



PHYSICIAN PROFESSIONAL LIABILITY INSURANCE ENTITY APPLICATION

All questions must be answered completely. If the answer to any question is "NONE" or "NOT APPLICABLE", so state. Upon receiving a copy of your final application from us, the application and all supplemental forms must be signed and dated by the applicant. If your most recent policy is "Claims Made" and you desire to continue coverage back to your "Initial Effective Date" (also known as "Retroactive Date"), please request Prior Acts coverage and submit proof of continuous Claims Made coverage with your final application. (The Declarations Page of your most recent policy is adequate proof.)

Please attach:
~ A copy of your current declaration page.

Broker Name:	
Address:	

ORGANIZATION INFORMATION

1) Entity Name			
2) Type of Legal Entity (check only one):			
<input type="checkbox"/> Professional Corp – Sole Shareholder	<input type="checkbox"/> Professional Association		
<input type="checkbox"/> Non Professional Corp-Sole Shareholder	<input type="checkbox"/> Limited Liability Corp/Partnership (LLC, LLP)		
<input type="checkbox"/> Professional Corp – Multi Shareholder	<input type="checkbox"/> Partnership - General		
<input type="checkbox"/> Non Professional Corp – Multi Shareholder	<input type="checkbox"/> Other: Please Explain Below		
2) Type of Organization (check only one):			
<input type="checkbox"/> Physician Group	<input type="checkbox"/> MRI/CI (fixed/mobile)		
<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Psychiatric/Substance Abuse Center		
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Rehab/Chronic Disease		
<input type="checkbox"/> Outpatient Surgi-Center			
2) Is this entity currently insured? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the declaration page from your current carrier.			
3) Type of Coverage Requested?			
<input type="checkbox"/> Claims Made		<input type="checkbox"/> Occurrence	
If requesting Claims Made coverage is retroactive coverage desired? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you answered yes, please list the Retro Date (mm/dd/yy)			
4) Coverage Period:			
	From		To
5) Location of Entity			
Street Number:			
Suite:			
City:	State:	Zip:	

6) Contact Person			
Name:		Title:	
Street Number:			
City:		State:	Zip:
Phone:		Fax:	
Email:			

GENERAL INFORMATION

1) Does the entity maintain current certificates of insurance on file for all doctors and allied health care providers employed or contracted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Will the entity perform activities covered by another professional liability policy? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Has the entity performed any contract work for or entered into any contract or agreement (written or oral) with any entity, including providing care at correctional facilities, prisons, mental health facilities, etc.? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Does the entity have an established process for follow-up on patient diagnostic and laboratory test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Has the entity added any new services, procedures or treatments in the last twelve months? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIM HISTORY

1) Has the entity ever been involved in a suit or stated demand for damages arising out of a medical incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Does any principle of the entity have any knowledge of any occurrence or circumstance likely to result in a malpractice claim or suit against you (or any corporation, association or partnership for which you are making application) on or after the effective date of any policy issued, or on or after the requested initial effective date retroactive date if prior acts coverage is being requested ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered yes to either of the above questions, please complete the "Claims Supplementary Form" at the bottom of this application.	

ROSTER OF STAFFING

Please list all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below. This list should include physicians, midwives, CRNP's, PA's, CRNA's, nurses and technicians.

Use the following Key for Individual Status (column 5).

- A.** Current PCA Insured
- B.** Requesting PCA coverage
- C.** Applying for coverage elsewhere or covered elsewhere

**** Note Include all applicant(s), all health care providers and non-health care owners.**

1. <i>Last name first, then first and middle initials (i.e. Jones, M. G.)</i>	2. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	3. Percentage of ownership (if shareholder or partner) Enter as a decimal	4. Specialty (write in)	5. Individual Status A, B, C (See Key Above)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

CLAIMS SUPPLEMENTARY FORM

(Please make copies if necessary as a separate form is required for each claim.)

Please Print or Type

1.

Applicant's Name

2.

Insurance Carrier covering this claim

3.

Name of Patient

Age at Treatment

4.

Date(s) of treatment related to this Claim

5.

Date this Claim was filed against you

6. To inform us about your diagnosis and treatment, please attach any of the following that you deem relevant:

Pertinent office records, history and physical, admission note, operative note (if any), pathology report (if any), discharge summary, narrative report.

Note: Attachment of this information is not mandatory, but may assist in our evaluation.

7. Patient Allegations and Outcome:

8. Indicate claim status: Pending Closed

9. If closed, was this by: Settlement Court proceedings

10. If by settlement, what was the amount? \$ _____.

11. If by court proceedings, what was the amount/result? \$ _____.

12. Please give us your comments on the case. Please indicate type of treatment, result of treatment and your involvement. Any additional information will help to expedite the process of obtaining a premium quotation.

Applicant Signature

Date

AGREEMENT, AUTHORIZATION and REPRESENTATION

I, the undersigned, hereby make application for Professional Liability Insurance on behalf of _____.

Applicant agrees: (a) to implement and comply with reasonable risk management and incident reporting programs for our private practices; (b) to actively participate in risk management and incident reporting programs in effect at any facility(ies) in which we practice or for any group of which we are a member; (c) to report claims and incidents as required by such programs and to Company in accordance with policy terms; and (d) to allow the program coordinator(s) for such programs and/or Company to perform such inspections as may be necessary for the evaluation of potential liability exposures and claims.

Applicant agrees to provide updated information to Company of changes in the status of any licensure or staff privileges or of changes in medical techniques or procedures I perform within 30 days of such changes. Applicant understands that failure to do so may result in policy cancellation.

Applicant authorizes any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organization, institutions or persons that may have any record or knowledge concerning any of the statements made and answers given herein to release such information to Company upon request. Applicant authorizes the use of a copy of this authorization in place of the original.

Applicant hereby represents that, if it is requesting Prior Acts coverage, it have no knowledge of any professional liability claims which have been asserted against any of the owners or the corporation, association or partnership for which Applicant making application or of any occurrence or circumstance likely to result in such a claim, on or after the requested initial Effective Date of Prior Acts Coverage.

Report any incidents involving serious injury including, but not limited to: brain injury, unexpected death, blindness (in one or both eyes), significant burns (including overexposure to radiation), significantly diminished life expectancy, injury to the spinal cord, significant sensory and motor loss, or loss of a significant portion of an arm or leg. Please give a brief description of each such claim, occurrence or circumstance. Please note that no coverage will be provided under the applied-for-policy, for any such claim, occurrence or circumstance permitted to be reported to your current insurance provider*. (*Insurance provider includes any self-insurance, or any other financial mechanism, whether public or private, established for the purpose of paying awards, judgments or settlements for loss or damages against any insured entitled to participate in such mechanism).

Applicant understands that if claims-made coverage under any policy issued is terminated at any time, an extended reporting period (tail) may be purchased where elected in writing within the period stated in such policy.

The information contained herein is true, complete and correct to the best of my knowledge, information and belief. Applicant understands and agrees that any policy Company may issue will be issued in reliance upon the representations made in the Application. Applicant also understands that this Application, including the above Agreement, Authorization and Representation, will become a part of any policy so issued. Applicant understands that failure to provide a true and accurate response to any of the information requested herein may result in the denial of claims under any policy so issued.

Upon acceptance by Company, this Application, including the above Agreement, Authorization and Representation, will be made a part of any policy issued.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of 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 subjects such person to criminal and civil penalties.

The undersigned acknowledges that he/she is completing the form on behalf of _____, is authorized to make the statements and representations set forth in this document and confirms that he/she had made sufficient inquiry to assure the accuracy of the information being provide with respect to, and behalf of, the entity.

Signature of Authorized Representative of Applicant

Date