# *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):**

- ❑ Professional Corp – Sole Shareholder
- ❑ Non Professional Corp-Sole Shareholder
- ❑ Professional Corp – Multi Shareholder
- ❑ Non Professional Corp – Multi Shareholder
- ❑ Professional Association
- ❑ Limited Liability Corp/Partnership (LLC, LLP)
- ❑ Partnership - General
- ❑ Other: Please Explain Below

**2) Type of Organization (check only one):**

- ❑ Physician Group
- ❑ Home Health Care
- ❑ Laboratory
- ❑ Outpatient Surgi-Center
- ❑ MRI/CI (fixed/mobile)
- ❑ Psychiatric/Substance Abuse Center
- ❑ Rehab/Chronic Disease

**2)** Is this entity currently insured? ❑Yes ❑ No

If yes, please provide declaration page for Company to confirm Retro Active date.

**3)** Is retroactive coverage desired? ❑Yes ❑ No

If yes, list Retro Date

**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***

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|---|---|
| 1) Does the entity maintain current certificates of insurance on file for all doctors and allied health care providers employed or contracted? | ❑Yes ❑No |
| 2) Will the entity perform activities covered by another professional liability policy?<br>If yes, please explain: | ❑Yes ❑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.?<br>If yes, please explain: | ❑Yes ❑No |
| 4) Does the entity have an established process for follow-up on patient diagnostic and laboratory test results? | ❑Yes ❑No |
| 5) Has the entity added any new services, procedures or treatments in the last twelve months?<br>If yes, please explain: | ❑Yes ❑No |

***CLAIM HISTORY***

| | |
|---|---|
| 1) Has the entity ever been involved in a suit or stated demand for damages arising out of a medical incident? | ❑Yes ❑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 ? | ❑Yes ❑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 identify all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below.***

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.***

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds.

| ***1.*** *Last name first, then first and middle initals (i.e. Jones, M. G.)* | ***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)* |
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# 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.

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_____ _____

Applicant Signature Date

## *AGREEMENT, AUTHORIZATION and REPRESENTATION*

I, the undersigned, hereby make application for Professional Liability Insurance.

I agree: (a) to implement and comply with reasonable risk management and incident reporting programs for my private practices; (b) to actively participate in risk management and incident reporting programs in effect at any facility(ies) in which I practice or for any group of which I am 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.

I agree 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. I understand that failure to do so may result in policy cancellation.

I authorize 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. I authorize the use of a copy of this authorization in place of the original.

I hereby represent that, if I am requesting Prior Acts coverage, I have no knowledge of any professional liability claims which have been asserted against me or any corporation, association or partnership for which I am 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).

I understand 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. I understand and agree that any policy Company may issue will be issued in reliance upon the representations made in the Application. I also understand that this Application, including the above Agreement, Authorization and Representation, will become a part of any policy so issued. I understand 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.

_____ _____

Signature of Authorized Representative of Applicant Date