If previously covered with Medical Protective, please enter the policy number: _____

# THE MEDICAL PROTECTIVE COMPANY

## PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

*For faster service, please enter your application online at WWW.MEDPRO.COM*

**Application Instructions**

**A.** If additional space is needed, please complete Section X. 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 | Start Date: MM / YYYY

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

Practice/Hospital Name

Number & Street

Suite | City | State | Zip Code

County | Start Date: MM / YYYY

## 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 Start Date: MM / YYYY

**E. Do you admit patients to any of the above hospital locations?** ☐ Yes ☐ No

If no, please explain your protocol to admit patients to a hospital if the circumstance would arise. _____

**F. Billing and Correspondence Address:**

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

Number & Street Suite

City State Zip Code -

## II. Educational Background

**A. Medical School:**

Name of School Degree

City State **Completed from:** MM / YYYY **To:** MM / YYYY

Country

**If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program?** ☐ Yes ☐ No

If no, please explain: _____

**B. Residency: List all Residency training programs.**

Please enter each specific specialty.

**1.** Name of Hospital/Facility/Program

City State Country

Specialty Type

**Completed?** ☐ Yes ☐ No ☐ Still in training **From:** MM / YYYY **To:** MM / YYYY

**2.** Name of Hospital/Facility/Program

City State Country

Specialty Type

**Completed?** ☐ Yes ☐ No ☐ Still in training **From:** MM / YYYY **To:** MM / YYYY

## II. Educational Background (continued)

**C. Have you participated in any additional training? (i.e. Fellowship, etc.)** ☐ Yes ☐ No

**1.** Name of Hospital/Facility/Program

City | State | Country

Specialty Type

**Completed?** ☐ Yes ☐ No ☐ Still in training **From:** MM / YYYY **To:** MM / YYYY

**2.** Name of Hospital/Facility/Program

City | State | Country

Specialty Type

**Completed?** ☐ Yes ☐ No ☐ Still in training **From:** MM / YYYY **To:** MM / YYYY

**D. Are you entering private practice for the first time?** ☐ Yes ☐ No

**E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 credit hours.**

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

## III. Practice Information

**A. 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 Section IV., Question H.)

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

**B. States in which you hold a license to practice medicine:**

(Exclude state abbreviation from license number.)

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

| | | Active | Inactive | Temporary | Pending |
|---|---|---|---|---|---|
| **1.** State | License # | ☐ | ☐ | ☐ | ☐ |
| **2.** State | License # | ☐ | ☐ | ☐ | ☐ |
| **3.** State | License # | ☐ | ☐ | ☐ | ☐ |
| **4.** State | License # | ☐ | ☐ | ☐ | ☐ |

**C. Do you have previous practice location(s)? If yes, list all location(s) within the past 10 years. If your requested retroactive date is greater than 10 years, provide locations back to the retroactive date. Please list most recent location first.** ☐ Yes ☐ No

**1.** Name of Practice

City | State | Country

Specialty **From:** MM / YYYY **To:** MM / YYYY

**2.** Name of Practice

City | State | Country

Specialty **From:** MM / YYYY **To:** MM / YYYY

**D. Please explain the following gaps if they occurred in the last 10 years:**

**1.** Gaps greater than 1 year between your medical school, residency, other training or first time in practice. _____

_____

**2.** Gaps greater than 6 months between practice locations. _____

_____

**E. To which Medical Societies or Associations do you belong?** _____

## III. Practice Information (continued)

**Note:** All percentages requested below for specialties, procedures and surgical activities are of your total practice.

****Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.****

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

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

**G. Are you permanently retired from the practice of clinical medicine?** ☐ Yes ☐ No

**H. American Board Certified?** ☐ Yes ☐ No

_____ Specialty Board ___/___ Date most recently certified

_____ Specialty Board ___/___ Date most recently certified

If not American Board Certified, are you board eligible? ☐ Yes ☐ No If yes, when do you plan on taking your boards? ___/___ MM YYYY

If not American Board Certified, have you ever taken a specialty board examination and failed to pass? ☐ Yes ☐ No

If yes, how many times? ___

If yes, please explain: _____

**I. Indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage.**

Hours per week ___ Patients seen per week ___ None ☐ Unscheduled walk-in patients per week ___ None ☐

**J. 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 - 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
- ☐ Electromagnetic Therapy
- ☐ Electroconvulsive/Shock Therapy
- ☐ Embolization
- ☐ 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
- 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
- ☐ Rectal Ozone Therapy
- ☐ Rhinoplasty _____% of total practice
- ☐ 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
- ☐ 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)

_____

_____

_____

## III. Practice Information (continued)

**K. Please indicate the percentage of your total practice performing the following surgical activities:**

| | | |
|---|---|---|
| ___ % Cardiac | ___ % Orthopedic (including back) | ___ % Thoracic |
| ___ % Gynecology | ___ % Orthopedic (not including back) | ___ % Traumatic |
| ___ % Hand | ___ % Otolaryngology | ___ % Urology |
| ___ % Neurosurgery | ___ % Plastic (cosmetic enhancement only) | ___ % Vascular |
| ___ % Obstetrics | ___ % Plastic (reconstruction only) | ___ % Other (Describe) _____ |
| ___ % Ophthalmology | | _____ |

**L. In the last 10 years,**

**1.** Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity? ☐ Yes ☐ No

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

_____

_____

**2.** 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% ☐ Never prescribed weight control medication

b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?
☐ <1% ☐ 1% - 10% ☐ 11%-50% ☐ >50% ☐ Never performed weight control surgery

**M. Do you have ownership or financial interests in a weight control clinic?** ☐ Yes ☐ No

If yes, what is the name of the weight control clinic with which you are affiliated? _____

**N. 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

**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, please complete Section IV, Question H.)

**O. Please use the space below for any comments you feel will help The Medical Protective Company better understand any special circumstances concerning your practice.**

_____

_____

_____

_____

## IV. Additional Professional Information

**Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the question.**

(For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)

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

**B. Indicate the average hours per week devoted to treating non-federal prison inmates.** ___ hrs None ☐

**C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes.** ___ % None ☐

**D. Indicate the percentage of your practice devoted to working in a nursing home facility.** ___ % None ☐

**E. 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.

**F. Do you practice as a medical director?** ☐ Yes ☐ No

Type and name of facility: _____

If yes, what percentage of your practice is devoted to this activity? ___ %

Briefly describe your responsibilities: _____

**G. Do you devise or review plant/employer safety standards?** ☐ Yes ☐ No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

## IV. Additional Professional Information (continued)

**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: _____

**I. 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 _____

**J. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy?** ☐ Yes ☐ No

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

**K. 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 _____

**L. 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) and 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):** _____

## V. 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 Medical Protective 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 ☐

**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 ☐

## VI. Practice Organization Information

**Please provide the 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 for each one.

**A. Type of Legal Entity:** (Check only one box)

☐ Solo Unincorporated/Sole Proprietor ☐ Solo Incorporated

☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company ☐ Other-please explain: _____

**B. Employment status:**

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date joined: ☐☐ / ☐☐ / ☐☐☐☐ (MM / DD / YYYY)

**C. Type of Organization:**

☐ Standard Medical Practice

☐ Hospital

☐ State Licensed Medical Surgery Center

- ☐ For use by other physicians
- ☐ Your patients only

☐ Other-please explain: _____

**D. Entity Name:** (As stated in the Articles of Incorporation and all formal entity/clinic names.)

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

**F. 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 or group number, if known.

Policy #: Group #: Sub-group #:

**G. Do you desire coverage for this entity?** ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

☐ Shared Policy Limits ☐ Separate Policy Limits

(To request Separate Limit Entity coverage, please contact your agent or Medical Protective Service Representative to complete an application for consideration.)

**H. If the purpose of the entity noted above is other than a medical office practice, please explain:**

**I. Indicate the number of each of the following who provide services in your office (please exclude yourself):**

| | | | | | |
|---|---|---|---|---|---|
| Physicians | ☐☐☐ | Nurse Midwives | ☐☐☐ | Physician Assistants | ☐☐☐ |
| Dentists | ☐☐☐ | Nurse Midwife Assistants | ☐☐☐ | Physician Surgical Assistants | ☐☐☐ |
| Aestheticians | ☐☐☐ | Nurse Practitioners | ☐☐☐ | Podiatrists | ☐☐☐ |
| Case Managers | ☐☐☐ | Nurse Surgical Assistants | ☐☐☐ | Psychologists | ☐☐☐ |
| CRNAs/RNAs | ☐☐☐ | Occupational Therapists | ☐☐☐ | Respiratory Therapists | ☐☐☐ |
| Chiropractors | ☐☐☐ | Perfusionists | ☐☐☐ | | |

**J. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services?** ☐ Yes ☐ No

If no, do you plan to do so within 12 months of your requested effective date? ☐ Yes ☐ No

If yes, please provide an explanation:

## VII. 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:** MM / DD / YYYY **To:** MM / DD / YYYY
Annual policy term will begin and end on the same month and day.

**C. The retroactive date shown on your current Claims-Made policy is:** MM / DD / YYYY
(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.)

**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: MM / DD / YYYY To: MM / DD / YYYY

**2.** Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: MM / DD / YYYY To: MM / DD / YYYY

**3.** Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: MM / DD / YYYY To: MM / DD / YYYY

**F. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your requested retroactive date.**

_____

_____

_____

**G. 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 a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying with The Medical Protective Company, if offered, will not provide Prior Acts coverage.

**Initial Here**

## VIII. Assignment of Right to Cancel Coverage

**Would you like to assign an employer or a named 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 sending written notice to The Medical Protective Company, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

**Initial Here**

Name: _____
Street: _____ Suite: _____
City: _____
State: _____ Zip Code: _____ Phone Number: _____

**Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.**

## IX. Notices and Agreements

**Any person who knowingly files an application for insurance or a statement of a 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.**

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 The Medical Protective 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

**If application is being signed by the applicant's agent:** By my signature, I hereby represent that the applicant has granted me full authority to execute this application on his or her behalf. I also represent that I have reviewed the responses contained in this application with the applicant, 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 application with the applicant and that applicant understands and agrees that such representations are binding upon him or her, even though I am executing this application on the applicant's behalf. I further acknowledge that any material misrepresentation or omission made on this application may form the basis for the company to terminate my agency agreement with cause.

_____ Date Signed: __ __ / __ __ / __ __ __ __
Agent's Signature MM DD YYYY

_____
Print Name

## X. Supplemental Information

# The Medical Protective Company

## Loss Information Supplement

Please make copies if additional forms are needed.

**Applicant's Name:** _____

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

**A. Is the matter related to:** **A** ☐ **B** ☐ **C** ☐ **from the Loss Information section? (Check only one)**

A. Current or prior claim.

B. Complication, incident, or adverse outcome.

C. Written request for records.

**B. Patient/Claimant Information:**

Last Name _____ First Name _____ Age _____

**C. Date of treatment and/or surgery which led, or could lead, to allegations against you.** MM / YYYY

**D. Date of notice received, if applicable.** MM / YYYY

**E. Has this matter been reported to your current or former insurer?** ☐ Yes ☐ No

If yes, date reported to your current or former insurer: MM / YYYY

Current or former insurer name: _____

If no, please explain: _____

**F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved.** _____

**G. Current status:** ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ _____

If closed:

1. Date of closing: MM / YYYY

2. Was a payment made? ☐ Yes ☐ No

   a. If yes, did you consent to the settlement? ☐ Yes ☐ No

   b. Total amount of settlement or award: $ _____

   c. Total amount of settlement or award paid on your behalf: $ _____

**H. Nature of allegations or potential allegations:**

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

**I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:**

_____

_____

_____

_____

_____

# The Medical Protective Company

## Practice Organization Information Supplement

**A. Type of Legal Entity:** (Check only one box)

☐ Solo Unincorporated/Sole Proprietor ☐ Solo Incorporated

☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company ☐ Other-please explain: _____

**B. Employment status:**

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date joined: ___ / ___ / ____
MM DD YYYY

**C. Type of Organization:**

☐ Standard Medical Practice
☐ Hospital
☐ State Licensed Medical Surgery Center
  ☐ For use by other physicians
  ☐ Your patients only
☐ Other-please explain: _____

**D. Entity Name:** (As stated in the Articles of Incorporation and all formal entity/clinic names.)

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

**F. 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 or group number, if known.

Policy #: Group #: Sub-group #:

**G. Do you desire coverage for this entity?** ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

☐ Shared Policy Limits ☐ Separate Policy Limits

(To request Separate Limit Entity coverage, please contact your agent or MedPro Service Representative to complete an application for consideration.)

**H. If the purpose of the entity noted above is other than a medical office practice, please explain:**

**I. Indicate the number of each of the following who provide services in your office (please exclude yourself):**

| | | | | | |
|---|---|---|---|---|---|
| Physicians | | Nurse Midwives | | Physician Assistants | |
| Dentists | | Nurse Midwife Assistants | | Physician Surgical Assistants | |
| Aestheticians | | Nurse Practitioners | | Podiatrists | |
| Case Managers | | Nurse Surgical Assistants | | Psychologists | |
| CRNAs/RNAs | | Occupational Therapists | | Respiratory Therapists | |
| Chiropractors | | Perfusionists | | | |

**J. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services?** ☐ Yes ☐ No

If no, do you plan to do so within 12 months of your requested effective date? ☐ Yes ☐ No

If yes, please provide an explanation: _____