American Physicians
ASSURANCE CORPORATION

AMERICAN PHYSICIANS ASSURANCE CORPORATION

Headquarters: 1301 N. Hagadorn Road, P.O. Box 1471, East Lansing, MI 48826-1471, 1-800-748-0465
New Mexico Office: 7770 Jefferson St., NE, Suite 410, Albuquerque, NM 87109-4368, 1-800-880-9485

Application for Professional Organization – Professional Liability Insurance

American Physicians Policy No.:______________________________
(Leave blank if you do not currently have your professional liability insurance with American Physicians.)

FOR AMERICAN PHYSICIANS USE ONLY	
CLIENT NO:	**APP ID:**
ACN NO:	

Agency Name: Morrissey Agency Inc. **Agency Code:** 0293500

Address: 400 N Executive Dr. #302 Brookfield, WI 53005

Agency Phone: (262) 784 7574 **Agent or Representative:** Joseph Jordan

Please type or legibly print your responses in full. Supplement this application with responses to questions requiring more room than contained in this form and submit copies of the documents requested on the last page of this application.

1. Name:

2a. Type of Organization: **Please attach a copy of Articles of Incorporation and Letterhead.**

☐ Partnership ☐ Corporation – Multi-owner ☐ Solo Practitioner - Incorporated

☐ Joint Venture – Describe:________________________ ☐ Other – Describe:________________________

NOTE: Complete the attached roster and attach an individual application for each partner, shareholder and employed physician. Also list all other employed medical professionals as requested on questions 24 and 25a.

2b. Does your organization practice under any other name, such as an "assumed name" (AKA) or "Doing Business As" (DBA)? If yes, indicate names and dates below. Attach a sheet of paper if additional space is needed. ☐ Yes ☐ No

Dates Used	Name

3. Federal ID Number:

4a. **Mailing Address:**

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Fax: ( )
Business manager/Contact person:		Telephone: ( )

4b. **Principal Office Address** (if different than mailing address):

Street:		
City/State/Zip:		
County:	Telephone: ( )	Fax: ( )
Kentucky residents only: Is this address within city limits? ☐ Yes ☐ No		

4c. **Additional Offices: (Attach a separate sheet for additional locations.)**

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )

5. Type of coverage requested: **PLEASE NOTE: ALL PARTNERS, SHAREHOLDERS, EMPLOYED/CONTRACTED PHYSICIANS AND ELIGIBLE EMPLOYED MEDICAL PROFESSIONALS MUST CARRY THE SAME TYPE OF COVERAGE AS THE PROFESSIONAL ORGANIZATION.**

TO AVOID ANY GAPS IN THIS IMPORTANT INSURANCE COVERAGE, PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE ABOUT THE DIFFERENCES IN THESE INSURANCE FORMS.

☐ Claims-made **(Not available in all states)** Covers incidents that take place and are reported during the policy period, which begins with the retroactive date.	☐ Occurrence **(Not available in all states)** Covers incidents that take place during the policy period regardless of when reported as a claim.
☐ TailGard® **(Not available in all states)** Claims-made coverage with a pre-paid reporting period extension.	

6a. Type of limits requested: **PLEASE NOTE: Non-Stacking Limits of Liability are not available in IN, NM, or WI.**

☐ Stacking Limits of Liability ☐ Non-Stacking Limits of Liability

OR

If your professional organization is a Facility where the premium is based on annual patient visits or receipts, please select the type of limits below: **PLEASE NOTE: Shared Limits of Liability are not available in IN, NM, or WI.**

☐ Separate Limits of Liability ☐ Shared Limits of Liability

6b. Requested limits of insurance: **NOT ALL OF THE LIMITS LISTED BELOW ARE AVAILABLE IN ALL STATES. PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE FOR DETAILS.**

☐ $100,000 per incident/$300,000 policy aggregate
☐ $200,000 per incident/$600,000 policy aggregate
☐ $250,000 per incident/$750,000 policy aggregate
☐ $300,000 per incident/$900,000 policy aggregate
☐ $500,000 per incident/$1,000,000 policy aggregate
☐ $500,000 per incident/$1,500,000 policy aggregate
☐ $1,000,000 per incident/$3,000,000 policy aggregate
☐ Other: $______________________________ per incident
$______________________________ policy aggregate

PLEASE NOTE: ALL PARTNERS, SHAREHOLDERS, EMPLOYED/CONTRACTED PHYSICIANS AND ELIGIBLE EMPLOYED MEDICAL PROFESSIONALS MUST CARRY THE SAME LIMIT AS THE PROFESSIONAL ORGANIZATION.

7. Requested effective date (12:01 a.m.): ______________________________

Requested retroactive date (12:01 a.m.): ______________________________

A "retroactive date" is applicable for "Claims-made" coverage only. Claims-made coverage is limited to claims which are first made while the insurance is in force and which arise out of professional incidents that first occur on or after the retroactive date.

8. Please list all partners and/or major shareholders: ______________________________

____

____

9. Nature of applicant's business (i.e. specialty group, multi-specialty group, emergency room group, surgicenter, managed care organization, etc.): ______________________________

10. Number of annual patient visits:	11. Annual receipts:
12. Length of time in business:	13. Length of time under current management:

14. List all hospitals and surgicenters with which this entity has privileges or other ongoing relationships, contractual or otherwise:

Name	City	County	State

15. Describe any subsidiary or related business, if any: ____________________

____

16. Please list all accreditations, if any: ____________________

____

17. Please describe in detail the process(es) used to perform peer review within the professional organization .

____

____

18. Please describe in detail the procedures used to credential physicians or otherwise check the qualifications of new employees or independent contractors.

____

____

19. Does your practice have a website? ☐ Yes ☐ No

If yes, please provide the website address: ____________________

20. Beginning with the most recent or current insurer, please list **ALL** current and prior medical professional liability insurers. Explain any gaps in the continuity of professional liability coverage. Attach a sheet of paper if additional space is needed.

Name of Insurer	Coverage Type (Claims-made or Occurrence)	Policy Number	Policy Period

21a. Have you ever had medical professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge, or any other special terms, or has renewal been refused or not offered for this entity? ☐ Yes ☐ No

21b. To your knowledge, has any medical professional liability insurer ever considered such an action or is such an action being considered? ☐ Yes ☐ No

22. Does the professional organization or any of its partners, shareholders, or employed/contracted physicians supervise any healthcare providers other than those employed at your practice? ☐ Yes ☐ No

If yes, please list facility, specialty, and number of healthcare providers supervised: ____________________

____

____

23. Does the professional organization or any of its partners, shareholders, or employed/contracted physicians supervise any residents or interns? ☐ Yes ☐ No

If yes, please describe: ____________________

24. Indicate number of the following healthcare providers that you employ (include independent contractors): ☐ None

Specialty

_____ Athletic Trainer	_____ Ophthalmology Assistant	_____ Physical Therapist
_____ EMT - Paramedic	_____ Optician	_____ Physical Therapist Assistant
_____ Nurse	_____ Optometrist	_____ Social Worker
_____ Operating Room Assistant	_____ Pathology Assistant	_____ X-Ray Technician

Other – please describe: ______________________________

PLEASE NOTE: Separate limits are ONLY available in IN and MI for healthcare providers listed in question 24 above. A separate Healthcare Providers application must be submitted in IN and MI for Healthcare Providers wanting a separate limit of liability. The healthcare provider must have the same coverage form and the limit of liability must be the same or higher than the professional organization.

25a. Indicate number of the following healthcare providers that you employ (include independent contractors): ☐ None

Specialty

_____ Chiropractor	_____ Perfusionist	_____ Podiatrist – No Surgery
_____ Nurse Anesthetist	_____ Physician Assistant	_____ Psychologist
_____ Nurse Midwife	_____ Podiatrist – Including Surgery	_____ Surgical Assistant
_____ Nurse Practitioner		

25b. Do you want to share your limit of liability with the healthcare providers listed in 25a above? ☐ Yes ☐ No

If yes, an additional shared limits charge will be made. **Shared limits are not available in IN, NM, or WI.**

If no, an additional vicarious charge will be made. Please attach a copy of the healthcare provider's separate insurance declarations sheet. If proof of coverage is not provided a shared limits charge will be made.

25c. Do any of the healthcare providers above want a separate limit of liability? ☐ Yes ☐ No

If yes, a separate Healthcare Providers application must be submitted. The healthcare provider must have the same coverage form and limit of liability must be the same or higher than the professional organization.

PLEASE NOTE: All healthcare providers must be listed on the Employee Roster (page 6) of this application.

26. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis; will a reporting period extension ("tail" coverage) be purchased from your current insurer? ☐ Yes ☐ No

Please provide a copy of the declarations page of your current coverage and any reporting period extension ("tail").

27. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees, or any professional association, corporation or partnership to which you currently belong or have belonged to in the past? ☐ Yes ☐ No

If yes, has such incident(s) been reported to a prior professional liability insurer and has that insurer acknowledged coverage for the incident(s)? ☐ Yes ☐ No

Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amounts or current status must be included.

28. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or persons for whom you are responsible, or any professional association, corporation or partnership to which you currently belong or have belonged to in the past, may become involved, including knowledge of any alleged injury arising out of the rendering of, or failure to render, professional services which may give rise to a claim? ☐ Yes ☐ No

If yes, has this incident (these incidents) been reported to a prior insurer? ☐ Yes ☐ No

Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OF A MATERIAL NATURE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO IMPRISONMENT, FINES AND DENIAL OF INSURANCE.

APPLICANT'S REPRESENTATIONS, WARRANTIES AND AUTHORIZATION

I understand that no coverage will be bound until after American Physicians Assurance Corporation has reviewed this completed application and formally bound the requested coverage. Acceptance of payment is not an expression of American Physicians Assurance Corporation's intent to provide coverage. If coverage is declined by American Physicians Assurance Corporation, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage or retroactive coverage on my professional liability policy, such coverage will apply only to liability arising out of an occurrence which happened prior to the effective date of the policy and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

1. any claim which has been reported to another insurance carrier prior to the effective date;
2. any claim known to the insured at the effective date which has not been reported to a prior carrier;
3. any claim that may arise out of an incident which has been reported to another insurance carrier prior to the effective date;
4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.

I specifically represent and warrant to the insurer that the information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the acceptance of the risks described to the underwriter in this application. I understand and acknowledge that this completed application shall be considered an integral part of any insurance policy issued to me by the insurer. I further agree that any false or misleading statement in this application shall be grounds for the insurer to cancel and void coverage at its sole and absolute discretion.

I authorize the release of any underwriting and/or claim information (and release from any and all liability for the provision of information) from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals or healthcare institutions, to American Physicians Assurance Corporation and its subsidiaries or agents.

I agree to cooperate with the Risk Management Department of American Physicians Assurance Corporation, and its subsidiaries or agents, including the performance of practice risk assessments when deemed appropriate by American Physicians Assurance Corporation and to support their efforts to enhance quality of patient care.

____ ____________________

Signature Title Date

____

Print Name

Please attach:

- ☐ Copy of current declarations page
- ☐ Latest audited financial statement
- ☐ Copy of letterhead or sample billing statement
- ☐ Supplemental Claim Information Form for each claim, regardless of outcome
- ☐ Copies of any advertising brochures
- ☐ Narrative about group practice
- ☐ Current loss runs from previous carrier(s)
- ☐ Articles of Incorporation

Employee Roster -- List Each Partner, Shareholder, Employed/Contracted Physician and Healthcare Provider

If more space is needed, please copy this blank form.

PLEASE NOTE: A Physicians and Surgeons Application must be completed for each partner, shareholder, and employed/contracted physician.
A Healthcare Provider Application must be completed for all medical professionals that are requesting a separate limit of liability.

Professional Organization Name: ______________________________ **Federal ID No.** ______________________

Full Name (First, Middle, Last)	Title	Location(s)	Average Hours Worked Per Week For This Policy	Specialty or Professional Occupation	Retroactive Date