NOTICE: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

PART I - PRODUCER INFORMATION

Agency Name		Submitted By	
Agency License Number	State	Telephone	Most Recent Coverys RRG Policy Number

PART II - APPLICANT INFORMATION

Name of Entity	Federal Tax ID	Website
Contact Person/Insured Representative		Email Address
Risk Management Contact Person		Telephone

Primary Office Address
Percentage of practice: _____
Address One
Address Two
City State Zip
Phone Fax

Mailing Address
(if different than primary office)
Address One
Address Two
City State Zip
Phone Fax

Billing Address
(if different than primary office)
Address One
Address Two
City State Zip

Type of Entity
❑ Professional Corporation ❑ Partnership ❑ Professional Association

If you are licensed as a corporation, are you listed as a:
❑ Business Corporation ❑ Charitable Corporation

PART III - COVERAGE INFORMATION

Type of Coverage (choose one)
❑ Occurrence ❑ Claims Made Retroactive date desired*_____

Coverage Effective Date
From _____ To _____

Do you wish to purchase Prior Acts Coverage? ❑ Yes ❑ No (If yes, please complete and submit CRRG APP 015, Prior Acts Application.)

*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Professional Liability
Each Claim $_____ Annual Aggregate $_____

For New Jersey Applicants Only

In accordance with the New Jersey Medical Care Access and Responsibility Patients First Act, you may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from $5,000 to $1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy the deductible must be fully collateralized. Would you like more information on deductibles? ❑ Yes ❑ No

PART IV - CLAIMS MANAGEMENT AND INCIDENT REPORTING PROCEDURES

Provide the name, title and phone number of the individual responsible for claims handling/incident reporting:

Name: _____ Title: _____ Phone Number: _____

Please describe or attach your written claims handling/incident reporting procedures:

PART V - OWNERSHIP AND CORPORATION INFORMATION

List the names of all owners, stockholders, and partners including their individual policy numbers.

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Coverys RRG Insured	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Applying for Coverys RRG Coverage	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Specialty				
Surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery
Assisting with Surgery	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients
General Anesthesia in Office	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Conscious Sedation in Office	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Graduation Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Residency Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Fellowship Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*

Please be advised, in order to be eligible for this coverage, at least 50% of corporate owners and employed practitioners of the corporation must be insured with Coverys. Employed practitioners include physicians, surgeons, dentists, and certified nurse midwives.

List all other DBAs and affiliated entities associated with the partnership/corporation and indicate if the ownership is the same:

Name					
Address One					
Address Two					
City					
State					
Zip					
Same Ownership	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

If the ownership of the DBA and affiliated entities are different and separate coverage is desired, please complete a separate **CRRG APP 002, Partnership & Corporation Application** for each entity.

PART V - OWNERSHIP AND CORPORATION INFORMATION (continued)

If the entity is providing service at locations other than the primary office address please complete the chart below.

Name of Facility					
Address One					
Address Two					
City					
State					
Zip					
% of Practice					

PART VI - CURRENT PRACTICE

Are you paid on capitation (flat fee) basis by an HMO, PPO, etc? ❑ Yes ❑ No

If yes, do you assume the finanical risk for referrals? ❑ Yes ❑ No

Please name the capitation program: _____

Does the partnership/corporation advertise? ❑ Yes ❑ No

If yes, please explain or attach a copy of any advertising materials. _____

_____

Are there any services that you provide by contract to other entities? ❑ Yes ❑ No

If so, are you agreeing to indemnify these entities? (If yes, please attach a copy of the contract.) ❑ Yes ❑ No

Is the facility equipped to handle emergency procedures (e.g., cardiac arrests)? ❑ Yes ❑ No

Is surgery performed in the office? ❑ Yes ❑ No

If yes, please list the procedures performed. _____

_____

_____

Indicate the type of anesthesia administered: ❑ None ❑ General ❑ Regional

Check the auxillary services provided: ❑ None ❑ Laboratory ❑ Radiology ❑ Pharmacy ❑ Other: _____

Please explain the extent of the above services or attach a patient pamphlet. _____

_____

_____

_____

If any of the above services are provided, does the state require that you be licensed to provide these services? (If yes, please attach a copy of the licenses.) ❑ Yes ❑ No

Do you or any of your employees perform Botox or Collagen injections? (If yes, complete and submit CRRG APP 042, Botox/Cosmetic Procedures Addendum.) ❑ Yes ❑ No

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ❑ Yes ❑ No

(If yes, please complete and submit CRRG APP 040, Clinical Trials Addendum.)

Do you participate in any telemedicine activities? (If yes, complete and submit CRRG APP 043, Telemedicine Addendum.) ❑ Yes ❑ No

Do you credential the practitioners in your group? ❑ Yes ❑ No

If yes, what are the minimum limits of liability required? _____

Do you maintain current certificates of insurance on file for all employed or contracted practitioners and non-physican employees? ❑ Yes ❑ No

Please attach documentation or describe the monitoring system to ensure malpractice policies of physicians are kept current: _____

_____

Has the license of any physician been restricted or suspended in the last two years? ❑ Yes ❑ No

Have the privileges of any physician been restricted or suspended in the last year? ❑ Yes ❑ No

If yes to either, please list and provide reasons for restriction or suspension.

Name	Reason

PART VII - EMPLOYEES/ADDITIONAL INSUREDS

Please list the following for any practitioner you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete *CRRG APP 041, Independent Contractor Addendum*.

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Independent Contractor	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Coverys RRG Insured	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Applying for Coverys RRG Coverage	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Specialty				
Surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery
Assisting with Surgery	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients
General Anesthesia in Office	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Conscious Sedation in Office	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Graduation Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Residency Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Fellowship Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*

If you employ non-practitioner employees, please list job category and number of each. (If necessary please attach additional sheets.)

Job Title/Specialty	Number of Employees

Do you want employee coverage under separate limits? ❑ Yes ❑ No

Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete ***CRRG APP 026, Employee Limit of Liability Application****.This coverage cannot be purchased for employed dentists.*

PART VIII- HISTORY

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	*From* *To*	*From* *To*	*From* *To*	*From* *To*
Insurer				
Policy #				
Coverage				
Premium				
Tail Purchased	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Retroactive Date				
Limit				
Facility				
State				
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? (If yes, please list company, date and reason for this action below.) ❑ Yes ❑ No

Company Date Reason

Company Date Reason

PART IX - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

Professional Contractual Liability

Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance*. There is a charge based on a percentage of your professional liability premium. ❑ Yes ❑ No

For New Jersey Applicants Only - Consent to Settle

The right to consent to settle is automatically provided to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. You may choose to waive this right for a 5% premium credit to your policy. Would you like to waive this right? ❑ Yes ❑ No

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- ❑ Copy of current Declaration Page
- ❑ Loss runs from all carriers for prior 15 years, or since the start of the practice, whichever is greater
- ❑ A narrative of all past claims - *a Claim Information Form may be used when necessary*
- ❑ Signed Notice to New Applicants (CRRG APP 028) for claims made policies
- ❑ Signed Anti-Fraud Statement (New Jersey)
- ❑ Copy of previously purchased tail policies, if applicable.

READ CAREFULLY BEFORE SIGNING

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

REPRESENTATIONS AS TO ACCURACY OF APPLICATION, THE AUTHORITY OF PERSON SIGNING, AND APPLICANT'S OBLIGATION TO SUPPLEMENT INFORMATION

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

AUTHORIZATION TO OBTAIN INFORMATION

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE OF APPLICANT	TITLE
PRINTED NAME OF APPLICANT	DATE