



Physicians and Surgeons Professional Liability Application for Corporations and Partnerships

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON A CLAIMS MADE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED ACCURATELY AND COMPLETELY.

Please type or print clearly.

- Answer ALL questions completely, leaving no blanks. If any question, or part thereof, does not apply, print "N/A" in the space.
- If you need more space for your responses, continue on the attached Additional Information Form.
- This application must be completed, dated and signed by the proposed insured.

SECTION I – PRODUCER INFORMATION		
Agency Name	Address	
Contact Person	Telephone	E-Mail Address
SECTION II – APPLICANT INFORMATION		
Name of Entity	Contact Person	
Business Address	Telephone	
Fax	E-Mail Address	Website
Risk Management Contact Person	Risk Management Contact Telephone	
Risk Management Contact Address	Risk Management Contact E-Mail Address	
Type of Entity: <input type="checkbox"/> Multi-Shareholder Corporation	<input type="checkbox"/> Solo Incorporated No Employed or Contracted Physicians	
<input type="checkbox"/> Partnership, LLC	<input type="checkbox"/> Solo Incorporated With Employed or Contracted Physicians	
<input type="checkbox"/> Professional Association	<input type="checkbox"/> Other: _____	
Date Business Established: _____		
If licensed as a corporation, are you listed as a:	<input type="checkbox"/> Business Corporation	<input type="checkbox"/> Charitable Corporation

SECTION III – COVERAGE REQUESTED

Coverage Effective Dates From: _____ To: _____	Policy Limits Requested: <input type="checkbox"/> \$1M per claim / \$3M annual aggregate <input type="checkbox"/> \$1M per claim / \$4M annual aggregate (CT Only) <input type="checkbox"/> Other: _____	Deductible Requested: <input type="checkbox"/> None <input type="checkbox"/> \$5,000 per claim <input type="checkbox"/> \$10,000 per claim <input type="checkbox"/> \$25,000 per claim <input type="checkbox"/> Other: _____
Retroactive Date Requested:		

SECTION IV – CURRENT PRACTICE

List all other DBA's and affiliated entities associated with this corporation/partnership with in the last three years and indicate any percentage of ownership:

Name	Address	Nature of Operations	% of Ownership

Are there any services that you provide by contract to other entities? Yes No

If so, are you agreeing to indemnify these entities? (If yes, please provide a copy of the contract.) Yes No

If the entity is providing service at more than one location, please complete the chart below:

Name of Facility	Address	% of Practice

List the names of all owners, stockholders, and partners:

Name	Specialty	Insurer

Please be advised, in order to be eligible for this coverage, at least 75% of corporate owners and employed practitioners of the corporation must be insured with Darwin Professional Underwriters, Inc.

List the names of all employed practitioners and independent contractors:

Name	Specialty	Insurer

List the names of all mid-level practitioners (e.g. NP, PA, CNMW, CRNA, and Clinical Nurse Specialist).

Name	Specialty	Insurer

Please note that coverage is not included for any of these practitioners. If coverage is desired, please complete a separate mid-level personal application.

List the number of additional personal employed.

Profession	Number	Profession (Other)	Number
RN's			
LPN's / LVN's			
Medical Assistants			

Do you maintain current certificates of insurance on file for all employed or contracted practitioners and non-physician employees? Yes No

Is surgery performed at any of the facilities owned or operated by this Corporation/Partnership that requires a level of sedation greater than local anesthesia? Yes No

If yes, please complete the Ambulatory Surgery Center Supplemental Application.

If no, please attach a list of procedures performed.

Check any auxiliary services provided by the Corporation/Partnership or any of its subsidiaries.

- Radiology Laboratory Pharmacy Walk in Clinic or Urgent Care Clinic
 PT/OT Other: _____

Explain the extent of the above services or please provide a patient pamphlet.

Does the state require that you be licensed to provide the above services? Yes No
(If yes, please provide a copy of the licenses.)

Does the Corporation/Partnership advertise? Yes No

If yes, please explain or provide a copy of any advertising materials.

Do you endorse any products or participate in offering professional advice to the public? Yes No
(i.e. newspaper columns, broadcasts, etc.)

Explain any telemedicine activities performed by the Corporation/Partnership or any of its subsidiaries.

- Operating a website Reviewing charts, films, or other media
 Providing medical information or advice Prescribing Medication
 Other _____

Any "yes" answers require a separate written explanation and supporting documentation.

Does the Corporation/Partnership or any of its subsidiaries participate in any experimental, investigational or other unconventional therapies including any alternative medicine activities? Yes No

Does the Corporation/Partnership or any of its subsidiaries participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No

Does the Corporation/Partnership or any of its subsidiaries contract to provide services to any Federal or non-federal prisons? Yes No

Does the Corporation/Partnership or any of its subsidiaries contract to provide services to any Nursing Home or Long Term Care facility? Yes No

Does the Corporation/Partnership or any of its subsidiaries provide care, treatment or professional advice to any professional athletes? Yes No

Does the Corporation/Partnership or any of its subsidiaries contract to provide teaching services or the supervision of residents? Yes No

SECTION V – HISTORY

Provide insurance history for a minimum of the last ten years. Start with the most recent and attach an additional sheet if necessary.

Insurer	Policy Period	Limits of Liability	Coverage Type	Claims Trigger	Retroactive Date	Deductible Amount	Tail Purchased	Policy Premium
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Has any insurance company ever declined, failed to renew, restricted or canceled your insurance? Yes No

If yes, please complete the following:

Insurer	Date	Reason

Has the Corporation/Partnership ever operated without insurance? Yes No

Have any of the Corporation/Partnership operations changed in the past 10 years? Yes No

If yes, explain what services/procedures have been added or deleted and the dates these changes were effective.

List any previously employed or contracted physician in the past five years

Name	Specialty	Dates (From/To)	Any Claims?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Has the Corporation/Partnership, any of its subsidiaries, owners, shareholders, employees, employed or contracted physicians, been investigated and or cited by any governmental or regulatory agency for violations arising out of their individual activities or for services performed as a representative of the Corporation/Partnership? (If yes, please attach an explanation) Yes No

Has an allegation or claim ever been made against the Corporation/Partnership, any of its subsidiaries, owners, shareholders, employees, employed or contracted physicians, regarding sexual harassment, sexual intimacy, exploitation or sexual assault in the performance of services for the Corporation/Partnership or otherwise? (If yes, please attach an explanation) Yes No

SECTION VI – CLAIM INFORMATION

Are you or have you ever been involved, directly or indirectly in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? Yes No

If yes, how many? _____ Yes No
 If yes, have these been reported to your insurer?

Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? Yes No

If yes, how many? _____ Yes No
 If yes, have these been reported to your current insurer, or any prior insurer?

List claims, potential claims or suits that have occurred within the last ten years and complete a supplemental claim form for each item listed below. A complete loss history from each prior Insurer will also be required.

Claim #	Insurer	Date of Occurrence	Date Reported to Insurer	Status	Closed Date	Payment/Reserve Amount
				<input type="checkbox"/> Open <input type="checkbox"/> Closed w/ payment <input type="checkbox"/> Closed w/out payment		
				<input type="checkbox"/> Open <input type="checkbox"/> Closed w/ payment <input type="checkbox"/> Closed w/out payment		
				<input type="checkbox"/> Open <input type="checkbox"/> Closed w/ payment <input type="checkbox"/> Closed w/out payment		
				<input type="checkbox"/> Open <input type="checkbox"/> Closed w/ payment <input type="checkbox"/> Closed w/out payment		

Please note, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in the above questions in SECTION VI – CLAIM INFORMATION are excluded from the proposed coverage.

The Following Must Be Included With This Application:

1. Copy of your current professional liability insurance declarations page.
2. Copy of your Curriculum Vitae.
3. Copy of your current medical license.
4. Copy of your business letterhead.

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONALEXPOSURES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN

APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Signature of Applicant: _____

Printed Name: _____

Title: _____

Date: _____