

Requested Coverage Effective Date: 12:01 a.m. ____/____/____

Policy Number: _____

The Medical Protective Company Health Care Providers (OD, DPM, or Other) Professional Liability Insurance Application

FOR FASTER SERVICE PLEASE ENTER YOUR APPLICATION ONLINE AT WWW.GEMEDICALPROTECTIVE.COM.

I. GENERAL INFORMATION

A. _____
LAST NAME

FIRST NAME

_____ / _____ / _____
MIDDLE NAME SUFFIX DATE OF BIRTH

_____ SOCIAL SECURITY NUMBER

Degree OD DPM Other _____

Please enter your requested coverage effective and expiration dates below:

FROM _____ / _____ / _____ TO _____ / _____ / _____
MM DD YYYY MM DD YYYY

This date cannot be earlier than the expiration date of your current policy.

Annual policy terms will begin and end on the same month and day.

Coverage Type Desired: Occurrence Claims Made

B. CURRENT EMPLOYMENT (List principal location first)

1. _____
SUITE STREET ADDRESS

_____ CITY COUNTY

_____ FROM _____ / _____ TO _____ / _____
STATE ZIP CODE MM YYYY MM YYYY % OF PRACTICE

2. _____
SUITE STREET ADDRESS

_____ CITY COUNTY

_____ FROM _____ / _____ TO _____ / _____
STATE ZIP CODE MM YYYY MM YYYY % OF PRACTICE

C. PREFERRED MAILING ADDRESS Office # _____ Other (below) Residence

(from B above)

_____ NUMBER & STREET

_____ SUITE/ADDRESS 2

_____ CITY STATE ZIP CODE

II. PROFESSIONAL INFORMATION (continued)

IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

2. Do you treat federal or non-federal prison inmates? Yes No

If yes, what percentage of your practice is devoted to each? Federal _____ % Non-Federal _____ %

If yes, please explain _____

Are you covered by another insurance for this activity? Yes No

3. Have you ever had any professional liability insurance refused, canceled or non-renewed? Yes No

If yes, please explain _____

4. Have you incurred or become aware of having a condition that impairs your ability to practice your professional duties? Yes No

(e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)

If Yes, please state the condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **statement from your physician attesting to your fitness to practice your specialty must accompany this application.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type of Illness

Duration of Illness

Treating Physician (Name & Address)

_____ to _____
MM/YYYY MM/YYYY

5. Please check any of the following functions performed as part of your professional activities.

- Limited "Scrub Nurse" functions such as holding retractors, suction, tying sutures, handing and counting of instruments.
- Casting and splinting
- Directly assisting as a non-physician first assistant in surgical procedures

6. If you practice as a dental hygienist, do you administer any form of analgesic or anesthesia? Yes No

If yes, please explain _____

7. If you are a podiatrist, do you perform surgery? Yes No

If yes, please explain _____

8. Do you independently prescribe/order drugs without same day authorization from your supervising physician? Yes No

If yes, please explain _____

F. Please check the box that best describes your practice affiliation:

Employment Status:

- Employee
- Shareholder/Partner
- Independent Contractor
- Other: _____

G. Do you work for a physician or dentist who is currently insured by The Medical Protective Company? Yes No

If yes and working for an **individual**, please complete the section below:

Policy # _____ Affiliation Name _____
Individual Affiliation Name

If yes and working in a **group practice**, please complete the section below:

Policy # _____ Affiliation Name _____
Corporation/Partnership Group # (optional) Affiliation Name

III. LOSS INFORMATION (IMPORTANT, COMPLETE FULLY)

IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

- A. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? Yes No
If "Yes", how many? _____
If "Yes", have these been reported to your insurer? Yes No
- B. Do you have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim? Yes No
If "Yes", how many? _____
If "Yes", have these been reported to your insurer? Yes No

IV. CLAIM/SUIT INFORMATION FORM (Please make copies if additional forms are needed)

If making additional copies, please enter applicant's name here: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

1. Patient/Claimant Information – Name: _____ Age: _____ Gender: Male Female

2. Date of treatment and/or surgery, which led to the allegations against you: _____ / _____ / _____
MM DD YYYY

3. Date claim/incident notice received _____ / _____
MM YYYY

4. Date claim reported to prior insurer _____ / _____
MM YYYY

5. 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
Date of Closing/Settlement or award (MM/YY) _____ / _____
MM YYYY

7. Indicate case value established by carrier, if known (in \$): _____

8. Defending Insurance carrier name: _____

9. Claim file number, if known: _____

10. Was this matter closed with your consent? Yes No

Was a suit filed? Yes No

Was payment made? Yes No

If no, was claim or suit withdrawn? Yes No

If Yes, indicate total amount of settlement or award (in \$): _____

Amount paid on your behalf (in \$) _____

11. Nature of allegations in the claim or suit:

Condition treated: _____

Treatment provided: _____

Alleged Negligence: _____

Alleged injury: _____

12. Please provide details of the claim information: (include, type of treatment and /or surgery; your involvement, etc.)

V. COVERAGE INFORMATION

IF ADDITIONAL SPACE IS NEEDED, USE THE SUPPLEMENTAL FORM

A. List all previous professional liability insurers beginning with the most recent.

1. _____ Claims Made Occurrence MM / DD / YYYY to MM / DD / YYYY
 Current Insurer

2. _____ Claims Made Occurrence MM / DD / YYYY to MM / DD / YYYY
 Insurer

3. _____ Claims Made Occurrence MM / DD / YYYY to MM / DD / YYYY
 Insurer

B. COVERAGE DESIRED

1. Occurrence
2. Claims-Made Coverage with Prior Acts Coverage
3. Claims-Made Coverage without Prior Acts Coverage

(A copy of current declaration page showing current retroactive date must be attached for option 2)

If 1 or 3 are selected from the above and the most recent prior coverage was issued on a CM basis, please 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.

*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 purchasing from The Medical Protective Company, will not provide prior acts 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 the differences between claims-made and occurrence coverage or the additional expense associated with an "extension contract" or "tail coverage."

C. Requested Coverage Effective Date 12:01 a.m. **From:** MM / DD / YYYY **12:01 a.m.**
 This date cannot be earlier than the expiration date of your current policy. **To:** MM / DD / YYYY **12:01 a.m.**
 Annual policy terms will begin and end on the same month and day.

D. The Retroactive Date Shown on my Current Claims-Made Policy is: MM / DD / YYYY **12:01 a.m.**
 This date cannot be greater than the retroactive date shown on your current policy

E. If your practice is in Indiana, Kansas, Louisiana, New Mexico, Nebraska, Pennsylvania, Wisconsin, or any fund state, and you are currently enrolled in the state compensation fund, please indicate your current fund retroactive date if different than the retroactive stated above.

MM / DD / YYYY

Are you aware of any gaps in your Fund coverage? Yes No

If yes, please provide the exact dates and written explanation: _____

F. Limits Desired: _____ per occurrence
 _____ annual aggregate

VI. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my Employer OR Named Third Party (Include Name & Address) _____

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g. termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to The Medical Protective Company's Home Office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

VII. STATE STATUTORY REQUIREMENT

NOTE: All Pennsylvania applicants must read and initial the following:

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.

Initial Here

VIII. PLEASE READ AND SIGN

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 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 specialty, 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.

Signature

Date Signed:

____ / ____ / ____
MM DD YYYY

Print Name

When would you like your quote delivered?

____ / ____ / ____
MM DD YYYY

FOR OFFICE USE ONLY

PRODUCER NAME _____

PRODUCER # _____

Lined writing area consisting of 30 horizontal lines.