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

THE MEDICAL PROTECTIVE COMPANY

HEALTHCARE 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 VIII. 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.)

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

Practice/Hospital Name

Number & Street

Suite | City | State | Zip Code -

County

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

Practice/Hospital Name

Number & Street

Suite | City | State | Zip Code -

County

I. General Information

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.

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

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 Medical Protective 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 ☐

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 _____

II. Professional Information (continued)

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 The Medical Protective Company? ☐ Yes ☐ No

If yes, answer the following:

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

Employer/Entity name:

Please provide The Medical Protective Company individual, corporation or partnership policy number or group number:

Policy #: Group #: Sub-group #:

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 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 ☐

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:** 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. 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 The Medical Protective Company, if offered, will not provide Prior Acts coverage.

Initial Here

V. 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 a 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.

VI. 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 bases 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

VII. Supplemental Information-The following must complete this supplemental: "Healthcare Professionals Directly Assisting in Surgery, Nurse Practitioners, Physician's Assistants, and Podiatrists".

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

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

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

VIII. 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:

_____

_____

_____

_____

_____