



Application for Professional Liability Insurance (Cornerstone)

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

1. Personal and Demographic Information				Requested effective date:	
Name:				Phone: ()	
Office Address:				Fax: ()	
				E-mail:	
City/State/Zip Code:			County:	Web Site:	
Residence Address:				Social Security #:	
				Date of Birth:	
				Sex:	Female
					Male
Preferred Mailing Address:		Office	Residence	Other	If "other", state here:
		Check one.			

2. Professional Education					
Please indicate the name of the medical or dental school and/or hospital and the city and state where located.		Degree and/or Specialty	Completed?		Date Completed (or expected)
			Yes	No	
Medical or Dental School:					
Internship:					
Residency:					
Residency:					
Fellowship:					

3. Certification							
Are you Board Certified (By a member-board of the American Board of Medical Specialties or Osteopathic Specialties)?		Yes	No	Are you Board Eligible (and currently in the exam process)?		Yes	No
Have you been recertified? If "Yes", indicate date:		Yes	No	Have you ever failed a specialty or sub-specialty exam? Number:		Yes	No
Name of Specialty Board:			Name of Specialty Board (if dual certified):				
General and/or Subspecialty Certificate in:			General and/or Subspecialty Certificate (or other training, e.g., laser or laparoscopic procedures) in:				
Date of Certification:			Date of Certification:				

4. Licensure

Please indicate in which states you are presently licensed to practice and indicate what percentage of your total practice is spent in each. For surgeons or obstetricians, base your percentages on surgeries or deliveries.

State	License Number	Date of License	% of Total Practice

D.E.A. Registration Number:

If you answer "Yes" to any of the following questions, please attach a complete explanation.	Yes	No
Has your medical or dental license in any state ever been suspended, revoked or limited?		
Are you currently under investigation by any state or federal licensing board or agency?		
Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited?		

5. Hospital Privileges

Please state the name and location (City and State) for each hospital where you hold staff privileges.

Note: **If you are approved for coverage, we will send you a Certificate of Insurance for each, unless you advise us not to.**

1.

2.

3.

4.

5.

Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges or your application or reapplication for medical staff privileges?	Yes	No
Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action?		

If "Yes" to either, please attach a complete explanation.

6. Other Exposures

Do you own or operate, or serve as an executive or administrative officer, medical director or department head for any hospital, nursing home, non-hospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization? If "yes", indicate its name and describe your duties below.	Yes	No

7. Type of Coverage

Policy Selection		Retroactive Coverage	
Please indicate your choice of policy type:		This section applies only to claims-made coverage.	
Claims-made	Claims-made coverage does not include extended reporting ("tail") coverage.	Retroactive coverage means coverage for claims that may yet be made from medical incidents that took place before the effective date of the policy applied for. If you are currently insured under a claims-made policy and wish your policy to provide retroactive coverage, please check the block below, then indicate your requested retroactive date and sign below.	
Permanent Protection	Permanent Protection is claims-made coverage that includes extended reporting ("tail") coverage.	I request retroactive coverage. Check here:	
A copy of your current policy Declarations is required.		Requested retroactive date: (from your current claims-made policy)	
Limits of Insurance		I decline or do not need retroactive coverage:	
Please check the limits of insurance desired: (each medical incident/aggregate)		I understand that the retroactive date on the policy applied for will be the same as the effective date of coverage.	
<input type="checkbox"/> \$1M/\$3M	<input type="checkbox"/> \$2M/\$4M	Signature of Applicant:	
<input type="checkbox"/> \$3M/\$5M	<input type="checkbox"/> \$5M/\$7M		

Solo Practice

If you wish to add your **Solo Professional Corporation** as an additional insured on your policy, sharing your limits of insurance (no additional premium), please check the box to the right. We will add the name you indicate on page 4. **Note:** If coverage is needed for any other type of corporation or partnership other than a Solo Corporation, please complete an **Application for Corporation/Partnership Insurance**. Coverage will not take effect unless an application has been approved by MIIX Advantage.

Add Solo Corporation?	
Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

8. Professional Liability Insurance History

	Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Insurance Company					
Limits of Insurance					
Type of Policy (Claims-made or Permanent Protection)					
Policy Period					
Retroactive Date					

If your previous policy was claims-made , did you obtain extended reporting period ("tail") coverage? If "yes", please enclose a copy.	Yes	No
If not, are you requesting prior acts coverage from MIIX Advantage?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever practiced without professional liability insurance? If "yes" , please attach a complete explanation including dates.	<input type="checkbox"/>	<input type="checkbox"/>
Has your professional liability insurance ever been cancelled or nonrenewed (other than at your request); has your policy premium ever been surcharged or has your application for professional liability insurance ever been declined? If "yes", please attach a complete explanation.	<input type="checkbox"/>	<input type="checkbox"/>

Note: If you practice as a general surgeon, obstetrician/gynecologist or orthopedic surgeon, you must also complete the specialty questionnaire on page 8.

9. Current Practice

Practice Organization	Name of Employer/Legal Entity	Members of Your Group
Check which applies:	Please indicate the name of your employer:	Please indicate the number of:
Solo unincorporated		Physicians, Surgeons, Dentists or Podiatrists in your group
Solo professional corporation		
Partner in a partnership		Those insured by or applying to MIIX Advantage: (Note: MIIX Advantage must insure at least 50% if you also wish to insure your corporation and paramedical employees with MIIX Advantage).
Shareholder & employee in a professional corporation		
Employee or contractor for a professional corp., hospital, clinic, etc.		

Practice Profile

Please indicate average number per week:

Number

Principal Medical or Surgical Practice

Please describe the practice for which this insurance is needed.

Practice hours (total hours – not just patient contact)		
Patient visits (in office, hospital, etc.)		
Surgeries (major – in hospital)		
Surgeries (major – in surgical centers)		
Obstetrical deliveries		

First Date of Practice: Please indicate your first date of practice (For physicians, surgeons or dentists entering practice for the first time after completing a residency or fellowship program or service in a government-funded health care program, such as the U.S. Public Health Service or the U.S. Military, as repayment of a medical education funding obligation). **Date:**

10. Underwriting Information

Other Positions?	Do you hold any positions outside of your principal medical or surgical practice (e.g., moonlighting in an E.R., serving part-time at a clinic or nursing home, working for an H.M.O. or other managed care or insurance company, serving as a Medical Director, etc.)? If yes, please describe below. Include for whom you provide these services.	Yes	No
Other Procedures?	Do you perform any procedures, techniques or treatment modalities that are not typical to the specialty in which you received your residency and/or fellowship training? If yes, please describe below.	Yes	No
Other Coverage?	Are you now covered under any malpractice insurance or indemnity agreement that will continue even after you are approved for the coverage to which this application applies? If yes, explain who will provide this coverage and what professional services it will cover.	Yes	No
Illegal Acts?	Have you ever been arrested for, charged with or convicted of a crime (other than a minor traffic violation)? If yes, please explain in detail below.	Yes	No
Obstacles to Practice?	Have you ever suffered from or been treated for any substance abuse, disability, mental illness or serious physical injury or illness that has or might affect your ability to practice medicine or surgery? If yes, please explain in detail below.	Yes	No

Please use the space below to give details for any question to which you answered "Yes" (above). Attach additional sheets as needed.
Lack of sufficient detail may delay an underwriting response to your application.

11. Allied Health Care Employees

(This section does not apply to any employed Physician, Surgeon, Dentist or Podiatrist)

If this application is approved, the limits of insurance will be shared by the health care provider applying for this insurance and his or her 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, Nurse/Surgical Assistants, Pharmacists, Physician's Assistants or Psychologists**. If coverage is sought through MIIX Advantage, additional premium will apply. **Note: There is no coverage for employees in these specialties unless an application is submitted to and approved by MIIX Advantage.**

Check One

Yes No

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

Name	Specialty	Present Insurer & Policy Number	Retroactive Date	Applying to MIIX Advantage?	
				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 Please indicate the total number of non-medical staff members you employ (receptionists, clerical, etc.):
Nurses (R.N.s, L.P.N.s)		Physical or Occupational Therapists		
Medical Assistants		Certified Case Managers		
Medical or Lab Technicians		Other (Type?)		
Perfusionists		Other (Type?)		

Claims: Have any of your allied health care employees ever been named in a claim or suit arising from professional services or from managed care services contracts? If "yes", you must complete the Claim History section on page 6 of this application.

Yes No

Adverse 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", you must provide complete details, including circumstances, allegations and outcomes.

Yes No

12. Claim History

Note: Your application will not be approved unless you provide complete claim information.

In the past ten years, has any claim or suit been made against you arising from your practice of medicine or surgery? If yes, please indicate the number of claims or suits:	Yes	No
Besides any claim or suit made against you, have you reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any of your previous insurers?		
Are you aware of any medical incidents, adverse outcomes or other circumstances that you expect to give rise to a claim in the future?		

Claim No. ___ of ___ Name of Patient:

Name of Insurance Carrier:

1. Date of medical/ surgical incident		8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	Yes	No
2. Date claim reported to your insurer:		9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	No	10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):	
4. Current Status	11. Describe the alleged injury or problem that led to the claim made against you.			
Open				
5. Amount paid on your behalf				
6. Amount paid on behalf of all defendants				
7. Amount of reserve, if an open claim (if known)				

Claim No. ___ of ___ Name of Patient:

Name of Insurance Carrier:

1. Date of medical/ surgical incident		8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	Yes	No
2. Date you reported the claim to your insurer:		9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	No	10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):	
4. Current Status	11. Describe the alleged injury or problem that led to the claim made against you.			
Open				
5. Amount paid on your behalf				
6. Amount paid on behalf of all defendants				
7. Amount of reserve, if known (if claim open)				

Note: You may be requested to provide additional information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.

Please use multiple copies of this form if you have had more than two claims.

Procedures

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the number you performed in the past year.	Yes	No	How Many?
1. Obstetrical deliveries			
2. Prenatal or postnatal care			
3. Any endoscopic procedure			
4. Any invasive procedure (incision, excision, puncture, tap, etc.) of any organ, including the skin.			
5. Any procedure performed while the patient is under any type of anesthesia (<input type="checkbox"/> local, <input type="checkbox"/> general, <input type="checkbox"/> regional, <input type="checkbox"/> acupuncture, etc.)			
6. Any procedure involving withdrawal by needle of bodily fluids (other than blood products) such as amniocentesis, lumbar puncture, abdominal tap, etc.)			
7. Biopsy of any type (excisional or needle)			
8. Catheterization (other than urethral)			
9. Weight reduction procedures, treatments or medications			
10. Cervical/vaginal smears			
11. Hair transplants and/or restorations			
12. Any procedure involving injection and/or diagnosis using any radiopaque contrast material			
13. Any imaging procedure that you perform and/or results that you interpret (x-ray, mammogram, etc.)			
14. Laser therapy or surgery			
15. Polyp removal (from any mucous membrane)			
16. Dialysis therapy (hemodialysis or peritoneal dialysis)			
17. Liposuction			
18. Diabetes management			
19. <input type="checkbox"/> Electrocardiography, <input type="checkbox"/> echocardiography, <input type="checkbox"/> cardiac stress tests or <input type="checkbox"/> implantation of any pacemaker			
20. Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			
21. Assist at any major surgical procedure as first assistant: (making incisions, excising or handling organs, suturing, etc.)			
22. Assist at any major surgical procedure other than as first assistant			
23. Any procedure not typical to the specialty in which you received your residency or fellowship training			
24. Teach, supervise or proctor medical students, residents or fellows (indicate number of hours per week)			

Please use this space to provide details about any item above to which you provided a "yes" answer. Attach additional sheets as needed. Include sufficient detail so as to avoid delay in processing your application.

Specialty Application for:

General Surgery

Obstetrics & Gynecology

Orthopedic Surgery

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the number you performed in the past year and provide a description on the following page.

General Surgery	Yes	No	How Many?
Breast surgery (excision of tumors, etc.)			
Bariatric surgery			
Cosmetic procedure (liposuction, abdominoplasty, rhinoplasty, breast reduction or augmentation, etc.)			
Any surgical procedure performed in a non-hospital setting?			
Any non-hospital procedure using anesthesia (other than local)			
Any laparoscopic procedure			
Any laser procedure			
Vascular or peripheral vascular surgery			
Transplant surgery (lung, kidney, liver, heart, etc.)			
Any orthopedic procedure			
Any obstetrical or gynecologic procedures, including, but not only, termination of pregnancies, etc.			
Any surgical procedure or treatment method that you have trained for after finishing your residency or fellowship			
Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			

Obstetrics & Gynecology

Termination of pregnancies after the first trimester			
Termination of pregnancies (or any invasive or surgical procedure) in a non-hospital setting (indicate type and number of procedures and location where performed)			
In-vitro fertilization			
If you perform mammography (or other methods of imaging), are these reviewed by a radiologist?			
Vaginal Birth after Caesarian Delivery			
Any surgical procedure outside the scope of your training in obstetrics and gynecology			
Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			
Do you employ, supervise or provide on-call backup for nurse midwives?			
Do you specialize in high-risk pregnancies?			
Delivery locations: <input type="checkbox"/> birthing centers <input type="checkbox"/> clinics <input type="checkbox"/> home <input type="checkbox"/> hospital			

Orthopedic Surgery

Spine surgery			
Microsurgical procedures			
Hip replacement surgery			
Any surgical procedure outside the scope of your training in orthopedics			
Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			

Please use the following page to provide details about any question to which you answered "yes". Attach additional sheets as needed.

Certification, Authorization and Signature

I certify that the information in this application is true and correct and I authorize the release and exchange of any information regarding my medical training, 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 or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which I am or have been a member and MIIX Advantage 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.

Applicant's Signature: _____ **Date:** _____

Assignment of Any Return Premium

This section should be completed if the premium for this insurance is paid by someone other than the Applicant.

If the premium for this insurance has been paid and the policy is later cancelled or otherwise changed, any refund of premium that results from such cancellation or change should be assigned to:

Name of the Payor

(employer or other person or entity to whom any refund check should be made payable)

The Payor agrees to pay any premium for the professional liability insurance policy applied for and any renewal or replacement of it. The Applicant for this insurance assigns any and all rights to receive any refund of premium in excess of that earned by MIIX Advantage Insurance Company of New Jersey for this insurance to the Payor named above. The Applicant appoints Payor or Payor's successors or assigns as Applicant's Attorney-in-Fact with full authority to cancel or amend the insurance policy applied for and to execute or receive any document, instrument, payment or notice of any kind relating to the insurance policy, except with respect to giving or withholding consent to settle claim or suit as may be provided in the insurance policy applied for.

No other interest in the insurance applied for may be assigned by any party without the written consent of MIIX Advantage Insurance Company of New Jersey.

This assignment will remain in effect unless both Payor and Applicant agree in writing to its termination.

Applicant's Signature: _____ **Date:** _____
