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 West North Temple
Salt Lake City, Utah 84116-3067
1-800-969-6447 toll free
1-801-990-2400 phone
1-801-990-2401 fax
www.mgis.com

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY—CORPORATE 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.

The policy provides additional benefits/coverage for:

- Defense Costs
- Attendance at Trial (at Company request)
- Appeal Bond Coverage
- Regulatory and Billing-Related Proceedings Defense Costs Reimbursement including Civil Monetary Penalties assessed in billing-related proceedings

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. If additional space is needed, please complete Section **G.** of this application or provide attachments. 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 “Corporate” application for each organization. Answer all questions. Indicate “N/A” if a question is not applicable.

C. Complete Census Information in Section **D.** for all individuals employed by, under contract to, or having any type of ownership interest in the entity.

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

E. For coverage to exist, 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 entity professional liability Insurance Declarations Page and any endorsements, and currently valued loss runs for the past ten (10) years for the entity and each group member.**
- **Copy of the entity organizational chart listing any subsidiaries, joint ventures, etc. including a brief description of how they interact. Copies of contracts between the entities, may be requested as deemed necessary by the underwriter.**
- **Copy of your entity’s business letterhead or sample billing statement.**
- **Claim/Suit Information Form with additional documentation as needed.**
- **Copies of all advertising that is used by the entity, including Yellow Page or Internet ads, relevant Web site, 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/1-8011-990-2400 phone/1-801-990-2401 fax
www.mgis.com

BROKER INFORMATION

Firm Name: ______________________ Firm Broker No.: ______________________

Producer: ______________________ Phone: ______________ E-mail: ______________________

A. ORGANIZATION INFORMATION

1. **Applicant/Legal Entity Name (Attach Articles of Incorporation)**

   Entity name: ______________________

   Federal tax identification number: ______________________

2. **Indicate the Entity's "Authorized Representative":**

   The "Authorized Representative" is the person designated in this application and the policy to act on behalf of all insureds for all purposes related to this policy.

   Authorized Representative Name: (first and last): ______________________

   Title: ______________ E-mail: ______________ Business Phone No: ______________

3. **Is this entity associated with a current insured?** .... ☐ Yes ☐ No

   If Yes, provide the Individual, Corporation or Partnership policy and group number if known:

   Policy No.: ______________ Account name: ______________________

4. **Type of legal entity (Place an "x" in the applicable spaces):**

   ☐ Professional Corporation—sole shareholder
   ☐ Professional Corporation—multiple shareholders
   ☐ Not for Profit
   ☐ Limited Liability Corporation (LLC)
   ☐ General Business Corporation
   ☐ Partnership or Professional Association
   ☐ Other (please describe): ______________________
   ☐ Joint Venture (indicate parties in venture and percentage of ownership): ______________________

   ____

5. **Number of owners, shareholders, partners or members of entity (List all members of entity in Section D. Census Information):** ______________

6. **Type of organization (Place an "x" in the applicable spaces):**

   ☐ Abortion Clinic
   ☐ Community Based Health Center
   ☐ Emergency/Walk-in Center/Urgent Care Facility
   ☐ Family Planning Clinic
   ☐ Home Health Care
   ☐ Laboratory—Own Patients
   ☐ Laboratory—Other than Own Patients
   ☐ Medical Spa
   ☐ MRI/CT (Fixed/Mobile)
   ☐ Physical Therapy Center
   ☐ Private Doctor's Office
   ☐ Other (specify): ______________________

7. **If above entity does business under any other name, list all additional entity/clinic names (e.g., DBA, fictitious, etc.):**

   ____

   ____

8. a. **Does applicant own, operate or manage another organization or entity?** .... ☐ Yes ☐ No

   b. **Is applicant owned, operated or managed by another organization or entity?** .... ☐ Yes ☐ No

9. **Practice office locations (List principal locations first. Total percentages of practice of all locations must equal one hundred percent [100%]):**

   Location 1.

   Street address: ______________________

   City: ______________________ County: ______________________

   State: ______ Zip code: ______________ From: ______________To: ______________ Percent of practice: __________%

Location 2.

Street address: ______________________________

City: ______________________ County: ______________________

State: ______ Zip code: ______________ From: __________ To: __________ Percent of practice: ________%

Location 3.

Street address: ______________________________

City: ______________________ County: ______________________

State: ______ Zip code: ______________ From: __________ To: __________ Percent of practice: ________%

10. In which state(s) is this entity authorized to do business?

List state of incorporation: ______________________________

List all states in which entity is authorized to do business: ______________________________

11. Are you currently enrolled in a state compensation fund or similar state-sponsored coverage? .... ☐ Yes ☐ No

a. If Yes, indicate state of coverage: ________

b. Have you at all times subsequent to your retroactive coverage date continuously qualified and/or been covered by the state fund?.. ☐ Yes ☐ No

c. If No, provide exact dates of coverage gaps and comment to explain: ______________________________

____

12. Preferred method of contact: ☐ E-mail ☐ Business fax ☐ Business phone

Contact name (first and last): ______________________ Title: ______________________

E-mail: ______________________ Fax No.: ______________ Business phone: ______________

13. Practice mailing/billing address:

Street address: ______________________________

City: ______________________ State: _____ Zip code: ________

14. Corporate officers

CEO or President Name (first and last): ______________________________

E-mail: ______________________ Business phone: ______________________

Medical director Name (first and last): ______________________________

E-mail: ______________________ Business phone: ______________________

Administrator Name (first and last): ______________________________

E-mail: ______________________ Business phone: ______________________

B. <u>GENERAL INFORMATION</u>

*If you answer Yes to any of the questions in this section, please provide full details in Section **G.** Applicant Additional Comments at the end of this application.*

1. Does the entity use a collection agency that has the authority to file collection suits without your knowledge? .... ☐ Yes ☐ No

If Yes, please explain: ______________________________

____

2. Has your organization or any of your employees:

a. Ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association? .... ☐ Yes ☐ No

If Yes, list individual(s) involved, dates and explanation: ______________________________

____

____

____

b. Ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? .... ☐ Yes ☐ No

If Yes, list individual(s) involved, dates and explanation: ____________________

____

____

____

c. Ever had any professional liability insurance refused, declined, canceled or nonrenewed by the insurance company (Not applicable to Missouri applicants)? .... ☐ Yes ☐ No

If Yes, list individual(s) involved, dates and explanation: ____________________

____

____

____

3. Does the entity:

a. Own or operate any laboratory? .... ☐ Yes ☐ No

If No, please explain: ____________________

____

b. Have a pharmacy? .... ☐ Yes ☐ No

If Yes, is the pharmacy providing services for your patients only? .... ☐ Yes ☐ No

If No, please specify: ____________________

____

c. Or any of its partners, shareholders, or employed physicians supervise any healthcare providers other than those employed at your practice or any residents or interns? .... ☐ Yes ☐ No

If Yes, list facility, specialty and number supervised: ____________________

d. Currently contract to supervise, manage or administer any departments within a hospital or other facility for an HMO, PPO or any government agency or program? .... ☐ Yes ☐ No

If Yes, please specify: ____________________

____

e. Perform any contract work for or has it entered into any contract or agreement (written or oral) with any entity/city/county/ state/federal agency/clinic including providing care at correctional facilities, prisons, mental health facilities, veterans administration, university, military or indigent care, etc.? .... ☐ Yes ☐ No

If Yes, please specify and explain: ____________________

____

____

f. Provide diagnostic, consulting or other professional services to patients (including telemedicine) in states other than those listed under section **A., ORGANIZATION INFORMATION,** Question **10.?** .... ☐ Yes ☐ No

If Yes, include states, type of service and annual number of encounters in your explanation: ____________________

____

____

____

g. Agree to hold harmless or indemnify others under contract? .... ☐ Yes ☐ No

h. Own or operate a hospital, sanitarium or clinic with regular bed and board facilities? .... ☐ Yes ☐ No

If Yes, list facility, specialty and number supervised: ____________________

4. **Do you employ or contract with any of the following health care providers?** .... ☐ Yes ☐ No

a. If Yes, indicate the number employed/contracted for each occupation below:

______ Chiropractor	______ Perfusionist*	______ Occupational Therapist
______ Nurse Midwife*	______ Podiatrist*	______ Nurse Anesthetist*
______ Optometrist	______ Nurse	______ Phys./Surgeon Asst.*
______ Physical Therapist	______ Psychologist	______ Medical/Lab Technician
______ Surgical Assistant	______ Dentist*	______ Nurse Practitioner*
______ Physician/Surgeon*	______ Respiratory Therapist	

______ Other (specify): ______________________________

*List all employed or contracted professionals with an asterisk (*) in Section D., CENSUS INFORMATION. All providers with an asterisk (*) must complete an individual physician or health care provider application to be eligible for coverage.

Total number of health care providers: ______________

b. Does any non-physician health care provider perform any cosmetic procedures? .... ☐ Yes ☐ No

If Yes, please provide name, occupation and procedure(s):

Name	Occupation	Procedures

5. **Will the entity be performing activities that will be covered by another professional liability policy?** .... ☐ Yes ☐ No

If Yes, state practice name, carrier name and location: ______________________________

C. BUSINESS PRACTICES

1. **Indicate annualized numbers for your operation/entity:**

Clinic Visits: ____________ Surgeries: ____________ Gross Revenue: $____________

2. **If you provide:**

a. **Dialysis services:**

(1) Is the filter changed after each patient? .... ☐ Yes ☐ No

(2) Does all equipment used for dialysis have an automatic shut-off fail safe device to prevent backwash? .... ☐ Yes ☐ No

b. **Outpatient surgical services:**

(1) Is the facility accredited by either: ☐ JCAHO ☐ AAAHC

(2) Do you have a medical services review committee? .... ☐ Yes ☐ No

(3) Does your recovery room provide full-time observation by a qualified healthcare provider? .... ☐ Yes ☐ No

c. **Pathology services:**

Is this facility approved by the College of American Pathology? .... ☐ Yes ☐ No

If No, please explain: ______________________________

d. **Walk-in clinic services:**

(1) Are your services available twenty-four (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

e. Diagnostic imaging/x-ray services:

(1) Do you have an X-ray, CT-SCAN or MRI facility? ☐ Yes ☐ No

(2) Do you provide any radiation therapy? ☐ Yes ☐ No

(3) Who interprets the results of the test performed?

Name: ______________ Specialty: ______________ ☐ Contracted ☐ Employed

Name: ______________ Specialty: ______________ ☐ Contracted ☐ Employed

f. Does your facility interpret results of tests performed at facilities other than those requesting insurance through this application? ☐ Yes ☐ No

3. In the last ten (10) years:

a. Has the entity or any of the employees discontinued major surgical procedures, performance of Obstetrics, or any other medical activity? ☐ Yes ☐ No

If Yes, list procedures/activities, date discontinued and reason for discontinuing, if applicable: ______________

____

____

b. Has the entity or any of the employees ever been a representative for an equipment or pharmaceutical manufacturer? ☐ Yes ☐ No

If Yes, list procedures/activities, date discontinued and reason for discontinuing: ______________

____

____

c. Have any of the employees performed weight control surgery or prescribed weight control medication? ☐ Yes ☐ No

(1) If Yes, what percentage of the practice (percentage of patient care) was devoted to prescribing anorectic drugs? ______%

(2) If Yes, what percentage of the practice (percentage of patient care) was devoted to performing weight control surgery? ______%

d. Does the entity or any of the physicians have ownership interests in a weight control clinic? ☐ Yes ☐ No

If Yes, what is the name of the weight control clinic, the entity or physicians affiliated? ______________

____

4. Are any of the following types of patient care services rendered within the facility? (Put an "x" in the applicable spaces.)

- ☐ Abortions: number per year:
  - Therapeutic ______
  - Elective ______
- ☐ Acupuncture
- ☐ AIDS/ARC
- ☐ Anesthesia
- ☐ Blood Banks
- ☐ Burn Care
- ☐ CAM Medicine
- ☐ Cardiac Intensive Care
- ☐ Cardiovascular Surgery
- ☐ Certified Trauma Center
- ☐ Chiropractic
- ☐ Cosmetic Aesthetic Proc.
- ☐ Cosmetic Plastic Surgery
- ☐ Dental
- ☐ Diagnostic Radiology
- ☐ Dialysis
- ☐ Endocrinology
- ☐ Experimental Surgery
- ☐ Genetics
- ☐ In Vitro Fertilization
- ☐ Laboratory (Pathology)
- ☐ Liposuction
- ☐ Nuclear Medicine
- ☐ Obstetrics
- ☐ Open Heart Surgery
- ☐ Organ Tissue Transplant
- ☐ Orthopedic
- ☐ Osteopathic Manipulation Therapy
- ☐ Outpatient Surgery
- ☐ Patient Care
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Psychiatric
- ☐ Radiation Therapy
- ☐ Research/Experimental
- ☐ Silicone Injections
- ☐ Sports Medicine
- ☐ Substance Abuse
- ☐ Tonsillectomy
- ☐ Weight Reduction
- ☐ None of these procedures are performed

5. **Indicate what type of Anesthesia, if any, is used in your practice to treat patients:**

   ☐ THIS SECTION DOES NOT APPLY. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar) or nitrous oxide only. Please continue to Section **D.**

   ☐ Conscious Sedation (excluding Nitrous Oxide). A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof. .... ☐ Oral ☐ IM/IV

   ☐ General Anesthesia (to include deep sedation). A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

   If your practice uses anesthesia, please complete the Anesthesia Questionnaire.

D. CENSUS INFORMATION

1. **List names of ALL owners employed and contracted individuals within your organization, including physicians who have practiced on behalf of the entity during the past five years. If any physician is no longer associated with the entity, indicate the period of association and whether a reporting endorsement ("tail") was purchased.**
2. **List names of all employed non-physician healthcare professionals [as noted with an asterisk (*) in Section B. General Information, Question 4.]. Note: If Entity coverage is provided, it will include Healthcare Professionals, other than physicians, as Additional Insureds as defined by a Shared Limit Endorsement.**

	Full Name (First, MI, Last)	Degree	Medical Specialty Or Professional Occupation	*	**	Percent Ownership	Avg. No. Hrs/ Week	Employment Dates		Tail Purchased?
								Start Date	End Date	Yes, No or N/A
1						%				
2						%				
3						%				
4						%				
5						%				
6						%				
7						%				
8						%				
9						%				
10						%				

* Surgical Categories (Key). Please use the number referenced in lieu of writing out the specialty.

1—No surgery
2—Minor surgery
3—Assisting in surgery on your own patients
4—Major surgery
5—Assisting in surgery on other than your own patients
6—Obstetrics

** Enter, (S) Shareholder, (P) Partner, (E) Employee or (C) Independent Contractor

If any individual should not be covered, please mark N/C and explain in the following why coverage is not requested and attach a current Certificate of Insurance.

No. From Census	Explanation

Is there a written agreement between the entity and each of its employed and independently contracted physicians, which specifies who is responsible for purchasing tail coverage if a physician leaves the group? .... ☐ Yes ☐ No

If Yes, who is responsible for purchasing the tail? .... ☐ Group/entity ☐ Physician

If No, please explain: ____

____

E. LOSS INFORMATION

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 carriers.*
If you answer Yes to any of Questions **1.-4.,** and a description of the events is 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 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 and/or attorney related to an adverse outcome? .... ☐ Yes ☐ No

   b. A letter from a patient or attorney regarding your medical treatment of a patient?.. ☐ Yes ☐ No

   c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities including those in relation to the use of Fen-Phen (Redux)?.. ☐ 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?**.. ☐ Yes ☐ No

5. **Has the applicant 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 or investigations or 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

1. List all previous professional liability insurers for the entity beginning with the most recent:

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

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)

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

5. Limits desired:..$_________________ per claim

Note: Requested limits may not be available from this company $_________________ annual aggregate

6. Deductible desired:..$_________________ per claim

☐ Indemnity Only ☐ Indemnity and Expense $_________________ annual aggregate

G. 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

H. 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 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 entity professional liability Insurance Declarations Page and any endorsements, and currently valued loss runs for the past ten (10) years for the entity and each group member.**
- **Copy of the entity organizational chart listing any subsidiaries, joint ventures, etc. including a brief description of how they interact. Copies of contracts between the entities, may be requested as deemed necessary by the underwriter.**
- **Copy of your entity's business letterhead or sample billing statement.**
- **Claim/Suit Information Form with additional documentation as needed.**
- **Copies of all advertising that is used by the entity, including Yellow Page or Internet ads, relevant Web site, social media, etc.**

Attach to your application

I. 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 entity's 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 entity's involvement): ____________________

____

____

____

____

____________________	____________________
SIGNATURE	DATE SIGNED
____________________	____________________
PRINT NAME AND TITLE	E-MAIL ADDRESS