MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

DATE (MM/DD/YYYY)

IMPORTANT - If CLAIMS MADE is checked in the COVERAGE / LIMITS section below, this is an application for a claims - made policy.

AGENCY NAME	CARRIER	NAIC CODE
AGENCY ADDRESS	APPLICANT (First Named Insured)	
	SOCIAL SECURITY #	DEA # (IF APPLICABLE)
CONTACT NAME:	US CITIZEN? ☐ YES ☐ NO	DATE OF BIRTH
PHONE (A/C, No, Ext):	PRIMARY BUSINESS ADDRESS	PHONE (A/C, No, Ext):
FAX (A/C, No):		
E-MAIL ADDRESS:		
CODE: SUBCODE:		
AGENCY CUSTOMER ID:		
	MAILING ADDRESS	

COVERAGE/LIMITS

☐ CLAIMS MADE ☐ OCCURRENCE

$ AGGREGATE

$ EACH OCCURRENCE

$ OTHER

PROPOSED EFFECTIVE DATE	PROPOSED RETROACTIVE DATE

PROFESSION

☐ PHYSICIAN - PRIMARY PRACTICE: SECONDARY PRACTICE:

☐ SURGEON - SPECIALTY: OTHER:

☐ PHYSICIAN'S ASSISTANT	☐ PERFUSIONIST	☐ NURSE PRACTITIONER
☐ NURSE ANESTHETIST	☐ REGISTERED NURSE	☐ COUNSELOR
☐ SURGEON'S ASSISTANT	☐ LICENSED PRACTICAL NURSE	☐ OTHER (SPECIFY):
☐ PSYCHOLOGIST	☐ OPTOMETRIST	
☐ NURSE MIDWIFE	☐ EMERGENCY MEDICAL TECHNICIAN	

PERSONAL INFORMATION

TYPE OF CERTIFICATION CURRENTLY HELD

STATES IN WHICH YOU ACTIVELY PRACTICE

STATE	LICENSE #

EDUCATION (LIST MOST RECENT ATTENDANCE FIRST)

INSTITUTION	DATES OF ATTENDANCE MM/YYYY	DATES OF ATTENDANCE MM/YYYY	DATE GRADUATED (MM/YYYY)	CERTIFICATION OR DEGREE RECEIVED

LIST CONTINUING EDUCATION COURSES AND CREDITS RECEIVED WITHIN THE LAST TWO (2) YEARS (OR ATTACH COPIES OF CERTIFICATES AND/OR CREDITS RECEIVED)

HAS YOUR CERTIFICATION/LICENSE IN ANY STATE EVER BEEN (VOLUNTARILY OR OTHERWISE) SUSPENDED, DENIED, REVOKED, RESTRICTED OR LIMITED IN ANY WAY? IF YES, EXPLAIN.

☐ YES ☐ NO

CURRENT PRACTICE (DESCRIBE GENERAL DUTIES AND EXTENT OF SUPERVISION (IF ANY)

LIST ANY ASSOCIATION/SOCIETY/MEMBERSHIPS RELATED TO YOUR PROFESSION

PRESENT EMPLOYEES AND POSITIONS

LOSS HISTORY

ENTER ALL CLAIMS (REGARDLESS OF FAULT) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY) ☐ CHK HERE IF NONE ☐ SEE ATTACHED LOSS SUMMARY

DATE OF OCCURRENCE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS
					☐ OPEN ☐ CLOSED
					☐ OPEN ☐ CLOSED
					☐ OPEN ☐ CLOSED

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION

CATEGORY				
CARRIER				
POLICY NUMBER				
POLICY TYPE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE
RETRO DATE				
EFF-EXP DATE	TO: FROM:	TO: FROM:	TO: FROM:	TO: FROM:
GENERAL AGGREGATE				
EACH OCCURRENCE				

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. HAVE YOU EVER BEEN INSURED BY MUTUAL ASSURANCE OR MEDICAL ASSURANCE FOR PROFESSIONAL LIABILITY? (If "YES", list policy # or name of previous employer) POLICY #: PREVIOUS EMPLOYER NAME:	☐
2. IF PROFESSIONAL LIABILITY COVERAGE IS PROVIDED THROUGH YOUR EMPLOYER, DO YOU MAINTAIN A SEPARATE POLICY FOR PROFESSIONAL LIABILITY? (If "YES", please provide a copy of your Declarations page. A Certificate of Insurance may also be required.)	☐
3. HAVE YOU EVER BEEN DIAGNOSED WITH OR PROFESSIONALLY ADVISED TO SEEK TREATMENT FOR ALCOHOL/DRUG ABUSE OR ADDICTION, MENTAL ILLNESS OR CHRONIC PHYSICAL ILLNESS?	☐
4. HAVE ANY FEE OR PROFESSIONAL RELATION COMPLAINTS BEEN REGISTERED AGAINST YOU WITH YOUR PROFESSIONAL ASSOCIATION(S), HOSPITAL(S) OR ANY STATE LICENSING AUTHORITY?	☐
5. HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A CRIMINAL OFFENSE?	☐
6. HAS YOUR PROFESSIONAL LIABILITY INSURANCE EVER BEEN CANCELLED, SUSPENDED, NON-RENEWED, DECLINED OR ISSUED ONLY ON SPECIAL TERMS? (Not applicable in MO)	☐
7. ARE YOU A SUBSIDIARY OF ANOTHER ENTITY OR DO YOU HAVE ANY SUBSIDIARY?	☐

SIGNATURE

THIS APPLICATION IS THE BASIS FOR COVERAGE; THEREFORE, ANY INCORRECT OR INCOMPLETE STATEMENTS OR ANSWERS COULD NULLIFY COVERAGE. COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.

I HEREBY REQUEST THAT MY APPLICATION FOR INSURANCE COVERAGE BE SUBMITTED FOR CONSIDERATION TO THE COMPANY SHOWN IN THIS APPLICATION. ACCORDINGLY, I AUTHORIZE AND DIRECT ANY PERSON OR ORGANIZATION WHATSOEVER TO RELEASE AND FURNISH TO THAT COMPANY ANY AND ALL INFORMATION REQUESTED WHICH MAY RELATE TO MY INSURABILITY.

I HEREBY WARRANT AND REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT AN INCORRECT OR INCOMPLETE STATEMENT OR ANSWER COULD VOID MY PROTECTION.

I HEREBY CONSENT TO THE REVIEW BY THE COMPANY SHOWN IN THIS APPLICATION OF ANY INCIDENTS OR OCCURRENCES LIKELY TO RESULT IN MALPRACTICE ALLEGATION OR CLAIM. I AGREE TO COOPERATE IN THE REVIEW OF CLAIMS AND INCIDENTS WHICH APPLY TO THE COVERAGE REQUESTED.

WHERE APPLICABLE, I HEREBY CONSENT TO THE REVIEW OF MY APPLICATION BY THE COMMITTEES APPOINTED BY MY COUNTY OR STATE PROFESSIONAL ASSOCIATION/SOCIETY. I AGREE TO COOPERATE WITH THESE COMMITTEES.

NOTICE OF INSURANCE INFORMATION PRACTICES

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION AND SUBSEQUENT RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)

APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER