MD ADVANTAGE™ INSURANCE COMPANY OF NEW JERSEY

Professional Liability Insurance Application

(For Professional Corporations or Other Legal Entities)

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Application for Professional Liability Insurance
(For Professional Corporations or Other Legal Entities)

This is an application for insurance and is not a binder. **No coverage exists until authorized in writing by the Company**.

Name of Applicant (Legal Entity applying for insurance):	Requested Effective Date:

Type of coverage desired:	☐ Claims-Made Policy Claims-made coverage does not include extended reporting ("tail") coverage.	☐ Permanent Protection Policy Permanent Protection is claims-made coverage that includes extended reporting ("tail") coverage.

Federal Tax I.D.:	Date of Incorporation:	Requested Retroactive Date:

Office Address:	Mailing Address (if different):
City/State/Zip:	City/State/Zip:
Billing Address (if different):	Office Phone:
	Fax:
	E-mail:
	Web Site:
City/State/Zip:	Business or Risk Manager:

Name of Billing Contact:		**Type of Legal Entity** (check one)			
Phone	Fax		Solo Professional Corporation		Partnership
E-mail			Multi-shareholder Corporation		Other (describe)

Subsidiaries or Related Entities	**Yes**	**No**
Does the Applicant own any subsidiary corporation, engage in any partnership or joint-venture operation or use any trade or fictitious name?		
If yes, is this entity covered under any professional liability insurance policy (other than that herein applied for)?		
If "yes" to either, please state name, type of entity, operations, name of insurance company, effective and retroactive dates on a separate sheet.		

Limits of Insurance – Shared or Separate (Choose One)

☐	**Shared Limits:** Subject to Company underwriting standards, the Applicant may be added as an additional insured to each MDAdvantage insured doctor's policy, sharing his or her limits of insurance. There is no additional premium for this coverage.
☐	**Separate Limits:** Limits of insurance may be purchased to apply separately to the Applicant. Additional premium will apply.

If you chose **separate limits**, select which limits you wish to purchase. **Note**: the limits selected may not exceed the lowest limits carried by any physician, surgeon, dentist or podiatrist employed by or contracted with the Applicant.

☐	**$1,000,000** each medical incident/**$3,000,000** aggregate	☐	**$3,000,000** each medical incident/**$5,000,000** aggregate
☐	**$2,000,000** each medical incident/**$4,000,000** aggregate	☐	**$5,000,000** each medical incident/**$7,000,000** aggregate

Underwriting & Rating Information

1. For the entity requesting coverage. Please provide 12 months of data for each year (in case of new enterprises, include projected amounts):

	Previous Year	Current	Projected
Annual gross receipts			
Number of patient visits			
Number of procedures performed			
Hours of operation per day			

2. Please list your previous Professional Liability insurers:

(2a)
Name of Insurer:_____
Policy Number:_____
Policy Dates:_____
Type of coverage:
☐ Occurrence ☐ Claims Made
If Claims Made, retroactive date:_____
Was a reporting endorsement purchased
(tail coverage)? ☐ Yes ☐ No

(2b)
Name of Insurer: _____
Policy Number: _____
Policy Dates: _____
Type of coverage:
☐ Occurrence ☐ Claims Made
If Claims Made, retroactive date: _____
Was a reporting endorsement purchased
(tail coverage)? ☐ Yes ☐ No

(**If yes**, **please include a copy of the reporting endorsement**.)

3. Are there any subsidiaries that need to be covered? ☐ Yes ☐ No

Name (s): _____

Location: _____
(*If yes, please complete a separate application.)*

4. Do you indemnify or hold harmless others under contract? ☐ Yes ☐ No
If yes, have you obtained insurance coverage for the risk? Please explain:_____
_____

5. Do you sell or lease medical equipment or products in connection with your operation? ☐ Yes ☐ No
If yes, please describe: _____
_____

6. Do you have a formal QA/Risk Management Program? ☐ Yes ☐ No
(If yes, please describe on a separate piece of paper.)

Roster of Providers

Please provide the following information for each **physician**, **surgeon**, **dentist** or **podiatrist** employed by or under contract with the Applicant, even if not insured by MDAdvantage. **Note**: **There is no coverage for any of these types of employees unless an application is submitted to and approved by MDAdvantage**:

Name/ Specialty	**Degree**	**Limits** Each medical incident Aggregate	**Retro-active Date**	**Present Insurer & Policy Number**	**Status** (S) Shareholder (P) Partner (E) Employee (I) Independent Contractor

Does the Applicant plan on increasing or decreasing the number of employed or contracted physicians, surgeons, dentists or podiatrists in the coming year? If "yes," please give details below:	Yes	No

Allied Health Care Employees

(This section does not apply to any Physicians, Surgeons, Dentists or Podiatrists)

If this application is approved, the limits of insurance will be shared by the legal entity applying for this insurance and its allied health care employees for whom coverage is sought. **If separate limits of insurance are desired for any employee, an application for Allied Health Care Employees Professional Liability Insurance (Separate Limits) must be submitted**.

Paraprofessional Employees

Please indicate if you employ or contract with anyone in any of the following specialties: **Nurse Anesthetists**, **Nurse Midwives**, **Nurse Practitioners**, **Pharmacists**, **or Physician's Assistants**. If coverage is sought through MDAdvantage, additional premium will apply. **Note: There is no coverage for employees in these specialties unless an application is submitted to and approved by MDAdvantage**.	Check One	
	Yes	No

Please complete this section if you answered "yes," above.

Name	Specialty	Present Insurer & Policy Number	Retro-active Date	Applying to MDAdvantage?	
				Yes	No

Paramedical Employees: If your application is approved, these employees will be automatically covered as additional insureds, sharing the limits of insurance with the Applicant (subject to limitations). **If separate limits of insurance are desired for any employee**, **an application for Allied Health Care Employees Professional Liability Insurance (Separate Limits) must be submitted**. Please indicate the **number** of each currently employed by the Applicant.

Type	How Many?	Type	How Many?	Non-Medical Staff
Nurses (R.N.s, L.P.N.s)		Physical or Occupational Therapists		Please indicate the **total number** of non-medical staff members you employ (receptionists, clerical, etc.):
Medical Assistants		Certified Case Managers		
Medical or Lab Technicians		Other (**Type**?)		
Perfusionists		Other (**Type**?)		

Does the Applicant plan any significant increase or decrease in staff for the coming year? If "yes," please give details below:	Yes	No

Operations

Does the Applicant, employee or any of its subsidiaries:	**Yes**	**No**
• operate any facility that is subject to accreditation, certification and/or licensure by the JCAHO or the New Jersey Department of Health and Senior Services?		
• have a formal, written Risk Management/Quality Assurance protocol in effect?		
• have a Credentialing Committee or a formal Credentialing protocol in effect?		
• have a Peer Review or Claim Review Committee?		
• provide Credentialing and/or Utilization Review services for or on behalf of any health care benefits payor or any managed care organization?		
• plan to add or discontinue any significant services or operations in the coming year?		

Please provide details about any "Yes" answer, including type of facility, who oversees Risk Management, Peer Review or Credentialing, etc. Note: you may be asked to provide copies of protocols or plans.

Patient Mix: Please indicate the **percentage** of your practice revenue derived from each:		**Other Services** – Please describe below any services provided that are not specifically related to the medical or surgical specialties of the Applicant's employees (e.g., drug testing, etc.)
Fee for Service:	%	
Discounted fee-for-service contracts	%	
Capitation Agreements	%	

Specialized Services

Please answer all sections that apply.

Anesthesia Services

1. How is anesthesia service provided? (Check all that apply.)
   - ☐ Employed Anesthesiologists
   - ☐ Contract Group
   - ☐ Certified Registered Nurse Anesthetists (CRNA's)
   - ☐ Other (specify) _____
2. If a contract group, provide name of the group: _____
3. Please indicate the maximum number of CRNA's supervised by a single anesthesiologist at any one time: _____
4. Does an anesthesiologist remain on premises until the last patient is discharged? ☐ Yes ☐ No
5. Is the recovery room supervised by a registered nurse? ☐ Yes ☐ No
6. Does anesthesia equipment include pulse oximeters? ☐ Yes ☐ No
7. Are there disconnect alarms on anesthesia equipment? ☐ Yes ☐ No

Surgicenters/Outpatient Services

1. List types of procedures performed at the facility: _____

_____

2. What are the minimum insurance limits required for surgeons using the facility? _____
3. Are Certificates of Insurance required? ☐ Yes ☐ No
4. Is the center licensed by the state or approved by an appropriate accrediting agency? ☐ Yes ☐ No
5. Are patients screened to ascertain that they are low-risk and are able to withstand having a surgical procedure performed on an outpatient basis? ☐ Yes ☐ No
6. Are nursing charts maintained, including patient's condition at discharge? ☐ Yes ☐ No
7. Are written postoperative orders submitted and signed by the surgeons? ☐ Yes ☐ No
8. Please check if the facility is equipped with the following on a 24-hour basis:
   - ☐ Anesthetics
   - ☐ Oxygen
   - ☐ C.P.R. equipment
   - ☐ Cardiac monitoring equipment
   - ☐ X-ray machine capable of accommodating an unconscious patient in any position
9. How long are orders, consent forms and charts maintained? _____

Surgicenters, Inpatient Facilities, and Urgent Care Centers

1. A licensed physician is on duty during _____ hours of operation.
2. Are all professional staff members licensed and/or certified? ☐ Yes ☐ No
3. Does the facility have a medical review committee to verify credentials and evaluate medical services? ☐ Yes ☐ No
4. Does the facility have written policies and procedures outlining infection control? ☐ Yes ☐ No
5. How many miles is it to the nearest hospital? _____
   Name of hospital: _____
6. Do you have an agreement allowing your patients to be directly admitted to the hospital in an emergency situation? ☐ Yes ☐ No
7. Do you have an agreement with an ambulance company for transportation of emergency cases? ☐ Yes ☐ No
8. If a critically ill patient must be transferred to a hospital, who accompanies the patient?

_____

Nuclear Medicine, Radiology (MRI, CT Scan)

1. What testing substances are injected into the patient? _____
2. Describe the method of administration and disposal of radioactive materials, if applicable: _____

_____

3. What emergency measures have you established in the event of adverse reaction? _____

_____

4. Are x-rays and/or scans performed only per physician request? ☐ Yes ☐ No
5. Are actual x-rays sent to physicians? ☐ Yes ☐ No
6. Are x-rays duplicated prior to release? ☐ Yes ☐ No
7. Are reports sent out under the name of the facility or under the name of the interpreting physician? ☐ Facility ☐ Physician

Claims History

In the past ten years, has any claim or suit been made against the Applicant or any Allied Health Care employee of the Applicant arising from professional services or from managed care services contracts? If yes, please indicate the number of claims or suits and provide the information requested below for each claim or suit. Attach additional sheets, as needed.	Yes	No

Total Number of Claims:

Name of Patient or other Plaintiff:

1. Date of medical incident or service that led to the claim:	4. Name of the insurance company that handled the claim:
2. Date claim was reported to your insurer:	5. Amount paid on employee's behalf:
3. Date claim was closed (or indicate if still open):	6. Amount of reserve, if claim is open (if known):

7. What medical treatment or other service or actions led to the alleged injury to the patient?

8. Describe the alleged injury or problem that led to the claim:

Licensing Board/Regulatory Authority Actions

Has any employee of the Applicant ever had any action taken against his or her license by any licensing board or regulatory authority or ever been the subject of any disciplinary action by any hospital or employer? If "yes," please provide complete details, including circumstances, allegations and outcomes:	Yes	No

Certification, Authorization and Signature

On behalf of the Applicant, I certify that the information in this application is true and correct, and I authorize the release and exchange of any information regarding operations, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent, broker or other person, licensing or regulatory agency or authority or any professional association, society or specialty board of which I am or have been a member and MDAdvantage Insurance Company of New Jersey.

I further agree to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

Notice: Any person who includes false or misleading information on any application for insurance commits insurance fraud and may be subject to civil or criminal penalties.

Signature:_____
President/Partner (or other person specifically authorized to execute this Application)

Title: _____ Date:_____

MD ADVANTAGE™ INSURANCE COMPANY OF NEW JERSEY

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