

THE MEDICAL PROTECTIVE COMPANY

PHYSICIAN ENTITY (CORPORATION/PARTNERSHIP) 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. 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 | | |

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.						
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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:

V. Loss Information

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below in which the entity's policy was triggered and 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. Is your entity involved now or has it 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. Is your entity aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? 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, has your entity 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?

If **yes**, how many? [][][][] None

VI. 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 Occurrence coverage
- Claims-Made coverage with Prior Acts coverage Occurrence coverage with Prior Acts coverage

B. Requested Coverage Period (12:01 am):

Annual policy term will begin and end on the same month and day.

From: [][] / [][] / [][][][] **To:** [][] / [][] / [][][][]
MM DD YYYY MM DD YYYY

C. The retroactive date shown on your current Claims-Made policy is:

(This date is required for Occurrence with prior acts or Claims-Made with Prior Acts.)

[][] / [][] / [][][][]
MM DD YYYY

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: [][] / [][] / [][][][] **To:** [][] / [][] / [][][][]
MM DD YYYY MM DD YYYY

2. **Previous Insurer:**

- Occurrence Claims Made

From: [][] / [][] / [][][][] **To:** [][] / [][] / [][][][]
MM DD YYYY MM DD YYYY

3. **Previous Insurer:**

- Occurrence Claims Made

From: [][] / [][] / [][][][] **To:** [][] / [][] / [][][][]
MM DD YYYY MM DD YYYY

F. 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

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