

THE MEDICAL PROTECTIVE COMPANY
Entity Professional Liability Insurance Application

APPLICANT'S INSTRUCTIONS

- A. This form must be completed for each ancillary activity which is a separate joint venture, partnership, or corporation. **Attach a copy of Articles of Incorporation, Partnership Agreement, etc.**
- B. Attach a copy of corporate organizational chart (flowchart) listing any subsidiaries, joint ventures, etc. and a brief description of how they interact.
- C. Attach a copy of your most recent corporation professional liability policy (including all endorsements).
- D. Answer all questions; if a question is not applicable, state NOT APPLICABLE.
- E. If space is insufficient to answer any questions fully, use last page or attach a separate sheet(s).
- F. Complete **Physician Roster** for all individuals employed, contracted or having ownership in the entity.

I. ORGANIZATION INFORMATION

A. _____
Entity Name Office Manager

B. If the above entity does business under any other name, please list **all** additional names:

C. Office locations (If additional space is needed, attach a separate sheet of paper)

Location #1:

Suite	Street Address	City	State	Zip
	()			
County	Telephone Number	Federal Tax I.D. Number		

Location #2:

Suite	Street Address	City	State	Zip
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Location #3:

Suite	Street Address	City	State	Zip
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Location #4:

Suite	Street Address	City	State	Zip
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D. Preferred Mailing Address: Location # _____ (from C above)

Other _____
Street Address City State Zip

Type of organization

- | | | |
|---|---|---|
| <input type="checkbox"/> Community Based Health Ctr | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Rehabilitation/Chronic Disease |
| <input type="checkbox"/> Emergency/Walk-in Center | <input type="checkbox"/> Outpatient Surgical Center | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Physical Fitness Center | <input type="checkbox"/> Standard Medical Practice |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Physical Therapy Center | <input type="checkbox"/> State/County Health Dept. |
| <input type="checkbox"/> Laboratory (Pathology) | <input type="checkbox"/> Psychiatric/Substance Abuse Center | <input type="checkbox"/> University/Teaching Facility |
| <input type="checkbox"/> MRI/CT (Fixed/Mobile) | | |
| <input type="checkbox"/> Other (please explain) _____ | | |

E. Type of legal entity

- | | | |
|--|---|--|
| <input type="checkbox"/> Solo Incorporated | <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Multi-Shareholder Corporation | <input type="checkbox"/> Governmental | <input type="checkbox"/> Joint Venture |
| <input type="checkbox"/> Other _____ | | |

F. List any non-physician owners and percentage of ownership (Attach a list of Board of Directors/Shareholders)

G. If Joint venture, indicate parties in venture and percentage of ownership

H. Are any of the following types of patient care services rendered within the facility?

- | | | |
|---|--|--|
| <input type="checkbox"/> Abortions | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Outpatient Surgery |
| <input type="checkbox"/> AIDS/ARC | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Experimental Surgery | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Genetics | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Blood Banks | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> InVitro Fertilization | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Cardiac Intensive Care | <input type="checkbox"/> Laboratory (Pathology) | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Cardiovascular Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Research/Experimental |
| <input type="checkbox"/> Certified Trauma Center | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Silicone Injections |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Cosmetic Plastic Surgery | <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Organ Tissue Transplant | <input type="checkbox"/> Weight Reduction |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Orthopedic | |

I. **PHYSICIAN ROSTER OF STAFFING** - Please identify all employed and contracted physicians within your organization and provide information concerning each staff member in each category listed below.

Indicate specialty per the Following:

- | | | |
|---|--|--|
| 1 - No Surgery | 3 - Major Surgery | 5 - Obstetrics |
| 2 - Assisting in surgery on your own patients | 4 - Assisting in surgery on other than your own patients | 6 - Cardiac catheterization (other than Swan-Ganz) |

	Last name first, then first and middle initials (i.e. Smith, J. G.)	Degree	(S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	Percentage of ownership (if shareholder or partner)	Specialty (See key above)	Company Use Only		
						Class	Policy Number	Agent Use Field
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

II. GENERAL INFORMATION

Please fully explain any "Yes" answer on a separate page.

- A. Does your collection agency have authority to file a collection suit at discretion without your prior approval? Yes No
- B. Has your organization or any of your employees:
1. Ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital or professional association? Yes No
 2. Ever been indicted for or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges or medical licenses revoked, suspended, restricted, placed on probation or voluntarily surrendered? Yes No
 3. Ever had any professional liability insurance refused, canceled or nonrenewed? Yes No
- C. Do you maintain current certificates of insurance on file for all doctors and allied health care providers employed, contracted or privileged at this facility? Yes No
- D. Is all biomedical equipment provided scheduled preventive maintenance each year by a qualified biomedical technician? Yes No
- E. If you provide **dialysis services**:
1. Is the filter changed after each patient? Yes No
 2. Does all equipment used for dialysis have an automatic shutoff fail safe device to prevent backwash? Yes No
- F. If you provide **outpatient surgical services**:
1. Is the facility accredited by either JCAHO or AAAHC? Yes No
 2. What is the time in minutes to the nearest fully equipped hospital? _____
 3. Do you have a medical services review committee? Yes No
 4. Does your recovery room provide full time nurse observation? Yes No
- G. If you provide **pathology services**:
1. Is this facility approved by the College of American Pathology? Yes No
ATTACH A COPY OF THE LATEST CAP TEST SCORES
- H. If you provide **walk-in clinic services**:
1. Are your services available 24 hours? Yes No
 2. What is the average number of physician extenders supervised by a physician? _____
 3. Do any physician extenders have authorization to write prescriptions? Yes No
- I. If you provide **diagnostic imaging/x-ray services**:
1. Do you provide any radiation therapy? Yes No
 2. Who interprets the results of the tests performed?
- | | |
|----------------|-------------------------|
| Name/Specialty | Contracted or Employed? |
| Name/Specialty | Contracted or Employed? |
3. Does your facility interpret results of test performed at facilities other than those requesting insurance through this application? Yes No

J. Please include annual numbers below:

Clinic visits _____

Surgeries _____

Revenues _____

III. LOSS INFORMATION (IMPORTANT, COMPLETE FULLY)

Complete a Claim/Suit Information Form or loss run identifying **EACH** claim, potential claim, or suit including a description and amounts (both paid and reserved) covering the last eight years of professional liability loss experience.

DO YOU HAVE KNOWLEDGE OF ANY CLAIM, SUIT, POTENTIAL CLAIM OR ANY CIRCUMSTANCE ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION, OR ANY FORMER OR PRESENT EMPLOYEE OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION?

Yes No

If "Yes", how many? _____

Have they been reported to your insurer?

Yes No

IV. CLAIM/SUIT INFORMATION FORM

(Please make copies if additional forms are needed.)

Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

Name of Applicant: _____

1. Patient/Claimant Information

Patient/Claimant Name Age Sex

2. Date(s) of treatment and/or surgery which led to the allegations against you. _____
Date (MM/YY)

3. Nature of allegations in the claim or suit: _____

4. Was a suit ever filed? Yes No If Yes, when: _____
Date (MM/YY)

5. Name 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
Indicate case value established by carrier, if known (in \$) _____
Was this matter closed with your consent? 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 \$): _____ Settlement or award date: _____

7. Defending insurance carrier information: _____
(Name of Insurance Carrier Defending You) Policy Number

8. Please attach a narrative description of the medical/dental facts; (must include, but not limited to the type of treatment and/or surgery; your involvement).

