

THE MEDICAL PROTECTIVE COMPANY

PHYSICIAN ENTITY (CORPORATION/PARTNERSHIP) PROFESSIONAL LIABILITY INSURANCE APPLICATION

Application Instructions

- A. If additional space is needed, please complete Section VIII. Supplemental Information with a reference to the question.
- B. For coverage to exist you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. **Additional documentation pertaining to the entity's existence and operations may be requested by the company as necessary.** For example: Articles of Incorporation, Declaration Page, copy of your most recent entity professional liability policy (including all endorsements), etc.
- C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

I. Organization Information

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

Entity Name(s): _____

DBA, Fictitious Name, etc.: _____

_____ - _____ Date Entity Formed: ____ / ____
 Federal Tax I.D. Number National Provider Identifier Number MM YYYY

Contact's Last Name: _____ Contact's First Name: _____

Contact's Title: _____

Email address: _____

Business Phone: _____ - _____ - _____ Business Fax: _____ - _____ - _____

B. If the above entity does business under any other name, please list all additional entity/clinic names.

Entity Name(s): _____

_____ - _____ Date Entity Formed: ____ / ____
 Federal Tax I.D. Number National Provider Identifier Number MM YYYY

C. If you have 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.)

- | | |
|---|--|
| <input type="checkbox"/> Professional Corporation - sole shareholder | <input type="checkbox"/> General Business Corporation |
| <input type="checkbox"/> Professional Corporation - multiple shareholders | <input type="checkbox"/> For Profit |
| <input type="checkbox"/> Partnership or Professional Association | <input type="checkbox"/> Not for Profit |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Other (please explain): _____ |
| <input type="checkbox"/> Limited Liability Company (LLC) or Limited Liability Partnership (LLP) | _____ |

E. Type of Organization/Business Practices: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Abortions | <input type="checkbox"/> General Hospital | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Therapeutic - Number Per Year: _____ | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Elective - Number Per Year: _____ | <input type="checkbox"/> Hospice | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> AIDS/ARC | <input type="checkbox"/> Hospital - Industrial | <input type="checkbox"/> Standard Medical Practice |
| <input type="checkbox"/> Alternative Medicine (Integrative/Complimentary) | <input type="checkbox"/> In Vitro Fertilization | <input type="checkbox"/> State/County Health Department |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Substance Abuse Center |
| <input type="checkbox"/> Bariatrics | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Surgical Center |
| <input type="checkbox"/> Behavioral Health Facility/Psychiatric Facility | <input type="checkbox"/> Managed Care Organization/
Managed Services Organization | <input type="checkbox"/> Telemedicine |
| <input type="checkbox"/> Blood Banks | <input type="checkbox"/> Medi-Spa | <input type="checkbox"/> University/Teaching Facility |
| <input type="checkbox"/> Cancer Treatment Center | <input type="checkbox"/> MRI/X-Ray/Imaging | <input type="checkbox"/> Urgent Care |
| <input type="checkbox"/> Clinical Trials | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Weight Reduction |
| <input type="checkbox"/> Community Based Health Center | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Osteopathic Manipulation Therapy | <input type="checkbox"/> Other (please explain): _____ |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Pathology | _____ |
| <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> Pharmacy | _____ |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Physical Therapy Center | |
| <input type="checkbox"/> Experimental Surgery | | |

II. General Information (continued)

B. Does the entity own or operate any laboratory?

Yes No

If yes, is the laboratory providing services solely for your patients?

Yes No

If no, please explain: _____

C. Will the entity be performing activities which will be covered by another professional liability policy?

Yes No

If yes, state practice name, location and insurer name.

Practice Name: _____

Location: _____

Name of Insurer: _____

D. Has the entity performed any contract work for or entered into any contract or agreement (written or oral) with any entity/city/county/state/federal agency/clinic including providing care at correctional facilities, prisons, mental health facilities, Veteran's Administration, university, military or indigent care, etc.?

Yes No

If yes, please explain: _____

E. Please include estimated annual numbers:

Clinic visits: _____

Surgeries: _____

Gross Revenue: \$ _____

F. In the last 10 years:

1. Has the entity or any of the employees 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 any of the employees performed weight control surgery or prescribed weight control medication? 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

G. Does the entity or any of the physicians 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 the entity or physicians are affiliated? _____

III. Anesthesia Information

A. As defined below, please enter an "X" if a shareholder/partner, employee or independent contractor treats patients under:

Conscious Sedation (excluding Nitrous Oxide) utilizing a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

Oral IM/IV

General Anesthesia (to include deep sedation) utilizing a controlled state of depressed consciousness or unconsciousness, accompanied by partial or completed loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia was checked, please complete the Anesthesia Supplement.

B. Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar), or nitrous oxide only. Please continue to Section IV.

IV. Roster of Staffing

A. Please identify all owners, employed and contracted individuals within your organization, and provide information concerning each member in each category listed in the following table:

Note: Include all applicant(s), all healthcare provider(s), and non-healthcare owner(s).

Individual Status: (Column 5)

- A. Requesting Individual Medical Protective coverage.
- B. Current Individual Medical Protective insured.
- C. Applying for coverage elsewhere or covered elsewhere.
- D. Shared Limit Coverage with entity for Healthcare Professionals, other than physicians or dentists, with Medical Protective.
- E. Other.

	1. Last name first, then first and middle initials (i.e. Smith, J. G.)	2. Degree	3. Specialty (Write In)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status- A,B,C, D, or E (See key above)	6. Medical Protective Policy Number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

B. Please provide an explanation as to why coverage is not requested for any individuals where Individual Status is C on Roster.

Number from Roster:

Explanation:

VI. Coverage Information (continued)

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

I. 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 and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying from The Medical Protective Company, will not provide Prior Acts coverage.

Initial Here

VII. 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 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.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit 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 an entity (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), I warrant that I am an Officer, Partner, Office Administrator or other Authorized Representative of the entity applying for coverage.

Application must be signed by a President, Chief Executive Office, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

Authorized Representative Signature

Date Signed:

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.

Agent's Signature

Date Signed:

MM / DD / YYYY

Joseph Jordan User ID ge682

Print Name

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

Anesthesia Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

A. Number of: Anesthesiologists CRNAs

B. Other than Anesthesiologists or CRNAs, list anyone who administers anesthesia or conscious sedation:

C. Are all the CRNAs supervised on site by an anesthesiologist? Yes No

D. Is the anesthesia provider currently licensed in your state? Yes No

If no, please explain: _____

E. Are all individuals who administer the sedation certified in one or more of the following? Yes No

CPR ACLS ATLS PALS

If no, please explain: _____

F. Are all Anesthesiologists required to be board-certified/eligible in Anesthesiology? Yes No

G. Please indicate who administers conscious sedation?

MD/DO RN/LPN
 AA/NA/CRNA Other (specify): _____

Where is conscious sedation performed?

Office Licensed Surgical Center
 Hospital Other (specify): _____

For:

Own Patients
 Other than own patients

H. Please indicate who administers general anesthesia?

MD/DO RN/LPN
 AA/NA/CRNA Other (specify): _____

Where is general anesthesia performed?

Office Licensed Surgical Center
 Hospital Other (specify): _____

For:

Own Patients
 Other than own patients

I. Is the office certified for general anesthesia by a state organization? Yes No

If administered outside of a hospital or a licensed surgery center, please answer Questions J through P.

J. How often does your staff participate in simulated emergency training?

Every: 3 months 6 months 12 months Other: _____

K. What American Society of Anesthesiology (ASA) categories are treated? _____

L. How often does your practice update health histories?

Every _____ Month(s) Every patient visit Anytime invasive procedures are performed

M. Is a pre-anesthesia evaluation done by an anesthesiologist? Yes No

N. Is there a separate informed consent for anesthesia? Yes No

O. Please place an "X" next to the equipment utilized.

<input type="checkbox"/> Fail safe mechanisms on anesthesia machines	<input type="checkbox"/> Sphygmomanometer/Stethoscope	<input type="checkbox"/> Portable Suction
<input type="checkbox"/> Basic Airway Equipment	<input type="checkbox"/> Electrocardiographic Monitoring Equipment	<input type="checkbox"/> Capnography
<input type="checkbox"/> Face Mask Resuscitator	<input type="checkbox"/> Pulse Oximeter	<input type="checkbox"/> Auxiliary Lighting
<input type="checkbox"/> Oral and Nasopharyngeal Airways	<input type="checkbox"/> CO2 Detector	<input type="checkbox"/> Emergency Pharmaceutical Kit
<input type="checkbox"/> Endotracheal Tubes (Adult/Child size)	<input type="checkbox"/> Internal/External Temperature Monitor	<input type="checkbox"/> Cardiac Defibrillator
<input type="checkbox"/> Laryngoscopes	<input type="checkbox"/> Tracheostomy/Cryothyrotomy Equipment	<input type="checkbox"/> Emergency Tube Thoracostomy Equipment

If you do not utilize any of the above equipment, please explain: _____

1. Who owns and maintains the oxygen equipment? _____

2. Do you monitor the use of reversal agents? Yes No

P. Do you treat children? Yes No