PMSLIC
MEDICAL LIABILITY INSURANCE

P.O. BOX 2080, MECHANICSBURG PA 17055-0787
800 445-1212 **T** 717 796-8080 **F** PMSLIC.com

CORPORATION/PARTNERSHIP PROFESSIONAL LIABILITY APPLICATION
(Complete One Application Per Entity)

PLEASE ANSWER ALL QUESTIONS. COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETED.

Producer Name

PART I NAME AND ADDRESS OF ENTITY

Name of Entity: ______________________________

Address of Entity: ______________________________

Principal Office Location: ______________________________
Address

City ______ State ______ Zip Code ______ County ______ % of Practice ______

Office Telephone (*including area code*): ______________ FAX (*including area code*): ______________

Business Mgr/Administrator: ______________________________

E-mail: ______________ Web Site: ______________

Other Practice Locations (base percentage of practice on the number of patients treated):

1. Suite ______ Number & Street ______ City ______
State ______ Zip Code ______ County ______ % of Practice ______

2. Suite ______ Number & Street ______ City ______
State ______ Zip Code ______ County ______ % of Practice ______

3. Suite ______ Number & Street ______ City ______
State ______ Zip Code ______ County ______ % of Practice ______

Preferred Mailing Address: ☐ Principal Office ☐ Other ______________
Address

City ______ State ______ Zip Code ______

PART II COVERAGE INFORMATION - PROVIDE A COPY OF YOUR DECLARATIONS PAGE FROM YOUR MOST RECENT INSURANCE POLICY

A. Coverage Desired
- ☐ Claims-made without prior acts coverage. Under this option the retroactive date will be the same as the effective date of coverage.
- ☐ Claims-made with prior acts coverage. Under this option the retroactive date will be the same as the retroactive date on your current policy.

B. Requested effective date 12:01 a.m. ______________ Retroactive Date ______________
NOTE: If you are moving to Pennsylvania you must purchase “tail” (retroactive reporting) coverage from your present carrier unless your existing coverage is on an occurrence basis.

C. Limit of Liability
- ☐ $500,000 each medical incident/$1,500,000 annual aggregate
- ☐ $1,000,000 each medical incident/$3,000,000 annual aggregate

NOTE: Limits of $1,000,000/$3,000,000 are available only to non-Mcare eligible entities.

PART III UNDERWRITING AND RATING INFORMATION

A. The legal entity named above is a:

☐ Professional Corporation
NOTE: Include a copy of the Articles of Incorporation and Certificate of Incorporation (*required only if incorporated prior to January 1, 1988*)

☐ Partnership
NOTE: Include a copy of the Agreement

☐ Limited Liability Company

☐ Other ______________________________

B. Do you use an unincorporated trade name (DBA)? ☐ **YES** ☐ **NO**
If **YES**, please provide the name(s) of any DBAs: ______________________________

C. Is this entity involved in the delivery of healthcare or professional medical services to patients within a direct professional provider-patient relationship? ☐ **YES** ☐ **NO**

If **NO**, thoroughly describe the entity's purpose in the **ADDITIONAL INFORMATION** section of this application.

D. At your practice site, do you provide outpatient surgical procedures? ☐ **YES** ☐ **NO**
If **YES**, is your facility available to other health-care providers NOT employed or contracted to your group? ☐ **YES** ☐ **NO**

E. Is the professional corporation/partnership currently insured for professional liability? ☐ **YES** ☐ **NO**

If **YES**, state where insured ______________________________ ______________________________
Company — Expiration Date 12:01 a.m.

F. List the names and medical specialties of all individual Physicians/Surgeons who are stockholders or partners.

STOCKHOLDERS/PARTNERS	INSURED BY
1.	
2.	
3.	

G. Does the entity **employ** other Physicians/Surgeons (non-stockholders/partners)? ☐ **YES** ☐ **NO**
If **YES**, please complete the following:

PHYSICIAN NAME	INSURED BY	SPECIALTY
1.		
2.		
3.		
4.		

H. Healthcare Extender Coverage

☐ Employee Shared Limits and Liability Endorsement
This coverage extends liability limits of $500,000/$1,000,000 to employees of the policyholder at no additional premium. The limit of liability is a shared limit among the employees and is separate from the policyholder's limit of liability.
Coverage under this endorsement does not include physicians, nurse midwives, certified nurse anesthetists, physician assistants, nurse practitioners, surgical assistants, optometrists, dentists or podiatrists.

☐ Designated Employee Coverage
This coverage is available to those non-physician healthcare extenders not included under the employee shared limit of liability. If you wish to apply for coverage for any such employed non-physician healthcare extender, please complete a Designated Employee Application for each individual.

PART IV CLAIMS INFORMATION

Has any malpractice claim or suit been brought against the corporation/partnership? ☐ **YES** ☐ **NO**
If **YES**, please complete a Claims Information Supplement form.

PART V ADDITIONAL INFORMATION

Please use the space below for any comments that you feel will help PMSLIC better understand any special circumstances concerning your practice. (Attach a separate sheet, if necessary.)

PART VI APPLICANT RELEASE OF INFORMATION AUTHORIZATION

We/I, on behalf of the corporation/partnership, authorize the release and exchange of information involving either underwriting or claims matters between all prior insurance carriers.

By ______________________________ Date ______________________

Authorized Signature

Pennsylvania law requires that we notify you of the following:

Any person who knowingly and with the 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.