

If previously covered with Medical Protective, please enter the policy number: _____

THE MEDICAL PROTECTIVE COMPANY PHYSICIAN 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 X. Supplemental Information with a reference to the question.
- B. **Additional documentation may be requested by the company as necessary.** For example: A copy of your most recent professional liability policy, including all endorsements, Declarations Page, etc.
- C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

I. General Information

A.

Last Name

First Name (Full)

Middle Name

Suffix

____/____/____
Date of Birth MM/DD/YYYY

Male Female

____-____-____
Social Security Number (Optional)

National Provider Identifier Number

____-____-____
Business Phone

____-____-____
Business Fax

____-____-____
Residence/Cell Phone

Email address: _____

B. If you have a web address, please provide the website address (URL): _____

C. Residence Address:

Number & Street

Apartment #

City

State

____-____
Zip Code

County

D. Practice Locations: (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. % of practice

Office Hospital Other

If other please explain: _____

Practice/Hospital Name

Number & Street

Suite

City

State

____-____
Zip Code

County

Start Date: ____/____/____
MM YYYY

2. % of practice

Office Hospital Other

If other please explain: _____

Practice/Hospital Name

Number & Street

Suite

City

State

____-____
Zip Code

County

Start Date: ____/____/____
MM YYYY

I. General Information (continued)

3. Office Hospital Other If other please explain: _____

% of practice _____

Practice/Hospital Name _____

Number & Street _____

Suite _____ City _____ State _____ Zip Code _____ - _____

County _____ Start Date: MM / YYYY

E. Do you admit patients to any of the above hospital locations?

Yes No

If no, please explain your protocol to admit patients to a hospital if the circumstance would arise. _____

F. Billing and Correspondence Address:

Location # (from Question D above): _____ Residence Other (Please enter below)

Number & Street _____ Suite _____

City _____ State _____ Zip Code _____ - _____

II. Educational Background

A. Medical School:

Name of School _____ Degree _____

City _____ State _____ Completed from: MM / YYYY To: MM / YYYY

Country _____

If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program? Yes No

If no, please explain: _____

B. Residency: List all Residency training programs.

Please enter each specific specialty.

1. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? Yes No Still in training From: MM / YYYY To: MM / YYYY

2. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? Yes No Still in training From: MM / YYYY To: MM / YYYY

III. Practice Information (continued)

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.

****Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.****

F. What is your present specialty? _____

--	--	--	--

% of total practice

What is your sub-specialty? _____

--	--	--	--

% of total practice

G. Are you permanently retired from the practice of clinical medicine? Yes No

H. American Board Certified? Yes No _____
Specialty Board

--	--	--	--	--	--	--	--

Date most recently certified

_____ Specialty Board

--	--	--	--	--	--	--	--

Date most recently certified

If not American Board Certified, are you board eligible? Yes No If yes, when do you plan on taking your boards?

--	--	--	--	--	--	--	--

MM YYYY

If not American Board Certified, have you ever taken a specialty board examination and failed to pass? Yes No

If yes, how many times?

--	--	--

If yes, please explain: _____

I. Indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage.

Hours per week

--	--	--	--

 Patients seen per week

--	--	--	--

 None

Unscheduled walk-in patients per week

--	--	--	--

 None

J. Please check any of the following procedures you will perform:

- Abdominoplasty - Tummy Tuck
- Abortions- Elective _____% of total practice
- Abortions- Therapeutic _____% of total practice
- Acupuncture - Therapeutic/Local Anesthetic
- Anesthesia General/Spinal/Caudal
- Angiography
- Angioplasty
- Arteriography
- Arthroscopy
- Assisting in major surgery - own patients only
- Assisting in major surgery - own & other than own patients
- Bariatric Surgery - Laparoscopic
- Bariatric Surgery - Non-Laparoscopic
- Biopsy - Endoscopic
- Blepharopigmentation - _____ % of total practice
- Blepharoplasty - Cosmetic _____ % of total practice
- Blepharoplasty - Reconstruction ____ % of total practice
- Botox _____ % of total practice
- Brachioplasty
- Breast Implants - Cosmetic _____ % of total practice
- Breast Implants - Reconstruction ____ % of total practice
- Breast Reduction - Cosmetic
- Bronchoscopy
- Bronco-esophagology
- Buttock Implants
- Calf Implants
- Cataract Surgery
- Catheterization - Left Heart
- Catheterization - Right Heart (other than CVP lines)/ Swan Ganz
- Cheek/Chin/Lip Implants
- Chelation Therapy
- Chemical Peels - Superficial / Medium
- Chemical Peels - Deep _____% of total practice
- Cleft Lip Surgery - Reconstructive
- Cleft Palate Surgery - Reconstructive
- Colonoscopy
- Cryosurgery (Cervical)
- Cryosurgery (non-external lesions)

- D & C
- Discectomy
- Open
- Other Than Open
- Electromagnetic Therapy
- Electroconvulsive/Shock Therapy
- Embolization
- ERCP
- Face Lifts
- Face Lifts Mini (done with laser)___% of total practice
- Gastrointestinal Endoscopy
- Gynecology - Major Surgery
- Hair Transplants - Follicular Unit Transplantations
- Hair Transplants - Other
- HVLA on the cervical spine on patients younger than 18 years of age
- Intrathecal Pumps
- Kyphoplasty
- Laparoscopic Cholecystectomy
- Laparoscopy
- Laser Surgery
- Laser Therapy (Endoscopic)
- Laser Therapy (Non-Endoscopic)
- Lipoinjection _____% of total practice
- Liposuction**
 - Other Than Tumescant Technique
 - Tumescant Technique Only___% of total practice
- Lithotripsy
- Lymphangiography
- Mammograms
- Myelography
- Nerve Blocks**
 - Facet
 - Lumbar Epidural Steroid
 - Myofascial
 - Occipital
 - Paraspinal/Paravertebral
 - Peripheral
 - Sciatic
 - Triggerpoint Injection
- Oxidation Therapy

- Pacemakers - Epicardial
- Pacemakers - Endocardial
- Pacemakers - Temporary
- Peritoneoscopy
- Phlebography
- Pneumoencephalography
- Polypectomy
- Prenatal /Gynecological Practice**
 - Prenatal Practice - 1st & 2nd Trimester
 - Prenatal Practice - to term, no delivery
 - Prenatal Practice - to term, and delivery
 - Normal Deliveries - total per year _____
 - Cesarean Deliveries - total per year_____
- Prolotherapy
- Radial/Laser Keratotomy
- Radiation/X-Ray Therapy
- Rectal Ozone Therapy
- Rhinoplasty _____% of total practice
- Sigmoidoscopy - 60 cm or less
- Sigmoidoscopy - greater than 60 cm
- Silicone Injections___ % of total practice
- Skin Flaps/Grafts**
 - Cosmetic _____% of total practice
 - Reconstruction __ % of total practice
- Spinal Cord Stimulators
- Thigh Lift
- Tubal Ligations
- Upper GI Endoscopy
- Vasectomies - own patients
- Vasectomies - own & other than your own patients
- Weight Control Medication _____ % of total practice
- Other Medical Techniques

List Procedures (do not restate your specialty)

III. Practice Information (continued)

K. Please indicate the percentage of your total practice performing the following surgical activities:

<input type="text"/> % Cardiac	<input type="text"/> % Orthopedic (including back)	<input type="text"/> % Thoracic
<input type="text"/> % Gynecology	<input type="text"/> % Orthopedic (not including back)	<input type="text"/> % Traumatic
<input type="text"/> % Hand	<input type="text"/> % Otolaryngology	<input type="text"/> % Urology
<input type="text"/> % Neurosurgery	<input type="text"/> % Plastic (cosmetic enhancement only)	<input type="text"/> % Vascular
<input type="text"/> % Obstetrics	<input type="text"/> % Plastic (reconstruction only)	<input type="text"/> % Other (Describe) _____
<input type="text"/> % Ophthalmology		

L. In the last 10 years,

1. Have you 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 you performed weight control surgery or prescribed weight control medication? Yes No

a. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?

<1% 1% - 10% 11%-50% >50% Never prescribed weight control medication

b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?

<1% 1% - 10% 11%-50% >50% Never performed weight control surgery

M. Do you 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 you are affiliated? _____

N. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.) Yes No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.)

hrs

2. On average how many of the above hours are you working in order to fulfill staff privilege requirements?

hrs

(If you have emergency room activities which are covered by another professional liability insurance policy, please complete Section IV, Question H.)

O. Please use the space below for any comments you feel will help The Medical Protective Company better understand any special circumstances concerning your practice.

IV. Additional Professional Information

Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the question.

(For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)

A. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates. hrs None

B. Indicate the average hours per week devoted to treating non-federal prison inmates. hrs None

C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes. % None

D. Indicate the percentage of your practice devoted to working in a nursing home facility. % None

E. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No

If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

F. Do you practice as a medical director? Yes No

Type and name of facility: _____

If yes, what percentage of your practice is devoted to this activity? %

Briefly describe your responsibilities: _____

G. Do you devise or review plant/employer safety standards? Yes No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

IV. Additional Professional Information (continued)

H. Will you be performing activities which will be covered by another professional liability policy?

Yes No

If yes, are you a(n): Employee Independent Contractor Resident/Fellow Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

I. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?

Yes No

If yes, please indicate the date(s) and explain: Date: / _____
MM YYYY

J. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy?

Yes No

If yes, please indicate the date(s) and explain: Date: / _____
MM YYYY

K. Have you ever been accused of sexual misconduct of any kind?

Yes No

If yes, please indicate the date(s) and explain: Date: / _____
MM YYYY

L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty?

Yes No

(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: _____

Date(s) of treatment(s): From: / To: / Currently in treatment
MM YYYY MM YYYY

Name of treating physician(s): _____

Address(es): _____

V. Loss Information (Important! Please fully complete.)

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below that 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. Are you now, or have you 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. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you?

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, have you or anyone from your practice 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 against you?

If **yes**, how many? None

VI. Practice Organization Information

Please provide the number of practice organizations of which you are an employee, shareholder/partner or independent contractor:

--	--

Please provide details below for your primary practice organization. If you indicated more than one organization above, please complete a Practice Organization Supplement for each one.

A. Type of Legal Entity: (Check only one box)

- Solo Unincorporated/Sole Proprietor Solo Incorporated
 Multi-Shareholder Corporation, Partnership, Limited Liability Company Other-please explain: _____

B. Employment status:

- Employee Shareholder/Partner Independent Contractor Other Date joined:

--	--

 /

--	--

 /

--	--	--	--

MM DD YYYY

C. Type of Organization:

- Standard Medical Practice
 Hospital
 State Licensed Medical Surgery Center
 For use by other physicians
 Your patients only
 Other-please explain: _____

D. Entity Name: (As stated in the Articles of Incorporation and all formal entity/clinic names.)

--

E. If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.)

--

F. Is this entity or employer currently insured with The Medical Protective Company?

Yes No

If yes, please provide The Medical Protective Company corporation or partnership policy or group number, if known.

Policy #:

--	--	--	--

 Group #:

--	--	--	--

 Sub-group #:

--	--	--	--

G. Do you desire coverage for this entity?

Yes No

If yes, please select the type of entity coverage desired:

- Shared Policy Limits Separate Policy Limits

(To request Separate Limit Entity coverage, please contact your agent or Medical Protective Service Representative to complete an application for consideration.)

H. If the purpose of the entity noted above is other than a medical office practice, please explain:

I. Indicate the number of each of the following who provide services in your office (please exclude yourself):

Physicians	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Nurse Midwives	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Physician Assistants	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			
Dentists	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Nurse Midwife Assistants	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Physician Surgical Assistants	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			
Aestheticians	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Nurse Practitioners	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Podiatrists	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			
Case Managers	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Nurse Surgical Assistants	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Psychologists	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			
CRNAs/RNAs	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Occupational Therapists	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Respiratory Therapists	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			
Chiropractors	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				Perfusionists	<table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>								

J. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services?

Yes No

If no, do you plan to do so within 12 months of your requested effective date?

Yes No

If yes, please provide an explanation: _____

VII. 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
- Claims-Made coverage with Prior Acts coverage
- Occurrence 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. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your requested retroactive date.

G. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of 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 insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying with The Medical Protective Company, if offered, will not provide Prior Acts coverage.

Initial Here

VIII. Assignment of Right to Cancel Coverage

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-800-398-6726 or sending written notice to The Medical Protective Company, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name: _____
 Street: _____ Suite: _____
 City: _____
 State: _____ Zip Code: _____ Phone Number: _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

IX. 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 understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

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.

_____ Date Signed: / /
Applicant's Signature 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.

_____ Date Signed: / /
Agent's Signature MM DD YYYY

_____ Print Name

X. Supplemental Information

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:

