FREEDOM SPECIALTY
INSURANCE COMPANY®
Home Office:
One Nationwide Plaza • Columbus, Ohio 43215
Administrative Office:
8877 North Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675

MGIS UNDERWRITING MANAGERS, INC.
1849 W. North Temple
Salt Lake City, UT 84116-3067
1-800-969-6447 toll free
1-801-990-2400 phone
1-801-990-2401 fax
www.mgis.com

HEALTHCARE PROVIDER PROFESSIONAL LIABILITY—INDIVIDUAL APPLICATION

NOTE: The insurance for which you are applying is a claims-made form of coverage. Only claims resulting from professional services rendered on or after the retroactive date of this insurance and reported during the policy period will be covered. See the policy for coverage and specific details.

Please follow these instructions when completing and submitting this application.

A. Please type or legibly print your responses in full. Any responses which require greater explanation may be supplemented with additional pages, forms or exhibits attached to this application form. Application must be signed and dated within sixty (60) days of the desired effective date and received prior to desired effective date.

B. Complete one application for each Healthcare Provider. Answer all questions. Indicate "N/A" if a question is not applicable.

C. Read and initial the State Statutory Requirement in Section **I.** of this application. Applications cannot be processed without completion of this statutory requirement.

D. For coverage to be considered by the underwriter, you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. If the entity is a corporation of any type, please attach a copy of Articles of Incorporation. Additional documentation pertaining to the entity's existence and operations may be requested as deemed necessary by the underwriter.

The following **MUST** be included with this application:

- **Copy of your current Professional Liability Insurance Declarations Page and any endorsements, if applicable, and currently valued loss runs for the past ten (10) years.**
- **Copy of your license, Curriculum Vitae, and any certification, if applicable.**
- **Claim/Suit Information Form with additional documentation as needed.**
- **Copies of all advertising that is used by you, including Yellow Page or Internet ads, relevant Web sites, social media, etc.**

Return completed application to:

MGIS UNDERWRITING MANAGERS, INC.
1849 West North Temple
Salt Lake City, UT 84116-3067
1-800-969-6447 toll-free
1-801-990-2400 phone
1-801-990-2401 fax
www.mgis.com

BROKER INFORMATION

Firm Name: ______________________ Firm Broker No.: ______________

Producer: ______________ Phone: ______________ E-mail: ______________

A. GENERAL INFORMATION

1. Applicant Information:

Last name: ______________ First name: ______________ Middle name: ______________

Degree: ______________ Social Security No.: ______________

Date of Birth: ______________ Place of Birth (City/State/Country): ______________

2. Group/Employer Office Locations: (List principal location first. Total percent of practice of all locations must equal one hundred percent [100%])

Location 1.

☐ Office ☐ Hospital/Surgi-Centers:

Percent of Practice: ________% Practice/Facility/Hospital Name: ______________

Street Address: ______________

City: ______________ State: ______________ Zip: ______________ County: ______________

Location 2.

☐ Office ☐ Hospital/Surgi-Centers:

Percent of Practice: ________% Practice/Facility/Hospital Name: ______________

Street Address: ______________

City: ______________ State: ______________ Zip: ______________ County: ______________

3. Preferred Mailing Address:

☐ Location No. (from **2.** above): ________ ☐ Residence ☐ Other (please enter below)

Street Address: ______________

City: ______________ State: ______________ Zip: ______________ County: ______________

4. Billing and Correspondence Address:

☐ Location No. (from **2.** above): ________ ☐ Residence ☐ Other (please enter below)

Business Manager/Contact Person: ______________

Street Address: ______________

City: ______________ State: ______________ Zip: ______________ County: ______________

5. Preferred Method of Contact: ☐ E-mail ☐ Business Fax ☐ Business Phone ☐ Residence Phone

E-mail: ______________ Business Fax No.: ______________

Business Phone No.: ______________ Residence Phone No.: ______________

6. Do you have a Web site address? .... ☐ Yes ☐ No

If Yes, please provide address: ______________

B. PROFESSIONAL & PRACTICE INFORMATION *(If additional space is needed, please use supplemental form)*

1. Medical Education/Healthcare Training:

a. Place an “x” in the box below to indicate the highest level of education you have completed relating to practice in your field:

☐ None required ☐ Baccalaureate Degree ☐ Post-Doctorate Degree

☐ Diploma ☐ Masters Degree ☐ Other: ______________

☐ Associate Degree ☐ Doctorate Degree

School Name: ____________________

City: ____________ State: ____________ Country: ____________

From: ____________ To: ____________

b. If you are a foreign medical school graduate, have you obtained an Educational Commission for Foreign Medical Graduates (ECFMG) certificate? .... ☐ Yes ☐ No

If Yes, list date certified: ____________

If No, please explain: ____________________

2. **Internship:** *(Indicate the facility name and location where you served internship[s]))*

Location 1.

Hospital/Facility Name: ____________________

City: ____________ State: ____________ Country: ____________

Specialty Type: ____________________

Completed?........ ☐ Yes ☐ No From: ____________ To: ____________

3. **Residency:** *(List all resident training locations—i.e., residency specialty training, anesthesia residency training, etc. If more than one specialty completed, please enter each specific specialty.)*

Location 1.

Hospital/Facility Name: ____________________

City: ____________ State: ____________ Country: ____________

Specialty Type: ____________________

Completed?........ ☐ Yes ☐ No From: ____________ To: ____________

Location 2.

Hospital/Facility Name: ____________________

City: ____________ State: ____________ Country: ____________

Specialty Type: ____________________

Completed?........ ☐ Yes ☐ No From: ____________ To: ____________

4. **Have You Participated In Any Additional Training?**

Location 1.

Hospital/Facility Name: ____________________

City: ____________ State: ____________ Country: ____________

Specialty Type: ____________________

Completed?........ ☐ Yes ☐ No From: ____________ To: ____________

Location 2.

Hospital/Facility Name: ____________________

City: ____________ State: ____________ Country: ____________

Specialty Type: ____________________

Completed?........ ☐ Yes ☐ No From: ____________ To: ____________

5. **Have you participated in any continuing medical education within the last three years?** .... ☐ Yes ☐ No

If yes, how many credit hours? ____________

6. **Check your specific professional occupation:** *(Indicate the percentage of your total practice)*

Occupation	%	Occupation	%
Acupuncture	%	Optometry Assistant	%
Case Manager	%	Oral Surgeon	%
Chiropractor	%	Orthotist/Prothetist	%
Chiropractor Assistant	%	Paramedic/EMT	%
Dental Hygienist	%	Perfusionist	%
Dentist	%	Pharmacist	%
Dietician or Nutritionist	%	Pharmacy Assistant	%
EEG/EKG Technician	%	Physical Therapist Employed	%
Laboratory Supervisor or Director	%	Physical Therapist Owner	%
Medical Office Assistant	%	Physical Therapy Assistant	%
Medical Technician	%	Physician/Surgeon Assistant	%
Nurse	%	Physicist or Biologist	%
Nurse Aide/Homemaker	%	Podiatrist	%
Nurse Midwife	%	Psychologist	%
Nurse Midwife Assistant	%	RNA/CRNA	%
Nurse Practitioner	%	Respiratory Therapist	%
Occupational Therapist	%	Respiratory Therapist Aide	%
Occupational Therapist Aide	%	Social Worker	%
Operating Room Technician	%	Surgical Assistant	%
Optician	%	X-ray Technician	%
Optometrist	%	*Other:	%

*If "Other" is checked, provide a brief description of your duties. Supplemental information advertising material available explaining duties should be included.

7. **Telemedicine: do you practice across state lines?**........ ☐ Yes ☐ No

   If Yes, which states? ____________________

   Please describe equipment used: ____________________

   Please indicate types of encounters: ____________________

8. **Indicate the average weekly number of hours for which you require coverage:**

   No. of Hours/Week: ____________________ No. of Patients/Week: ____________________

9. **Are you required to be licensed in the state(s) where you practice?**........ ☐ Yes ☐ No

   If Yes, provide your license number(s) for each state that requires a license. Please check the appropriate box to indicate the status of your license.

STATE	LICENSE NO.	ACTIVE	INACTIVE	TEMPORARY	PENDING
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

10. Do you prescribe drugs? ☐ Yes ☐ No

If Yes, Narcotices/DEA No.: ____________________

11. Do you perform surgical procedures? ☐ Yes ☐ No

12. Where have you practiced your profession since completion of your formal training? *(Including military or any public service organization)*

City	State	County	From	To

13. List medical societies and professional organizations in which you are currently a member: ____________________

14. Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If Yes, complete the following: ☐ Employee ☐ Independent Contractor

Practice Name and Locations: ____________________

Name of Carrier: ____________________

C. ADDITIONAL PROFESSIONAL AND PRACTICE INFORMATION

Please fully explain any "Yes" answer in Section H., Applicant Additional Comments, or add a separate sheet.

1. If you answer "Yes" to any of the following, please indicate date(s) and explain:

a. Have you ever had your membership to any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society? ☐ Yes ☐ No

b. Has any state ever refused your license to practice medicine? ☐ Yes ☐ No

c. Has any state ever restricted, suspended or revoked your license to practice medicine? ☐ Yes ☐ No

d. Has any state agency ever placed you on probation or restricted your practice? ☐ Yes ☐ No

e. Have you ever been investigated by any governmental agency? ☐ Yes ☐ No

f. Has any hospital ever denied, restricted, reduced or suspended your privileges or invoked probation? ☐ Yes ☐ No

g. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? ☐ Yes ☐ No

h. Are you now, or have you ever been, treated for or suffered from alcoholism, chemical dependency or mental illness? ☐ Yes ☐ No

i. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine? ☐ Yes ☐ No

j. Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you? ☐ Yes ☐ No

k. Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense? ☐ Yes ☐ No

l. Have you ever been refused board certification? ☐ Yes ☐ No

m. Have you ever had professional liability insurance declined, canceled, rescinded, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had a renewal refused? (Not applicable in Missouri) ☐ Yes ☐ No

To your knowledge is any such action under consideration by any current medical professional liability insurer? (Not applicable in Missouri) ☐ Yes ☐ No

2. **Please check any of the following functions performed as part of your professional activities:**

☐ Limited "Scrub Nurse" functions such as holding retractors, suction, tying sutures, handling and counting of instruments

☐ Casting and splinting

☐ Directly assisting as a non-physician first assistant in surgical procedures

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

If Yes, please explain: ______________________________

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

If Yes, please explain: ______________________________

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

If Yes, please explain: ______________________________

6. **Please check the box that best describes your practice affiliation**

☐ Employee ☐ Shareholder/Parnter ☐ Independent Contractor ☐ Other: ______________

If other, please explain: ______________________________

7. **Member/Partner Information:**

Name of Member or Partner	Services

8. **Name of professional corporation, association or other organization:** ______________________________

Retroactive Date: ______________

9. **Is separate limit of liability desired for entity?** .... ☐ Yes ☐ No

Note: You, your partners or members of your PA or PC must be covered together. Please complete an application for each partner or member of the PA or PC.

D. INFORMATION ON PROFESSIONAL EMPLOYEES *(If additional space is needed, please use supplemental form)*

1. **If you have professional employees, list job categories and number of employees for each:**

Job Categories	Count	Job Categories	Count

2. **For your employees, please indicate one of the following:**

☐ Employees are to be covered individually. (Policy limits apply individually and separate applications are required.)

☐ Employees are to be covered as additional insureds (Policy limits are shared.)

☐ No coverage for employees

3. **Do employees carry their own professional liability insurance?** ☐ Yes ☐ No
   - **a.** If Yes, do you require your employees to carry minimum professional liability insurance limits? ☐ Yes ☐ No
   - **b.** Do you require proof of insurance? ☐ Yes ☐ No
4. **Do you have independent contractors working for you?** ☐ Yes ☐ No

   If Yes, please describe: *(Include type and in what capacity the independent contractor is working.)*

   Type and capacity the independent contractor is working: ______________________

   Number of Contractors: ______________

   Total Hours per Month Worked by all Contractors: ______________

   - **a.** Do you require independent contractors to carry their own professional liability insurance? ☐ Yes ☐ No
   - **b.** If Yes, indicate limits required: $______________
   - **c.** Do you require proof of insurance? ☐ Yes ☐ No

E. LOSS INFORMATION (If additional space is needed, please use supplemental form)

Complete and attach a Claims/Suit Information Form for EACH claim, potential claim, or suit.

New Business Applicant: *Please attach a current loss run from all previous carrier.*

If you answer Yes to any of Questions **1.-4.,** and a description of the events are not included with the loss run, please provide copies of report(s) made to previous carriers or detail circumstances.

1. **Have any professional liability claims or notices against you been arbitrated, mediated, litigated, dismissed, settled, or are currently pending?** ☐ Yes ☐ No

   If Yes, how many? ______________

   If Yes, have these been reported to your insurer? ☐ Yes ☐ No
2. **Indicate below if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you *(even if you believe the claim or suit would be without merit)*:**
   - **a.** A request for records from a patient/attorney related to an adverse outcome? ☐ Yes ☐ No
   - **b.** A letter from a patient/attorney regarding your medical treatment of a patient? ☐ Yes ☐ No
   - **c.** Intra-operative complications or other complications resulting in death, paralysis or any significant injuries including those related to the use of prescribed drugs? ☐ Yes ☐ No
3. **Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits, *(even if you believe the claim or suit would be without merit)*, that have not been reported to your current or prior professional liability carrier?** ☐ Yes ☐ No
4. **Have you ever been accused of professional negligence, or has a suit or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged based upon your acts or omissions?** ☐ Yes ☐ No
5. **Have you ever had any insurance company decline, cancel, rescind or non-renew any professional and/or general liability insurance policy? (Not applicable in Missouri)** ☐ Yes ☐ No

   If Yes, provide details: ______________________
6. **Have you ever had any proceedings/investigations/audits regarding billing practices or billing errors, HIPAA, EMTALA, or STARK proceedings instituted against you?** ☐ Yes ☐ No

   If Yes, did they result in legal or audit expenses, fines or penalties? ☐ Yes ☐ No

F. COVERAGE INFORMATION (If additional space is needed, please use supplemental form)

1. List all previous professional liability insurers dating back to completion of formal training beginning with the most recent:

Name of Insurer	Coverage Type C=Claims-Made O=Occurrence	Limits per claim/annual aggregate	Deductible (if any)	Policy Period	
				From	To
		$	$		
		$	$		
		$	$		
		$	$		

Please explain any gaps in coverage back to your start date of practice: ______________________________

____

____

2. Coverage desired

a. ☐ Claims-made Coverage without Prior Acts Coverage

b. ☐ Claims-made Coverage with Prior Acts Coverage (A copy of current declaration page showing current retroactive date must be attached)

If **a.** is selected above and the most recent prior coverage was issued on a claims-made basis, 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 (please explain)

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 applying for will not provide prior acts of 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 claims-made coverage or the additional expense associated with an Extended Reporting Endorsement or "tail coverage."

3. Requested coverage effective date 12:01 a.m.

FROM: ________________12:01 a.m. TO: ____________________ 12:01 a.m.

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

Note: Annual Policy terms will begin and end on the same month and day. If you are joining an existing insured/group, your coverage may be issued to a common expiration date.

4. Retroactive date shown on my current claims-made policy is: .... ____________ 12:01 a.m.

5. If you practice in the fund states of Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, or Wisconsin, please indicate your current fund retroactive date if different than the retroactive date stated above: .... ____________ 12:01 a.m.

Are you aware of any gaps in your fund coverage? .... ☐ Yes ☐ No

If Yes, provide exact dates and an explanation: ______________________________

6. **If you practice in more than one state, indicate the state and the limits desired for each state.**

Add additional states if needed.

State	Limits Desired	Per claim	Annual Aggregate
	$	$	$
	$	$	$
	$	$	$

Note: Requested limits may not be available from this company. You may be eligible for fund coverage in accordance with state fund guidelines. Limits may be adjusted accordingly.

G. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

By initialing below, I assign to the following employer or named third party (include name and address) both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to Freedom Specialty Insurance Company, Administrative Offices at 8877 North Gainey Center Drive, Scottsdale, Arizona 85258.

Name: ______________________________

Address: ______________________________

Initial Here: ___________

NOTE: Your right to cancel and receive any premium refund will automatically be assigned.

1. To the First Named Insured if you are covered under a group policy.

2. To a third-party finance company if it pays your premium on your behalf.

H. APPLICANT ADDITIONAL COMMENTS

Use this space to provide any additional details, explanations or information that you believe may be pertinent to this application. You are also encouraged to attach any pages containing supplemental information that you believe may be helpful.

Question No.	Explanation

I. STATE STATUTORY REQUIREMENT

Notice to Arizona Applicants: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas and Rhode Island 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 fines and confinement in prison.

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 policyholder 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 Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: 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 in the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana 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 fines and confinement in prison.

Notice to Maine 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 Maryland Applicants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Notice to 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 Ohio Applicants: Any person who, with intent to defraud or knowing that he 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.

Notice to Oklahoma Applicants: WARNING: 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 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 Tennessee and 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.

Notice to 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 include imprisonment, fines and denial of insurance benefits.

Notice to New York 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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, including all attachments 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 entity, 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.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity) I warrant that I am an Officer, Partner, Office Administrator or AUTHORIZED REPRESENTATIVE of the entity applying for coverage.

Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC or PA or the Office Administrator or AUTHORIZED REPRESENTATIVE.

SIGNATURE

DATE SIGNED

PRINT NAME AND TITLE

E-MAIL ADDRESS

The following **MUST** be included with this application:

- **Copy of your current Professional Liability Insurance Declarations Page and any endorsements, if applicable, and currently valued loss runs for the past ten (10) years.**
- **Copy of your license, Curriculum Vitae, and any certification, if applicable.**
- **Claim/Suit Information Form with additional documentation as needed.**
- **Copies of all advertising that is used by you, including Yellow Page or Internet ads, relevant Web sites, social media, etc.**

Attach to your application

J. CLAIMS/SUIT INFORMATION FORM (Complete one form for each claim, potential claim or suit)

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

NOTE: Additional documentation (office/hospital records) may be requested at the underwriting department's discretion.

1. Claimant information (indicate if different from patient):
Name (First, MI, Last) ____________________ Age: ____ ☐ Male ☐ Female

2. Date of treatment and/or surgery, which led to the allegations against you: ____________

3. Date claim/incident notice received: ____________

4. Date claim reported to prior insurer: ____________

5. List 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
If closed, indicate date of closing/settlement or award: ______________

7. Indicate case value established by carrier, if known: $______________

8. Defending insurance carrier name: ____________________

9. Claim file number: ____________________

10. Additional claim information:
- **a.** Was a suit filed?.. ☐ Yes ☐ No
- **b.** Was payment made? .... ☐ Yes ☐ No
- **c.** If No, was claim or suit withdrawn?.. ☐ Yes ☐ No
- **d.** If Yes, was verdict or judgment in favor of entity or plaintiff? .... ☐ Entity ☐ Plaintiff
- **e.** If Yes, indicate total amount of settlement or award: $__________________
- **f.** Amount paid on your behalf: $____________________

11. Nature of allegations in the claim or suit:
- **a.** Condition treated: ____________________
- **b.** Treatment provided: ____________________
- **c.** Alleged negligence: ____________________
- **d.** Alleged injury: ____________________

12. Provide a narrative description of the medical facts (must include, but is not limited to, the type of treatment and/or surgery and your involvement): ____________________

____

____

____

____

____________________ ____________
SIGNATURE DATE SIGNED

____________________ ____________________
PRINT NAME AND TITLE E-MAIL ADDRESS