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

- If additional space is needed, please complete Section IX. Supplemental Information with a reference to the question.
- 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.
- Please print legibly.
- Please answer all questions; if a question is not applicable, state "N/A".

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-	GENERAL INFORMATION				
IN	NDIVIDUAL APPLICANTS ONLY: Individuals with a Cor	poration or Partnership	should apply below a	as a Group Applican	nt.
A.	Please check all that apply:  □ Individual Sole Proprietor  □ Independent Contractor/Self-Employed  □ Employed Practitioner	□ Individual joining a Corporation or Part □ Other, please expla	nership: Policy Nur	mber:	
В.	Name of Individual Applicant (Last Name, First Name	e, Middle Name, Suffix)			
C.	If we need to contact you for additional information	on, please indicate th	e preferred metho	od of contact:	
	□ Email Address:	□ Phone:		□ Fax:	
	ROUP APPLICANTS/INDIVIDUALS WITH A CORPORTED PRACTICE Information.	RATION OR PARTNE	RSHIP ONLY: Indi	ividual Applicants, p	please skip to Section II.,
A.	Please check all that apply:  □ Professional Corporation: sole shareholder  □ Partnership or Professional Association  □ Limited Liability Company (LLC)/Partnership (LLP)	□ Professional Corpor □ Other, please expla	•		
В.	Name of Group Applicant/Organization Entity Nan	ne (As stated in the Art	·	•	ate of Incorporation
	Federal Tax I.D. Number National Provider N	umber (optional)	Date Entity Fo (MM/YYYY)	rmed Current	Entity Retro Date made (MM/DD/YYYY)
C.	If the entity does business under any other name, name, etc.	list additional entity	/clinic name(s), D	oing Business As	("DBA"), fictitious
D.	Is this entity joining a current Medical Protective	Insured's Policy?			□ Yes □ No
	If Yes, please provide the <b>Policy Number</b> :				
E.	If you are an owner of the entity identified in Quest If Yes, please select one of the following:  □ Add this entity on a "Shared Limit" basis with the Schet □ Add this entity with an additional "Separate Limit" to m	eduled Named Insured F	roviders. (Not availa	-	
F.	If this group/entity has a web address, please pro	vide the website add	ress (URL):		
G.	If we need to contact the group/entity for addition method of contact:	nal information, plea	se indicate the pri	mary contact nar	ne and preferred
	Primary Contact Name (Last Name, First Name, Middle	e Name, Suffix)		Title	
	□ Email Address:			□ Fax:	<u>-</u>

Α.	<b>Practice Location(s):</b> (Pleatequal values.)	. ,							50% and Cannot be
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C.	#3 % of Practice	Name of Pr	actice Locat	ion				Co	unty
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	If yes, please provide the					<i>3</i> • <i>1</i>			e print below:
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Name (L	_ast, First, M.I., Suffix)	Date of Birth	Degree	Specialty	
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		Pending/Temporary		Active □ Inactive □ Pending/Te	empor
License	# State	Lice	ense # State	Active □ Inactive □ Pending/Te	·
Indicate	e the estimated average hours per we			<u> </u>	
/ Graduat	tion Date (MM/YYYY)	First Date in Practice	(MM/YYYY)	Current Retro Date (if claims	s-made
Current	Prof. Assoc. Membership Name	National Provider Nu	mber (Optional)	Soc. Security No. (C	ptiona
. Profes	SSIONAL INFORMATION (ATTACH A	SEPARATE PIECE OF P	APER, IF NEEDED.)		
-	ou, your entity, or any applicant reque				_
•	convicted of, any act committed in vi	•		nor traffic offenses? ☐ Yes	□ No
	lease explain:				
Applicant	t Name(s):			Date: / (MM/YYYY	<u>``</u>
_	ou, your entity, or any applicant reque			es had hospital privileges, D	ÉA/
	cs license, healthcare license or reimb and, placed on probation or voluntarily	•	used, denied, revoked,	suspended, restricted, subject   Yes	
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## 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, <u>or any other coverage for which Medical Protective coverage is being requested</u>, <u>for each applicant</u> (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.

any	one from your practice, even i	ir it is believed the claim or suit would be without merit.	
Α.		dividual applicant now, or ever been, involved in a claim or suit arising out of the rerervices, or related to any other coverage requested from Medical Protective (e.g. CGL	
	If yes, how many?	Applicant Name(s):	
В.		vidual applicant from the practice aware of any complication, incident or adverse ou nt reasonably result in a claim or suit against an applicant, entity or anyone from the ed to, the following:	_
	♦ Amputation ♦ Permane	ent Neurological Injury $\diamond$ Loss of Major Organ Function $\diamond$ Death $\diamond$ Loss of Vision.	□ Yes □ No
	If yes, how many?	Applicant Name(s):	
C.	an attorney for treatment	as your entity, or any individual applicant or anyone from the practice received a writh the records concerning any current or former patient(s) which might reasonably result wity or anyone from the practice?	
	If yes, how many?	Applicant Name(s):	
VI.	COVERAGE INFORMATIO	DN .	
If C	Occurrence Coverage is Des	sired:	
A.	Coverage desired:   Occu	urrence coverage	
В.	Requested Coverage Effe	ective Date: Annual policy terms will begin and end on the same month and day.	
	From: / / /	12:01 AM To:// 12:01 AM	
C.	Desired Limits: Per Occur	rrence/Per Claim Filed: \$ , , Annual Aggregate: \$ , ,	
D.		ional liability insurer(s) for the last 10 years, or back to your start date of practice. I a separate piece of paper, if necessary.):	Please explain any
	Current Insurer:   Occurrent	nce	12:01 AM
If C	Claims-Made Coverage is D	Desired: If selecting Occurrence coverage above, skip to Extended Reporting Section on the follows:	owing page.
Not 1.	services rendered between any questions pertaining	limited generally to liability for injuries for which claims are first made during the penthe retroactive date and expiration date of the policy. Please contact your agent to the differences between Claims-Made and Occurrence coverage or the additional nsion contract(s)" or "tail coverage".	should you have
2.		policy types may not be available in all states.	
Α.	Coverage desired:   Cla	aims-Made <u>without</u> Prior Acts Coverage	
	□ Cla	aims-Made with Prior Acts Coverage	
	□ Co	onvertible Claims-Made: Step to Occurrence 4th-yr. if claim free	
В.	Requested Coverage Effe	ective Date: Annual policy terms will begin and end on the same month and day.	
	From:///	12:01 AM To:// 12:01 AM	
C.	Current Claims-Made poli Please attach a copy of yo	licy retroactive date (Date is required for Claims-Made with Prior Acts.)://_ rour current Declaration Page(s). (MM/DD/YYYY)	
D.	<b>Desired Limits:</b> Per Claim Filed: \$,	, , , , ,	
E.		evious professional liability insurer(s) for the last 10 years, back to your current retro ease explain any gaps in coverage. (Attach a separate piece of paper, if necessary.)	oactive date, or
	Current Insurer:   Occurrence	ce - Claims-Made  From:/	12:01 AM

Extended Reporting Section:		
If "Occurrence" or "Claims-Made coverage without prior coverage was issued on a Claims-Made basis  An extension contract endorsement (tail coverage An extension contract endorsement (tail coverage)	, please complete one of the following: e) has been or will be purchased.	d coverage, and the most recent
	nt carrier will result in an uninsured exposure for any current carrier's policy. I understand that the policy	claims which may arise as a result of
VII. FRAUD NOTICE		
MANDATORY: ALL APPLICANTS must read the followant person who knowingly and with intent to definite statement of claim containing any materially falsion any fact material thereto, commits a fraudulent penalties.	raud any insurance company or other person, fil e information or conceals, for the purpose of m	isleading, information concerning
VIII. NOTICES AND AGREEMENTS		
By my signature, I hereby represent that all applicants ha am authorized to represent and sign on behalf of anyor application with the applicants, and we are in agreement represent that I have discussed the representations provi such representations are binding upon him, her or the en	ne from my practice. I also represent that I have revi they are full and complete to the best of our combined ided throughout this application with the applicants and	iewed the responses contained in this d knowledge and belief. In addition, I d that they understand and agree that
I further acknowledge that the above statements and p supplemental pages or other attachments (hereinafter "I true and that I, nor any applicant, have not knowingly su and any <b>Attachments</b> , shall be the basis of the contract any answer to this application, or its <b>Attachments</b> , arrangement with any other healthcare professional, facility	Attachments") for the purposes of my, or any applicate ppressed or misstated any material facts and I, and any with the Company. I agree to notify the Company if the including without limitation, any change in profession	ants' initial or renewal application, are applicant, agree that this application, ere are any future material changes in
I understand that, to the extent permitted by law, the Co made misrepresentations, omissions, or incorrect state acceptance of the risk or to the hazard assumed by the would not have issued the policy in as large an amount, true facts had been made known to the Company as requ	ments, or if I have concealed facts that are: (1) for Company; and (3) the Company in good faith would or would not have provided coverage with respect to	raudulent; (2) material either to the either not have issued the policy, or the hazard resulting in the loss, if the
I further understand and agree that I, or any applicant completed application(s); (2) offered a premium quote; a agreed to finance the premium, the first installment due. by check, electronic transfer or money order, it shall not be	nd (3) received, as a precondition to coverage, the tota In addition, I or any applicant understands that if payr	Il premium due or, if the Company has ment of premium or first installment is
I AGREE THAT IF I, OR ANY APPLICANT, FAIL TO COMPL POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.	Y WITH THESE TERMS WE WILL HAVE NO COVER	AGE FOR ANY CLAIM UNDER ANY
I, or any other applicant, understand that the Company liability insurers or other entities to verify and/or ascert issuance of a contract of insurance. Therefore, I hereby insurer or other entity to release to the Company any in applicable and pertinent to this application and if issued, to	ain information regarding credentials and background instruct any such person, hospital, school, employer, iformation regarding me or any applicant, which the C	both prior to and if issued, after the insurance agent, professional liability
By signing this application on behalf of a group, or an ent company, a general business corporation, a partnership, Partner, or other Authorized Representative of the group	, a joint venture, or a governmental entity), I represe	
I represent that I am authorized to disclose all informa application, including authority to disclose such information		
Application must be signed by the Individual Application of a PC or PA, or the equivalent Authorized Representations.		er Officer, Shareholder, or Partner
Authorized Representative Signature/Title	Printed Name	Date Signed (MM/DD/YYYY)
Agent/Producer Name	License Number	
Agent Name & License Number:		
	(Signature)	

IX. SUPPLEMENTAL INFORMATION	
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