Requested Coverage Effective Date: 12:01 a.m. _____/_____/_____ Policy Number: __________

The Medical Protective Company
Health Care Providers (OD, DPM, or Other)
Professional Liability Insurance Application

FOR FASTER SERVICE PLEASE ENTER YOUR APPLICATION ONLINE AT WWW.GEMEDICALPROTECTIVE.COM.

I. GENERAL INFORMATION

A.

LAST NAME

FIRST NAME

MIDDLE NAME | SUFFIX | DATE OF BIRTH __/__/__ | SOCIAL SECURITY NUMBER

Degree ☐ OD ☐ DPM ☐ Other __________

Please enter your requested coverage effective and expiration dates below:

FROM MM DD / YYYY TO MM DD / YYYY

This date cannot be earlier than the expiration date of your current policy.

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

Coverage Type Desired: ☐ Occurrence ☐ Claims Made

B. CURRENT EMPLOYMENT (List principal location first)

1.

SUITE | STREET ADDRESS

CITY | COUNTY

STATE | ZIP CODE | FROM MM / YYYY TO MM / YYYY | % OF PRACTICE

2.

SUITE | STREET ADDRESS

CITY | COUNTY

STATE | ZIP CODE | FROM MM / YYYY TO MM / YYYY | % OF PRACTICE

C. PREFERRED MAILING ADDRESS ☐ **Office #** __________ **(from B above)** ☐ Other (below) ☐ Residence

NUMBER & STREET

SUITE/ADDRESS 2

CITY | STATE | ZIP CODE

I. GENERAL INFORMATION (continued) — IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

D. PREFERRED METHOD OF CONTACT ☐ Business Phone ☐ Business Fax ☐ Residence Phone ☐ Email

BUSINESS PHONE BUSINESS FAX RESIDENCE PHONE

EMAIL ADDRESS

II. PROFESSIONAL INFORMATION — IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

A. WHAT IS YOUR PRESENT SPECIALTY? ______ % of Practice

SUB-SPECIALTY: ______ % of Practice

SUB-SPECIALTY: ______ % of Practice

NAME OF SCHOOL /HEALTHCARE TRAINING

STATE or COUNTRY TYPE COMPLETED (ie. BS, RN, etc)

COMPLETED FROM MM/YYYY **TO** MM/YYYY

B. INDICATE THE AVERAGE WEEKLY NUMBER OF HOURS FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE

______ Hours per week

C. ARE YOU REQUIRED TO BE LICENCED IN THE STATE(S) WHERE YOU PRACTICE? ☐ Yes ☐ No

If yes, please provide your license number(s) for each state that requires a license.

			Active	Inactive	Temp	Pending
1. STATE		LICENSE #	☐	☐	☐	☐
2. STATE		LICENSE #	☐	☐	☐	☐

D. WILL YOU BE PERFORMING ACTIVITIES THAT WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY?

If yes, please complete the following:

Practice Name ______

City ______ **State** ______ ☐ Employee ☐ Independent Contractor

Name of Carrier ______

E. Please fully explain a "yes" answer to the questions below on a separate page

1. 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 privileges or license revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

   If yes, please explain and indicate the date(s): ______ MM/YYYY **TO** MM/YYYY

II. PROFESSIONAL INFORMATION (continued) — IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

2. Do you treat federal or non-federal prison inmates? ☐ Yes ☐ No

   If yes, what percentage of your practice is devoted to each? Federal ________ % Non-Federal ________ %

   If yes, please explain ____________________

   Are you covered by another insurance for this activity? ☐ Yes ☐ No

3. Have you ever had any professional liability insurance refused, canceled or non-renewed? ☐ Yes ☐ No

   If yes, please explain ____________________

4. Have you incurred or become aware of having a condition that impairs your ability to practice your professional duties? ☐ Yes ☐ No

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

   If **Yes**, please state the condition, date(s) and identify your treating physician 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.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type of Illness	Duration of Illness	Treating Physician (Name & Address)
____________	__/____ (MM/YYYY) to __/____ (MM/YYYY)	____________

5. Please check any of the following functions preformed as part of your professional activities.
   - ☐ Limited "Scrub Nurse" functions such as holding retractors, suction, tying sutures, handing and counting of instruments.
   - ☐ Casting and splinting
   - ☐ Directly assisting as a non-physician first assistant in surgical procedures

6. If you practice as a dental hygienest, do you administer any form of analgesic or anesthesia? ☐ Yes ☐ No

   If yes, please explain ____________________

7. If you are a podiatrist, do you perform surgery? ☐ Yes ☐ No

   If yes, please explain ____________________

8. Do you independently prescribe/order drugs without same day authorization from your supervising physician? ☐ Yes ☐ No

   If yes, please explain ____________________

F. Please check the box that best describes your practice affiliation:

Employment Status:

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other: ____________

G. Do you work for a physician or dentist who is currently insured by The Medical Protective Company? ☐ Yes ☐ No

If yes and working for an **individual**, please complete the section below:

Policy # ____________ (Individual) ____________ (Affiliation Name)

If yes and working in a **group practice**, please complete the section below:

Policy # ____________ (Corporation/Partnership) ____________ (Group # (optional)) ____________ (Affiliation Name)

III. LOSS INFORMATION (IMPORTANT, COMPLETE FULLY) — IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

A. Are you now, 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? ________

If **"Yes"**, have these been reported to your insurer? ☐ Yes ☐ No

B. Do you have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim? ☐ Yes ☐ No

If **"Yes"**, how many? ________

If **"Yes"**, have these been reported to your insurer? ☐ Yes ☐ No

IV. CLAIM/SUIT INFORMATION FORM (Please make copies if additional forms are needed)

If making additional copies, please enter applicant's name here: ________________________

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

1. Patient/Claimant Information – Name: ________________________ Age: ______ Gender: ☐ Male ☐ Female
2. Date of treatment and/or surgery, which led to the allegations against you: __ __ / __ __ / __ __ __ __ (MM DD YYYY)
3. Date claim/incident notice received __ __ / __ __ __ __ (MM YYYY)
4. Date claim reported to prior insurer __ __ / __ __ __ __ (MM YYYY)
5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: ________________________
6. Disposition or current status of claim or suit: ☐ Open ☐ Closed
   Date of Closing/Settlement or award (MM/YY) __ __ / __ __ __ __ (MM YYYY)
7. Indicate case value established by carrier, if known (in $): ________________________
8. Defending Insurance carrier name: ________________________
9. Claim file number, if known: ________________________
10. Was this matter closed with your consent? ☐ Yes ☐ No
    Was a suit filed? ☐ Yes ☐ No
    Was payment made? ☐ Yes ☐ No
    If no, was claim or suit withdrawn? ☐ Yes ☐ No
    If Yes, indicate total amount of settlement or award (in $): ________________________
    Amount paid on your behalf (in $) ________________________
11. Nature of allegations in the claim or suit:
    Condition treated: ________________________
    Treatment provided: ________________________
    Alleged Negligence: ________________________
    Alleged injury: ________________________
12. Please provide details of the claim information: (include, type of treatment and /or surgery; your involvemen, etc.t)

____

____

____

V. COVERAGE INFORMATION

IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

A. List all previous professional liability insurers beginning with the most recent.

1. ______________________ ☐ Claims Made ☐ Occurrence __/__/____ to __/__/____
Current Insurer MM DD YYYY MM DD YYYY

2. ______________________ ☐ Claims Made ☐ Occurrence __/__/____ to __/__/____
Insurer MM DD YYYY MM DD YYYY

3. ______________________ ☐ Claims Made ☐ Occurrence __/__/____ to __/__/____
Insurer MM DD YYYY MM DD YYYY

B. COVERAGE DESIRED

1. ☐ Occurrence
2. ☐ Claims-Made Coverage with Prior Acts Coverage
3. ☐ Claims-Made Coverage without Prior Acts Coverage

(A copy of current declaration page showing current retroactive date must be attached for option 2)

If 1 or 3 are selected from the above and the most recent prior coverage was issued on a CM basis, please select one of the following:

☐ An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)

☐ 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 result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am purchasing from The Medical Protective Company, will not provide prior acts coverage.*

Initial Here ☐

Claims-Made coverage is limited generally 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 an "extension contract" or "tail coverage."

C. Requested Coverage Effective Date 12:01 a.m. **From:** __/__/____ (MM DD YYYY) **12:01 a.m.**
This date cannot be earlier than the expiration date of your current policy.
Annual policy terms will begin and end on the same month and day. **To:** __/__/____ (MM DD YYYY) **12:01 a.m.**

D. The Retroactive Date Shown on my Current Claims-Made Policy is: __/__/____ (MM DD YYYY) **12:01 a.m.**
This date cannot be greater than the retroactive date shown on your current policy

E. If your practice is in Indiana, Kansas, Louisana, New Mexico, Nebraska, Pennsylvania, Wisconsin, or any fund state, and you are currently enrolled in the state compensation fund, please indicate your current fund retroactive date if different than the retroactive stated above.

__/__/____
MM DD YYYY

Are you aware of any gaps in your Fund coverage? ☐ Yes ☐ No
If yes, please provide the exact dates and written explanation: ______________________

____

F. Limits Desired: ______________ **per occurrence**
______________ **annual aggregate**

VI. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my ☐ Employer OR ☐ Named Third Party (Include Name & Address) ______________________

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to The Medical Protective Company's Home Office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

VII. STATE STATUTORY REQUIREMENT

*NOTE: **All New Jersey applicants must read and initial the following:***

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Initial Here

VIII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company.I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, 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 WITHOUT EFFECT OR PROVIDE THE COMPANY WITH 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 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 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 my organization, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature ______________________ **Date Signed:** __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)

Print Name ______________________

When would you like your quote delivered? __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)

FOR OFFICE USE ONLY

PRODUCER NAME ______________________ **PRODUCER #** ______________________

CONTACT NAME ______________________ **TITLE (CSR, MM, etc)** ______________

Preferred Method of Contact ☐ PHONE ☐ FAX ☐ EMAIL

Phone | Fax | Email

Entity Name ______________________

GEMP Corp # ________ **GEMP Group #** ________ **GEMP SubGroup #** ________ **CMS #** ________

GEMP Policy # ________ **Modular Policy #** ________ ☐ New Group **Number of Insureds** ________

Billing: ☐ With Group ☐ As Individual **AT END OF POLICY PERIOD:** ☐ Do Not Renew ☐ Renew

Comments: ______________________

FUND STATES - IN, NE, LA, NM, WI, PA, KS

PROVIDER TYPE (WI ONLY) ________ **LEVEL (KS ONLY)** ☐ A ☐ B ☐ C

*****Attach Kansas Health Care Stabilization Record*****

VIII. SUPPLEMENTAL FORM

VIII. SUPPLEMENTAL FORM (continued)