- ☐ Hair Transplants - Follicular Unit Transplantations
- ☐ Hair Transplants - Other
- ☐ HVLA on the cervical spine on patients younger than 18 years of age
- ☐ Intrathecal Pumps
- ☐ Kyphoplasty
- ☐ Laporoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Laser Therapy (Endoscopic)
- ☐ Laser Therapy (Non-Endoscopic)
- ☐ Lipoinjection _____% of total practice
- Liposuction
  - ☐ Other Than Tumescent Technique
  - ☐ Tumescent Technique Only___% of total practice
- ☐ Lithotripsy
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- ☐ Needle Biopsy
- Nerve Blocks
  - ☐ Facet
  - ☐ Lumbar Epidural Steroid
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Paraspinal/Paravertebral
  - ☐ Peripheral
  - ☐ Sciatic
  - ☐ Triggerpoint Injection
- ☐ Oxidation Therapy
- ☐ Pacemakers - Epicardial
- ☐ Pacemakers - Endocardial
- ☐ Pacemakers - Temporary
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Polypectomy
- Prenatal /Gynecological Practice
  - ☐ Prenatal Practice - 1st & 2nd Trimester
  - ☐ Prenatal Practice - to term, no delivery
  - ☐ Prenatal Practice - to term, and delivery
  - ☐ Normal Deliveries - total per year _____
  - ☐ Cesarean Deliveries - total per year ____
- ☐ Prolotherapy
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye-Non Ionic or Other than Non Ionic
- ☐ Rectal Ozone Therapy
- ☐ Rhinoplasty _____% of total practice
- ☐ Sclerotheraphy
- ☐ Sigmoidoscopy - 60 cm or less
- ☐ Sigmoidoscopy - greater than 60 cm
- ☐ Silicone Injections___% of total practice
- Skin Flaps/Grafts
  - ☐ Cosmetic _____% of total practice
  - ☐ Reconstruction ____% of total practice
  - ☐ With Arterial Blood Supply Other Than Cancer Therapy
- ☐ Spinal Cord Stimulators
- ☐ Thigh Lift
- ☐ Tubal Ligations
- ☐ Upper GI Endoscopy
- ☐ Vasectomies - own patients
- ☐ Vasectomies - own & other than your own patients
- ☐ Weight Control Medication ___% of total practice
- ☐ Other Medical Techniques

List Procedures (do not restate your specialty)

_____

_____

I. Practice Information (continued)

E. **Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, Telemedicine or Internet Medicine?** ☐ Yes ☐ No

(If this is covered by another professional liability insurance policy, complete Question G.)

If yes, which state(s): _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____

F. **Please indicate the percentage of your total practice devoted to the following surgical activities:**

_____ % Cardiac	_____ % Obstetrics	_____ % Plastic (reconstruction only)
_____ % Endocrinology	_____ % Ophthalmology	_____ % Thoracic
_____ % Gynecology	_____ % Orthopedic (including back)	_____ % Traumatic
_____ % Neoplastic Surgery	_____ % Orthopedic (not including back)	_____ % Urology
_____ % Nephrology	_____ % Otolaryngology	_____ % Vascular
_____ % Neurosurgery	_____ % Plastic (cosmetic enhancement only)	_____ % Other (Describe)_____

G. **Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.)** ☐ Yes ☐ No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours) _____ hrs

   Indiana Only: _____ % Major Surgery _____ % Minor Surgery

2. On average how many of the above hours are you working in order to fulfill staff privilege requirements? _____ hrs

(If you have emergency room activities which are covered by another professional liability insurance policy, complete Question G.)

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

If yes, are you a(n): ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

II. Agreements

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.

_____ Date Signed: _____ / _____ / _____

Applicant's Signature MM DD YYYY

_____

Print Name

If this form is being signed by the insured's agent: By my signature, I hereby represent that the insured has granted me full authority to execute this form on his or her behalf. I also represent that I have reviewed the responses contained in this form with the insured, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this form with the insured and that the insured understands and agrees that such representations are binding upon him or her, even though I am executing this form on the insured's behalf. I further acknowledge that any material misrepresentation or omission made on this form may form the basis for the Company to terminate my Agency Agreement with cause.

_____ _____

Agent's Signature Date

_____

Printed Name

III. Supplemental Information (Attach a separate piece of paper if additional space is needed)