If previously covered with Medical Protective, or joining a current Medical Protective Healthcare Professional group policy, please enter the Policy Number: _____

THE MEDICAL PROTECTIVE COMPANY
MULTI-SPECIALTY HEALTHCARE PROFESSIONAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

APPLICATION INSTRUCTIONS

1. If additional space is needed, please complete Section IX. Supplemental Information with a reference to the question.
2. You must apply for coverage for each individual or entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture which you are requesting Medical Protective Company coverage. Additional documentation may be requested by the Company as necessary. For example: Articles of Incorporation, Declaration Page, copy of your most recent entity professional liability policy (including all endorsements), etc.
3. Please print legibly.
4. Please answer all questions; if a question is not applicable, state "N/A".

I. GENERAL INFORMATION

INDIVIDUAL APPLICANTS ONLY: Individuals with a Corporation or Partnership should apply below as a Group Applicant.

A. Please check all that apply:

□ Individual Sole Proprietor
□ Independent Contractor/Self-Employed
□ Employed Practitioner
□ Individual joining a current Medical Protective Healthcare Professional Group, Corporation or Partnership: **Policy Number**: _____
□ Other, please explain: _____

B. _____
Name of Individual Applicant (Last Name, First Name, Middle Name, Suffix)

C. If we need to contact you for additional information, please indicate the preferred method of contact:

□ Email Address: _____ □ Phone: _____-_____-_____ □ Fax: _____-_____-_____

GROUP APPLICANTS/INDIVIDUALS WITH A CORPORATION OR PARTNERSHIP ONLY: Individual Applicants, please skip to Section II., General Practice Information.

A. Please check all that apply:

□ Professional Corporation: sole shareholder
□ Partnership or Professional Association
□ Limited Liability Company (LLC)/Partnership (LLP)
□ Professional Corporation: multiple shareholders
□ Other, please explain: _____

B. _____ _____
Name of Group Applicant/Organization Entity Name (As stated in the Articles of Incorporation.) **State of Incorporation**

_____ _____ ____ / _____ _____ / _____ / _____
Federal Tax I.D. Number **National Provider Number** (optional) **Date Entity Formed** (MM/YYYY) **Current Entity Retro Date** If claims-made (MM/DD/YYYY)

C. _____
If the entity does business under any other name, list additional entity/clinic name(s), Doing Business As ("DBA"), fictitious name, etc.

D. Is this entity joining a current Medical Protective Insured's Policy? □ Yes □ No

If Yes, please provide the **Policy Number**: _____

E. If you are an owner of the entity identified in Question B. above, do you desire coverage for this entity? □ Yes □ No
If Yes, please select one of the following:

□ Add this entity on a "Shared Limit" basis with the Scheduled Named Insured Providers. (Not available in some states.)
□ Add this entity with an additional "Separate Limit" to my policy for an Additional Charge.

F. If this group/entity has a web address, please provide the website address (URL): _____

G. If we need to contact the group/entity for additional information, please indicate the primary contact name and preferred method of contact:

_____ _____
Primary Contact Name (Last Name, First Name, Middle Name, Suffix) Title

□ Email Address: _____ □ Phone: _____-_____-_____ □ Fax: _____-_____-_____

II. General Practice Information

A. Practice Location(s): (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Type of Facility: □ Office □ Hospital □ Surgical Center (Accredited Facility) □ Other, please explain: _____

Loc. #1 _____ % of Practice

Name of Primary Practice Location (All documents will be mailed to this location, unless a different mailing address is requested in Question B. below.) | **County**

Street Address | **Suite** | **City** | **State** | **Zip Code**

2. Type of Facility: □ Office □ Hospital □ Surgical Center (Accredited Facility) □ Other, please explain: _____

Loc. #2 _____ % of Practice

Name of Practice Location | **County**

Street Address | **Suite** | **City** | **State** | **Zip Code**

3. Type of Facility: □ Office □ Hospital □ Surgical Center (Accredited Facility) □ Other, please explain: _____

Loc. #3 _____ % of Practice

Name of Practice Location | **County**

Street Address | **Suite** | **City** | **State** | **Zip Code**

B. Does the group/entity require a mailing address other than the primary practice location address? □ Yes □ No

If yes, please select one of the following mailing preferences: □ **Billing only** □ **All Documents**

If yes, please provide the Location # or print the different mailing address: □ **Loc.#** ___ □ **Other, please print below**:

Street Address | **Suite** | **City** | **State** | **Zip Code**

III. Individual Applicant Information

Individual Applicants, please fill out Section 1. only. Group Applicants, please fill out each section for each applicant requesting coverage. If more than three individual applicants, please use the Individual Applicant Information Supplemental Application.

1. Please select your affiliation to the practice: □ Shareholder □ Partner □ Employee □ Independent Contractor/Self-Employed □ Faculty

Name (Last, First, M.I., Suffix) | **Date of Birth** _____ / _____ / _____ | **Degree** | **Specialty**

Percentage of Practice: (Total must equal 100%.) □ **Loc.#1 _____%** □ **Loc.#2 _____%** □ **Loc.#3 _____%**

License # | **State** □ Active □ Inactive □ Pending/Temporary | **License #** | **State** □ Active □ Inactive □ Pending/Temporary

Indicate the estimated average hours per week for which you require Medical Protective coverage. _____ Hrs.

Graduation Date (MM/YYYY) _____ / _____ | **First Date in Practice** (MM/YYYY) _____ / _____ | **Current Retro Date** (if claims-made) _____ / _____ / _____

Current Prof. Assoc. Membership Name | **National Provider Number** (Optional) | **Soc. Security No.** (Optional) _____-_____-_____

2. Please select your affiliation to the practice: □ Shareholder □ Partner □ Employee □ Independent Contractor/Self-Employed □ Faculty

Name (Last, First, M.I., Suffix) | **Date of Birth** _____ / _____ / _____ | **Degree** | **Specialty**

Percentage of Practice: (Total must equal 100%.) □ **Loc.#1 _____%** □ **Loc.#2 _____%** □ **Loc.#3 _____%**

License # | **State** □ Active □ Inactive □ Pending/Temporary | **License #** | **State** □ Active □ Inactive □ Pending/Temporary

Indicate the estimated average hours per week for which you require Medical Protective coverage. _____ Hrs.

Graduation Date (MM/YYYY) _____ / _____ | **First Date in Practice** (MM/YYYY) _____ / _____ | **Current Retro Date** (if claims-made) _____ / _____ / _____

Current Prof. Assoc. Membership Name | **National Provider Number** (Optional) | **Soc. Security No.** (Optional) _____-_____-_____

III. Individual Applicant Information (continued)

3. Please select your affiliation to the practice: □ Shareholder □ Partner □ Employee □ Independent Contractor/Self-Employed □ Faculty

_____ _____ / _____ / _____ _____ _____
Name (Last, First, M.I., Suffix) **Date of Birth** **Degree** **Specialty**

Percentage of Practice: (Total must equal 100%.) □ **Loc.#1** _____**%** □ **Loc.#2** _____**%** □ **Loc.#3** _____**%**

_____ _____ □ Active □ Inactive □ Pending/Temporary _____ _____ □ Active □ Inactive □ Pending/Temporary
License # **State** **License #** **State**

Indicate the estimated average hours per week for which you require Medical Protective coverage. _____ Hrs.

_____ / _____ _____ / _____ _____ / _____ / _____
Graduation Date (MM/YYYY) **First Date in Practice** (MM/YYYY) **Current Retro Date** (if claims-made)

_____ _____ _____-_____-_____
Current Prof. Assoc. Membership Name **National Provider Number** (Optional) **Soc. Security No.** (Optional)

IV. Professional Information (Attach a separate piece of paper, if needed.)

A. Have you, your entity, or any applicant requesting coverage above, or any of your employees, ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than minor traffic offenses? □ Yes □ No

If yes, please explain: _____

Applicant Name(s): _____ Date: _____ / _____ (MM/YYYY)

B. Have you, your entity, or any applicant requesting coverage above, or any of your employees had hospital privileges, DEA/ narcotics license, healthcare license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? □ Yes □ No

If yes, please explain: _____

Applicant Name(s): _____ Date: _____ / _____ (MM/YYYY)

C. Have you, your entity or any applicant requesting coverage above or any of your employees ever incurred or become aware of having a condition that impairs your ability to practice your specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics, or other controlled substances, etc. Note: Functional addiction is considered a reportable impairment.) □ Yes □ No

If yes, state condition(s), date(s), and identify the treating physician(s) in the space provided below. In the event of any such impairment, **a statement from the treating physician attesting to your fitness to practice your specialty must accompany this application.**

If yes, please explain: _____

Applicant Name(s): _____

Treating Physician(s) Name(s): _____ Date: _____ / _____ (MM/YYYY)

D. Have you, your entity, or any applicant requesting coverage above, or any of your employees ever been accused of sexual misconduct of any kind? □ Yes □ No

If yes, please explain: _____

Applicant Name(s): _____ Date: _____ / _____ (MM/YYYY)

CALIFORNIA and **MISSOURI APPLICANTS:** Do **NOT** answer the following question:

E. Have you, your entity or any applicant requesting coverage ever had any professional liability insurance refused, declined, canceled or non-renewed by an insurance company? □ Yes □ No

If yes, please explain: _____

Applicant Name(s): _____ Date: _____ / _____ (MM/YYYY)

F. Will you, your entity or any applicant requesting coverage be treating or reviewing treatment of federal prison inmates? □ Yes □ No

If yes, how many hours per week? _____Hrs. Applicant Name(s): _____

G. Will you, your entity or any applicant requesting coverage be treating non-federal prison inmates? □ Yes □ No

If yes, how many hours per week? _____Hrs. Applicant Name(s): _____

V. Loss Information

Please complete a Loss Information Supplement for each written request, incident, claim or suit (A, B or C) in which the group, entity and/or individual's policy was triggered and that has NOT been covered by a Medical Protective policy.

Report all matters related to professional liability, commercial general liability, employment practices liability, cyber liability, business errors and omissions, hired non-owned auto, or any other coverage for which Medical Protective coverage is being requested, for each applicant (including but not limited to, board complaints, etc.).

For **Questions B. and C.** below, report all matters that might reasonably lead to a claim or suit being brought against the group, entity, and/or anyone from your practice, even if it is believed the claim or suit would be without merit.

A. Has your entity or any individual applicant now, or ever been, involved in a claim or suit arising out of the rendering or failure to render professional services, or related to any other coverage requested from Medical Protective (e.g. CGL, EPLI, etc.)? □ Yes □ No

If yes, how many? _____ Applicant Name(s): _____

B. Is your entity or any individual applicant from the practice aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against an applicant, entity or anyone from the practice? This includes, but is not limited to, the following:

◇ Amputation ◇ Permanent Neurological Injury ◇ Loss of Major Organ Function ◇ Death ◇ Loss of Vision. □ Yes □ No

If yes, how many? _____ Applicant Name(s): _____

C. In the last 12 months, has your entity, or any individual applicant or anyone from the practice received a written request from an attorney for treatment records concerning any current or former patient(s) which might reasonably result in a claim or suit against an applicant, entity or anyone from the practice? □ Yes □ No

If yes, how many? _____ Applicant Name(s): _____

VI. Coverage Information

If Occurrence Coverage is Desired:

A. Coverage desired: □ Occurrence coverage

B. Requested Coverage Effective Date: Annual policy terms will begin and end on the same month and day.

From: ____ / ____ / ____ 12:01 AM (MM/DD/YYYY) **To: ____ / ____ / ____ 12:01 AM** (MM/DD/YYYY)

C. Desired Limits: Per Occurrence/Per Claim Filed: $ _____ , _____ , _____ Annual Aggregate: $ _____ , _____ , _____

D. List your current professional liability insurer(s) for the last 10 years, or back to your start date of practice. Please explain any gaps in coverage. (Attach a separate piece of paper, if necessary.)**:**

_____

Current Insurer: □ Occurrence □ Claims-made

From: ____ / ____ / ____ 12:01 AM (MM/DD/YYYY) **To: ____ / ____ / ____ 12:01 AM** (MM/DD/YYYY)

If Claims-Made Coverage is Desired: If selecting Occurrence coverage above, skip to Extended Reporting Section on the following page.

Notes:

1. **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(s)" or "tail coverage".**
2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage desired:
- □ Claims-Made without Prior Acts Coverage
- □ Claims-Made with Prior Acts Coverage
- □ Convertible Claims-Made: Step to Occurrence 4th-yr. if claim free

B. Requested Coverage Effective Date: Annual policy terms will begin and end on the same month and day.

From: ____ / ____ / ____ 12:01 AM (MM/DD/YYYY) **To: ____ / ____ / ____ 12:01 AM** (MM/DD/YYYY)

C. Current Claims-Made policy retroactive date (Date is required for Claims-Made with Prior Acts.)**: ____ / ____ / ____** (MM/DD/YYYY)
Please attach a copy of your current Declaration Page(s).

D. Desired Limits:
Per Claim Filed: **$** _____ , _____ , _____ Annual Aggregate: **$** _____ , _____ , _____

E. List your current and previous professional liability insurer(s) for the last 10 years, back to your current retroactive date, or start date of practice. Please explain any gaps in coverage. (Attach a separate piece of paper, if necessary.)

_____

Current Insurer: □ Occurrence □ Claims-Made

From: ____ / ____ / ____ 12:01 AM (MM/DD/YYYY) **To: ____ / ____ / ____ 12:01 AM** (MM/DD/YYYY)

Extended Reporting Section:

If "Occurrence" or "Claims-Made coverage without Prior Acts" coverage was selected as the desired coverage, and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- □ An extension contract endorsement (tail coverage) has been or will be purchased.
- □ An extension contract endorsement (tail coverage) has not been 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 a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, for which I am applying from The Medical Protective Company, will not provide Prior Acts coverage.

VII. Fraud Notice

MANDATORY: ***ALL APPLICANTS must read the following statement carefully:***
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.

VIII. Notices and Agreements

By my signature, I hereby represent that all applicants have granted me full authority to execute this application on his, her or the entity's behalf and I am authorized to represent and sign on behalf of anyone from my practice. I also represent that I have reviewed the responses contained in this application with the applicants, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicants and that they understand and agree that such representations are binding upon him, her or the entity, even though I am executing this application on the applicants' behalf.

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my, or any applicants' initial or renewal application, are true and that I, nor any applicant, have not knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare professional, facility, firm or professional association.

I understand that, to the extent permitted by law, the Company reserves the right to deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the Company as required either by this application for the policy, subsequent notice, or otherwise.

I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered 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 or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I, OR ANY APPLICANT, FAIL TO COMPLY WITH THESE TERMS WE **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

I, or any other applicant, 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 me or any applicant, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

By signing this application on behalf of a group, or 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 represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

I represent 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.

Application must be signed by the Individual Applicant, a President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

Authorized Representative Signature/Title	Printed Name	Date Signed (MM/DD/YYYY)
Agent/Producer Name	License Number	

Agent Name & License Number: _____
(Signature)

IX. Supplemental Information