FREEDOM SPECIALTY
INSURANCE COMPANY®
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the mgis companies®
**MGIS UNDERWRITING MANAGERS, INC.**
1849 West North Temple
Salt Lake City, Utah 84116-3067
1-800-969-6447 toll free
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# PHYSICIANS AND SURGEONS 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.

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 **J.** 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 "Individual" application for each physician. Answer all questions. Indicate "N/A" if a question is not applicable.

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

**D.** 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 professional liability Insurance Declarations Page and any endorsements, and currently valued loss runs for the past ten (10) years.**
- **Copy of your medical license, Curriculum Vitae, and copy of board certification.**
- **Copy of your letterhead or sample billing statement.**
- **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 site, social media, etc.**

Return completed application to:

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

**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. Practice 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: (☐ Admitting ☐ Non-Admitting)

Percent of Practice/Admissions: _____% Practice/Facility/Hospital Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

**Location 2.**

☐ Office ☐ Hospital/Surgi-Centers: (☐ Admitting ☐ Non-Admitting)

Percent of Practice/Admissions: _____% Practice/Facility/Hospital Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

**Location 3.**

☐ Office ☐ Hospital/Surgi-Centers: (☐ Admitting ☐ Non-Admitting)

Percent of Practice/Admissions: _____% Practice/Facility/Hospital Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

**3. Residence Address:**

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. EDUCATIONAL BACKGROUND** *(If additional space is needed, please use supplemental form)*

**1. Medical School:**

School Name: _____

Street Address: _____

City: _____ State: _____ Country: _____

Degree: _____ From: _____ To: _____

If foreign medical school graduate:

Are you certified by The Educational Commission for Foreign Medical Graduates (ECFMG)? ..... ☐ Yes ☐ No

If Yes, list date certified: _____

If No, please explain: _____

_____

_____

**2. 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: _____

**3. Have You Participated In Any Additional Training** (i.e., Fellowship, etc.)?

**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. Explain any gaps greater than six months between your medical school, residency, other training, or first time in private practice:** _____

_____

_____

**5. If you are currently in a residency or fellowship program, what is your anticipated residency/fellowship ending date?**..... _____

**a.** Will this policy be covering your residency or fellowship? ..... ☐ Yes ☐ No

**b.** Will this policy be covering your moonlighting while you are in your residency or fellowship? ..... ☐ Yes ☐ No

***Note: Your policy may be issued for less than one year in order to have the policy expiration date equal to the end date of your residency.***

**6. Are you entering private practice for the first time?** ..... ☐ Yes ☐ No

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

If Yes, how many Category 1 credit hours? _____

**8. Have you completed a risk management education course within the last twelve (12) months?** ..... ☐ Yes ☐ No

**9. Are you a member of a medical school faculty?** ..... ☐ Yes ☐ No

If Yes, what percentage of your time is spent treating patients whose treatment is unrelated to your physician duties at the medical school? ..... _____%

## C. PRACTICE INFORMATION *(If additional space is needed, please use supplemental form)*

**1. Do you perform consultations, read x-rays or interpret test results for other physicians or organizations who render medical professional services in another state?** ..... ☐ Yes ☐ No

*If this is covered by another professional liability insurance policy, complete Section D, Question 9)*

If Yes, which state(s)? _____

**2. a. List states in which you hold a license to practice medicine:**

Please check the appropriate box to indicate the status of your license:

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

b. Narcotices/DEA No.: _____

**3. Previous locations of practice:** *(List most recent first, dating back to completion date of formal training)*

*If no previous location(s), indicate your earliest start date at your current location(s):* _____

**Location 1.**

Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty Type: _____ From: _____ To: _____

**Location 2.**

Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty Type: _____ From: _____ To: _____

**Location 3.**

Name of Practice: _____

City: _____ State: _____ Country: _____

Specialty Type: _____ From: _____ To: _____

**4. Explain any gaps greater than one month between practice locations:** _____

_____

_____

**5. To which medical societies/organizations do you belong (such as AMA, state, board specialty, MGMA, etc.)?**

_____

If none, please explain: _____

_____

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

**NOTE: All percentages requested below for specialties, procedures and surgical activities are of your total practice. Please enter complete name of specialty/sub-specialty. Combined percentages must equal one hundred percent (100%).**

| | | | |
|---|---|---|---|
| **Present specialty** | | Percent of Total Practice | % |
| **Present sub-specialty** | | Percent of Total Practice | % |

**2. Are you permanently retired from the practice of clinical medicine?** ..... ☐ Yes ☐ No

**3. Are you American Board Certified?** ..... ☐ Yes ☐ No

If Yes, list Specialty Board: _____ Date Certified: _____

If No, are you Board Eligible? ..... ☐ Yes ☐ No

If Yes, when do you plan on taking your boards? _____

If No, have you ever taken a specialty board examination and failed to pass? ..... ☐ Yes ☐ No

If Yes, how many times? _____

If Yes, please explain: _____

_____

**4. Indicate the average weekly numbers in each of the following categories for which you require coverage. If you practice in multiple states, please identify the following information for each state** (Please provide whole numbers. If "NONE" enter "0" in the space provided below.)

| Patients Seen Per Week | Hours Per Week | Walk-In Patients Per Week |
|---|---|---|
| | | |

**5. Please check any of the following procedures you will perform:**

| | | |
|---|---|---|
| ☐ Abdominoplasty (Tummy Tuck) | ☐ Colonoscopy | ☐ Pacemakers—Epicardial |
| ☐ Abortions<br>Therapeutic No./yr: _____<br>Elective No./yr: _____ | ☐ Correct Anesthesia/ General/Spinal/Epidural | ☐ Pacemakers—Endocardial |
| | | ☐ Pacemakers—Temporary |
| | ☐ Correct Bariatric—Non-Laparoscopic | ☐ Peritoneoscopy |
| ☐ Acupuncture—General Anesthetic | | ☐ Obstetrics |
| ☐ Acupuncture—Therapeutic/Local Anesthetic | ☐ Cryosurgery (Cervical) | ☐ Phlebography |
| | ☐ Cryosurgery (non-external lesions) | ☐ Pneumoencephalography |
| ☐ Anesthesia General/Spinal/Caudal | ☐ D&C | ☐ Polypectomy |
| ☐ Anesthesia—Other: | ☐ Electromagnetic Therapy | ☐ Prenatal/Gynecological Practice<br>☐ Prenatal—1st & 2nd Trimester<br>☐ Prenatal—to term, no delivery<br>☐ Prenatal—to term, delivery<br>☐ Vaginal Deliveries—_____ total per year<br>☐ Caesarean Deliveries—_____ total per year<br>☐ Vaginal after Caesarean Deliveries—_____ total per year |
| ☐ Angiography | ☐ Embolization | |
| ☐ Angioplasty | ☐ ERCP—Upper GI Endoscopy | |
| ☐ Arteriography | ☐ Face Lifts | |
| ☐ Arthroscopy | ☐ Face Lifts Mini (done with laser) _____% of total practice | |
| ☐ Assisting in major surgery—own patients only | ☐ Gastrointestinal Endoscopy | |
| ☐ Assisting in major surgery—own & other than own patients | ☐ Gynecology—Major Surgery | |
| ☐ Bariatric Surgery—Laparoscopic | ☐ Hair Transplants—Follicular Unit Transplantations | |

| | | |
|---|---|---|
| ☐ Bariatric Surgery—Non-Laparoscopic | ☐ Hair Transplants—Other | ☐ Prolotherapy |
| ☐ Biofeedback | ☐ HVLA on the cervical spine on patients younger than eighteen (18) years of age | ☐ Radial/Laser Keratotomy |
| ☐ Biopsy—Endoscopic | | ☐ Radiation—Diagnostic |
| ☐ Blepharopigmentation—<br>_____% of total practice | ☐ Kyphoplasty | ☐ Radiation—Interventional |
| ☐ Blepharoplasty—Cosmetic<br>_____% of total practice | ☐ Laparoscopic Cholecystectomy | ☐ Radiation—X-Ray Therapy |
| ☐ Blepharoplasty—Reconstruction—<br>_____% of total practice | ☐ Laparoscopy | ☐ Radiopaque Dye—Non-Ionic Only |
| ☐ Botanical Medicine | ☐ Laser Surgery | ☐ Radiopaque Dye—Other than Non-Ionic |
| ☐ Botox ___% of total practice | ☐ Laser Therapy (Endoscopic) | ☐ Rectal Ozone Therapy |
| ☐ Brachioplasty | ☐ Laser Therapy (Non-Endoscopic) | ☐ Rhinoplasty<br>_____% of total practice |
| ☐ Breast Implants—Cosmetic<br>_____% of total practice | ☐ Lipoinjection<br>_____% of total practice | ☐ Sclerotherapy |
| ☐ Breast Implants—Reconstruction<br>_____% of total practice | ☐ Liposuction—Other than Tumescent Technique | ☐ Shock Therapy |
| ☐ Breast Reduction—Cosmetic | ☐ Liposuction—<br>Tumescent Technique Only<br>_____% of total practice | ☐ Sigmoidoscopy—60cm or less |
| ☐ Bronchoscopy | ☐ Lithotripsy | ☐ Sigmoidoscopy—Greater than 60cm |
| ☐ Bronco—Esophagology | ☐ Lymphangiography | ☐ Silicone Injections<br>_____% of total practice |
| ☐ Buttock Implants | ☐ Mammograms | ☐ Skin Flaps/Grafts<br>☐ Cosmetic<br>_____% of total practice<br>☐ Reconstruction<br>_____% of total practice |
| ☐ Calf Implants | ☐ Manipulation Therapy | ☐ Thigh Lift |
| ☐ Cataract Surgery | ☐ Myelography | ☐ Tubal Ligations |
| ☐ Catheterization—Left Heart | ☐ Nerve Blocks<br>☐ Facet<br>☐ Intrathecal Pumps<br>☐ Lumbar Epidural Steroid<br>☐ Myofascial<br>☐ Occipital<br>☐ Paraspinal<br>☐ Paravertebral<br>☐ Peripheral<br>☐ Sciatic<br>☐ Spinal Cord Stimulators | ☐ Vasectomies—Own Patients Only |
| ☐ Catheterization—Right Heart (other than CVP lines) | | ☐ Vasectomies—Own & Other than Own Patients |
| ☐ Cheek/Chin/Lip Implants | | ☐ Vertebroplasty |
| ☐ Chelation Therapy | | ☐ Weight Control Medication<br>_____% of total practice |
| ☐ Chemical Peels—Superficial | | |
| ☐ Chemical Peels—Medium | | ☐ Other Medical Techniques<br>_____ |
| ☐ Chemical Peels—Deep<br>_____% of total practice | ☐ Triggerpoint Injection | ☐ Other Medical Techniques<br>_____ |
| ☐ Cleft Lip Surgery—Reconstructive | ☐ Needle Biopsy | |
| ☐ Cleft palate Surgery—Reconstructive | ☐ Oxidation Therapy | ☐ Other Medical Techniques<br>_____ |

**6. Indicate the percentage of your total practice devoted to the following surgical activities:**

| | | | |
|---|---|---|---|
| Abdominal..... % | Hand ..... % | Orthopedic (including Back)..... % | Urology ..... % |
| Bariatric..... % | Head and Neck ..... % | Orthopedic (not including Back) ..... % | Vascular..... % |
| Cardiac..... % | Neoplastic Surgery..... % | Otorhinolaryngology... % | Other (Describe): |
| Colon/Rectal ..... % | Nephrology..... % | Plastic (Cosmetic Enhancement) ..... % | _____ |
| Endocrinology ..... % | Neurosurgery ..... % | Plastic (Reconstruction Only) ..... % | _____ |
| General..... % | Obstetrics..... % | Thoracic..... % | _____ |
| Gynecology..... % | Ophthalmology..... % | Traumatic..... % | _____ |

**7. In the last ten (10) years:**

**a.** Have you 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: _____

_____

_____

**b.** Have you performed weight control surgery or prescribed weight control medication? ..... ☐ Yes ☐ No

If Yes, what percentage of your practice (percentage of patient care) was devoted to prescribing anorectic drugs?

☐ <1% ☐ 1%-10% ☐ 11%-50% ☐ >50% ☐ Never prescribed weight control medication

If Yes, what percentage of your practice (percentage of patient care) was devoted to performing weight control surgery?

☐ <1% ☐ 1%-10% ☐ 11%-50% ☐ >50% ☐ Never performed weight control surgery

**c.** Do you have ownership interests in a weight control clinic? ..... ☐ Yes ☐ No

If Yes, what is the name of the weight control clinic with which you are affiliated? _____

**8. Do you serve in a hospital emergency room for which you require coverage?**..... ☐ Yes ☐ No

**a.** If Yes, list number of hours per month (excluding "on-call" hours): _____

**b.** If Yes, are the hours you work in the ER the minimum number of hours required to maintain hospital privileges?..... ☐ Yes ☐ No

**c.** For what institution? _____

*If coverage is to be provided by another carrier, please provide evidence of other coverage.*

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

If Yes, complete the following: ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice Name and Locations: _____

Name of Carrier: _____

**10. Please use the space below for any comments you feel will help the insurer to better understand any special circumstances concerning your practice:** _____

_____

_____

_____

## E. ADDITIONAL PROFESSIONAL INFORMATION

**Please fully explain any "Yes" answer, in *Section J., Applicant Additional Comments*.**

**1. Do you perform surgery on or are you a team physician for any professional or collegiate athletes?** ☐ Yes ☐ No

If Yes, what percentage of your practice is devoted to this activity? _____%

*(If you are covered by other insurance for this activity, please complete Section **D.**, Question **9.**)*

**2. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?** ☐ Yes ☐ No

If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

*(If you are covered by other insurance for this activity, please complete Section **D.**, Question **9.**)*

**3. Do you practice in a nursing home facility?** ☐ Yes ☐ No

If Yes, what percentage of your practice is devoted to this activity? _____%

*(If you are covered by other insurance for this activity, please complete Section **D.**, Question **9.**)*

**4. Do you treat or review treatment of federal prison inmates?** ☐ Yes ☐ No

*(If you are covered by other insurance for this activity, please complete Section **D.**, Question **9.**)*

**5. Do you treat non-federal prison inmates?** ☐ Yes ☐ No

If Yes, what percentage of your practice is devoted to this activity? _____%

Does this facility have a Law Library? ☐ Yes ☐ No

*(If you are covered by other insurance for this activity, please complete Section **D.**, Question **9.**)*

**6. Are you an employee of, or do you do contract work for, any government agency?** ☐ Yes ☐ No

If Yes, provide name: _____

**7. Do you use a collection agency which has the authority to file collection suits without your knowledge?** ☐ Yes ☐ No

**8. Do you practice as a medical director?** ☐ Yes ☐ No

If Yes, what percentage of your practice is devoted to this activity? _____%

Type and Name of Facility: _____

*(If you are covered by other insurance for this activity, please complete Section **D.**, Question **9.**)*

**9. Do you admit patients for other physicians?** ☐ Yes ☐ No

**10. Do you practice as a hospitalist?** ☐ Yes ☐ No

**a.** Individual (Solo Practice)? ☐ Yes ☐ No

Please provide name and Federal ID of the solo professional corporation or service corporation: _____

_____

**b.** Employee? ☐ Yes ☐ No

Name of employer: _____

**c.** Independent Contractor? ☐ Yes ☐ No

Name of hiring party to contract: _____

**d.** Partner/Shareholder? ☐ Yes ☐ No

Name of corporation/partnership: _____

Federal ID of the solo professional corporation or service corporation: _____

**11. Do you engage in any "moonlighting" activity, apart from your practice?** ☐ Yes ☐ No

**12. Do you work with a blood bank?** ☐ Yes ☐ No

**13. If you are *NOT* a radiologist:**

**a.** Do you take and/or interpret your own X-rays or other imaging procedures? ☐ Yes ☐ No

If Yes, estimated number per year: _____

**b.** Does a radiologist over-read your X-rays? ☐ Yes ☐ No

**c.** If a non-radiologist is over-reading your X-rays, indicate who and what specialty: _____

_____

**14. Do you perform surgery in your office?** ☐ Yes ☐ No

If Yes, list the specific procedures you perform: _____

Is general anesthesia administered for these office procedures? ☐ Yes ☐ No

If Yes, by whom and with what training? _____

**15. Do you perform invasive pain management procedures?** ☐ Yes ☐ No

If Yes, list the procedures you perform and indicate if each is done in a hospital or office: _____

_____

**16. Do you devise or review plan/employer safety standards?** ☐ Yes ☐ No

If Yes, what products are manufactured by the company? _____

Company Name and Location: _____

*(If you are covered by other insurance for this activity, please complete Section **D.,** Question **9.**)*

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

**a.** Have you ever had your membership in 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 being, 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 renewal refused? ☐ Yes ☐ No

To your knowledge is any such action under consideration by any current medical professional liability insurer? ☐ Yes ☐ No

**F. PRACTICE ORGANIZATION INFORMATION** *(If additional space is needed, please use supplemental form)*

**1. Indicate the number of each of the following who provide services in your office *(include yourself)*:**

| | | | |
|---|---|---|---|
| Dentists | | Perfusionists | |
| Case Managers | | Physicians | |
| Chiropractors | | Physician Assistants | |
| CRNAs/RNAs | | Physician Surgical Assistants | |
| Nurse Midwife Assistants | | Podiatrists | |
| Nurse Midwives | | Psychologists | |
| Nurse Practitioners | | Respiratory Therapists | |
| Occupational Therapists | | Surgical Assistants | |

**2. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services?** ..... ☐ Yes ☐ No

If No, do you plan to do so in the future? ..... ☐ Yes ☐ No

If Yes, please provide an explanation: _____

_____

**3. Practice organization:**

*Check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under employment status. You MUST check at least ONE box.*

☐ **SOLO UNINCORPORATED/SOLE PROPRIETOR**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other

If other, please explain: _____

☐ **SOLO INCORPORATED**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other

If other, please explain: _____

Is this entity or employer currently insured with us? ..... ☐ Yes ☐ No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? ..... ☐ Yes ☐ No

If Yes, do you have any employed or contracted physicians associated with your practice? ..... ☐ Yes ☐ No

If No, do you wish to share your individual policy limits with your solo corporation? ..... ☐ Yes ☐ No

If Yes, and you desire to share your individual policy limits, please initial here: ..... _____(initials)

*Note: To qualify for shared limit solo corporation coverage, you must have no physician employees or physician independent contractors.*

*If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate Corporate Application for consideration.*

☐ **MULTI-SHAREHOLDER CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other

If other, please explain: _____

Is this entity or employer currently insured with us? ..... ☐ Yes ☐ No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? ..... ☐ Yes ☐ No

☐ **HOSPITAL** ☐ **INDUSTRIAL** ☐ **GOVERNMENT-BRANCH**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other

If other, please explain: _____

Is this entity or employer currently insured with us? ..... ☐ Yes ☐ No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? ..... ☐ Yes ☐ No

☐ **STATE LICENSED MEDICAL SURGERY CENTER:**

☐ **FOR USE BY OTHER PHYSICIANS** ☐ **YOUR PATIENTS ONLY**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other

If other, please explain: _____

Is this entity or employer currently insured with us? ..... ☐ Yes ☐ No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? ..... ☐ Yes ☐ No

☐ **OTHER (PLEASE EXPLAIN)**

Entity Name: _____

Date Joined/Formed: _____

Employment Status: ☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other

If other, please explain: _____

Is this entity or employer currently insured with us? ..... ☐ Yes ☐ No

If Yes, provide Policy No.: _____

If No, do you desire coverage for this entity? ..... ☐ Yes ☐ No

**4. If the business purpose of the entity noted above is other than a medical office practice, please explain:** _____

_____

_____

_____

_____

_____

_____

**G. 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 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 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

**H. 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 | 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.*

## I. 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.

**J. 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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**K. 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, and currently valued loss runs for the past ten (10) years.**
- **Copy of your medical license, Curriculum Vitae, and copy of board certification.**
- **Copy of your letterhead or sample billing statement.**
- **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 site, social media, etc.**

*Attach to your application*

**K. 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