



- Medical Professional Mutual Insurance Company
- ProSelect Insurance Company
- ProSelect National Insurance Company

PART I - PRODUCER INFORMATION

Producer Name		Address		Telephone
Producer License Number	State	Federal Tax ID	E-Mail Address	

- New Business (if new business, any previous policy with ProMutual Group? If so, indicate policy number) # _____
- Renewal (if renewal, please give current policy number) # _____

PART II - APPLICANT INFORMATION

Name of Applicant		Business Address	
Telephone		Mailing Address	
Contact Person		E-Mail Address	

PART III - ADDITIONAL INFORMATION

Have you had any previous medical malpractice insurance? Yes No

If yes, complete the chart below.

Carrier's Name	Policy No.	Policy Retroactive Date	Tail Purchased	Specialty Practiced
			<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	

Attach a copy of all previous and current policy declarations pages and copies of all Certificates of Insurance for all hospitals where you have/had admitting privileges along with name and address of anyone who required you furnish them with proof of insurance.

Retroactive Date Requested _____ / _____ / _____

- Have any claims ever been made against you? Yes No
- Do you know of any pending claims, incidents or activities, including any request for patient records, that might give rise to any claim in the future? Yes No

If you answered "yes" in either question above, complete the chart and sign below (attach additional pages if necessary).

	(1)	(2)	(3)	(4)	(5)
Carrier:					
Policy Term:					
Policy Limits:					
Policy Number:					
Plaintiff Name: (specify if open or closed)					
Amount Paid For Settlements:					
Defense Costs:					

Please attach a brief description of any claim or incident on a separate sheet.

Have you reported all claims or activities described above to your prior insurance carrier(s)? Yes No
 If no, identify each claim or incident that has not been reported on a separate sheet and attach.

RELEASE OF INFORMATION. BY SIGNING THIS APPLICATION, THE APPLICANT AUTHORIZES ANY INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION CONCERNING MEDICAL MALPRACTICE CLAIMS AGAINST THE APPLICANT AND SUCH OTHER INFORMATION WHICH, IN THE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON THE APPLICANT'S ACCEPTABILITY TO THE COMPANY AS AN INSURED. THE APPLICANT HEREBY RELEASES AND AGREES TO HOLD HARMLESS ANY PERSON PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES OR AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OR USE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

NO FACT, CIRCUMSTANCE OR SITUATION INDICATING THE PROBABILITY OF A "CLAIM" OR ACTION AGAINST WHICH INDEMNIFICATION WOULD BE AFFORDED BY THE PROPOSED INSURANCE IS NOW KNOWN BY ANY PERSON OR ENTITY APPLYING FOR THIS INSURANCE OTHER THAN THAT WHICH IS DISCLOSED IN THIS APPLICATION. IT IS AGREED BY ALL CONCERNED, WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE COMPANY, THAT IF ANY PERSON OR ENTITY APPLYING FOR THIS INSURANCE HAS ANY KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY "CLAIM" SUBSEQUENTLY EMANATING THEREFROM SHALL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE AS TO ALL INSURED PERSONS.

SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS APPLICATION WILL BECOME PART OF SUCH POLICY, IF ISSUED, AND ATTACHED THERETO. THE COMPANY IS HEREBY AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT MAY DEEM NECESSARY.

BY SIGNING THIS APPLICATION, THE APPLICANT CERTIFIES THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF THE APPLICANT'S KNOWLEDGE AND BELIEF AND ACKNOWLEDGES THAT PROVIDING TRUTHFUL AND ACCURATE INFORMATION IS A CONDITION PRECEDENT TO OBTAINING THE INSURANCE REQUESTED IN THIS APPLICATION. THE APPLICANT FURTHER ADKNOWLEDGES THAT ANY INSURANCE WHICH MAY BE ISSUED UPON RECEIPT OF THIS APPLICATION WILL BE ISSUED BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED, AND IF SUCH INFORMATION IS MISLEADING OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.

IT IS AGREED THAT IN THE EVENT THERE IS ANY MATERIAL CHANGE IN THE ANSWERS TO THE QUESTIONS CONTAINED HEREIN PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY AND, AT THE SOLE DISCRETION OF THE COMPANY, ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN.

 Date

 Signature of Applicant