NORCAL MUTUAL®

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# APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

## PHYSICIANS, SURGEONS, DENTISTS, AND PODIATRISTS

This application is for claims-made or occurrence coverage. It is subject to review and acceptance by The Company and does not bind coverage. Additional information may be requested by The Company.

| |
|---|
| **Agency Name:** |
| **Agency Location:** |
| **Producer Name:** |

**REQUESTING ADDITION TO A CURRENT NORCAL MUTUAL POLICY**

*If accepted, coverage will be extended only while you are acting within the course and scope of your duties for the group and will be subject to the terms, conditions, and limitations of the policy. A copy of the policy will be made available to you upon request.*

| Name of Entity/Organization or Physician | Policy Number |
|---|---|
| | |

## APPLICATION CHECKLIST

**Please complete the entire application, sign, and date. Indicate not applicable (n/a) where appropriate.**

- ☐ Answer all questions fully and completely. Alternatively, you may attach a credentialing application or application for another insurer that you have completed within the past 90 days and complete this application beginning with Section VI, Claims Information.
- ☐ A copy of the Declarations page and endorsements from your most recent insurance policy. If an extended reporting endorsement (tail) has been purchased, please provide a copy as well.
- ☐ Loss runs for the past 10 years, or since the date you began practicing medicine if you began in the last 10 years.
- ☐ A copy of your letterhead.
- ☐ A copy of your current Curriculum Vitae (CV).
- ☐ If you are requesting coverage for a corporation, please include a completed Entity/Organization Application and the Articles of Incorporation.
- ☐ If you employ, independently contract with, or otherwise maintain an association with other health care providers (including physicians and/or health care extenders) and desire coverage for them, a separate application is required for each provider.
- ☐ Please download and print the NORCAL Mutual Business Associate Agreement at http://www.norcalmutual.com/resources and file with your other HIPAA compliance documents. Revised regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Privacy, Security, Enforcement and Breach Notification Rules, requiring NORCAL Mutual to enter into a revised Business Associate Agreement with all business associates who manage or distribute protected health information.

## SECTION I: GENERAL INFORMATION

### GENERAL INFORMATION

| First Name | Middle Name | Last Name | ☐ MD ☐ DO ☐ DMD ☐ DDS ☐ DPM |
|---|---|---|---|
| Date of Birth (mm/dd/yyyy) | DEA License # | FEIN License # | ☐ Male ☐ Female |
| Authorized Office Representative | Title | Email | Website |

| Primary Office Phone | Home Phone | Cell Phone | Fax |
|---|---|---|---|

| Primary Office Address | City | State | Zip Code | ☐ Preferred Mailing |
|---|---|---|---|---|
| Home Address | City | State | Zip Code | ☐ Preferred Mailing |
| Billing Address | City | State | Zip Code | ☐ Preferred Mailing |
| Other Address | City | State | Zip Code | ☐ Preferred Mailing |

### MEDICAL LICENSURE

| State | License # | Expiration Date | % of Practice | Status of License |
|---|---|---|---|---|
| | | | | ☐ Active ☐ Inactive ☐ Pending |
| | | | | ☐ Active ☐ Inactive ☐ Pending |
| | | | | ☐ Active ☐ Inactive ☐ Pending |

## SECTION II: COVERAGE INFORMATION

### COVERAGE DESIRED

Please provide a copy of your current Declarations page from your most recent Insurance Carrier, as well as copies of any extended reporting endorsements (tails) that you may have purchased.

- ☐ **Claims-made WITHOUT prior acts coverage.** Under this option, the retroactive date will be the same as the effective date of coverage. Coverage for claims arising from an act or omission that occurred prior to the effective date of this policy will not be provided.
- ☐ **Claims-made WITH prior acts coverage.** Under this option, the retroactive date will be the same as the retroactive date on your current policy.
- ☐ **Occurrence coverage.**

| Requested Effective Date (mm/dd/yyyy) | Retroactive Date (mm/dd/yyyy) | Limit Amount | Limit Type ☐ Shared ☐ Separate | Hours (per week) |
|---|---|---|---|---|

Will you also carry insurance with another company? ☐ Yes ☐ No If yes, please explain in the Remarks Section.

### COVERAGE HISTORY

List all previous medical professional liability insurance you have had for the past 5 years, beginning with the most current.

| **Coverage Period** (mm/dd/yyyy) | **Insurer** | **Coverage Type** | **Limit Amount** | **Premium** | **Tail Purchased** |
|---|---|---|---|---|---|
| From:<br><br>To: | | ☐ Occurrence<br>☐ Claims-made<br><br>Retro: | Amount:<br><br>☐ Shared<br>☐ Separate | | ☐ Yes<br>☐ No |
| From:<br><br>To: | | ☐ Occurrence<br>☐ Claims-made<br><br>Retro: | Amount:<br><br>☐ Shared<br>☐ Separate | | ☐ Yes<br>☐ No |
| From:<br><br>To: | | ☐ Occurrence<br>☐ Claims-made<br><br>Retro: | Amount:<br><br>☐ Shared<br>☐ Separate | | ☐ Yes<br>☐ No |

## SECTION III: SPECIALTY AND PRACTICE INFORMATION

### SPECIALTY INFORMATION

1. Please describe your current medical specialty.

| | **Medical Specialty** | **% of Practice** (must total 100%) | **Board Certified** | **Board Eligible?** |
|---|---|---|---|---|
| **Primary Specialty** | | | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| **Sub Specialty** | | | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |

### MEDICAL PROCEDURES

2. Please check the appropriate box, indicating the extent of surgery you perform:

   ☐ **No Surgery** except incisions of boils, cysts, circumcisions (newborns), or other superficial abscesses or suturing minor lacerations.

   ☐ **Minor Surgery** includes most procedures performed under local anesthesia; or assisting in major surgery on your own patients.

   ☐ **Major Surgery** includes major surgical procedures done under general, spinal or caudal anesthesia; or assisting in major surgery on other than your own patients.

3. If you assist in surgery, please provide the number of procedures performed annually:

   Assisting in major surgery on own patients: # Per Year

   Assisting in major surgery on patients other than your own: # Per Year

4. Please check the procedures, which you perform, for which you are requesting coverage. Please check any procedure that you have performed in the last 5 years.

- ☐ Abdominoplasty
- ☐ Abortion
  - Trimester: ☐ 1st ☐ 2nd ☐ 3rd
  - ☐ Elective % of Practice:
  - ☐ Therapeutic % of Practice:
- ☐ Acupuncture or Acupressure
- ☐ Addiction Medicine
  - ☐ Suboxone Therapy
- ☐ Anesthesia (General/Spinal/Caudal)
- ☐ Angiography/Arteriography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Bariatric Surgery
  - ☐ Gastric Bands # Per Year:
  - ☐ Bypass or Staples # Per Year:
  - ☐ Gastric Sleeve # Per Year:
  - ☐ Other # Per Year:
- ☐ Botox # Per Year:
- ☐ Bronchoscopy
- ☐ Cardiac Catheterization
- ☐ Chelation Therapy
- ☐ Cryosurgery (internal lesions)
- ☐ D&C
- ☐ Dermatology Procedures
  - ☐ Chemabrasion/Dermabrasion
  - ☐ Chemical Peels
    - ☐ Deep ☐ Superficial only
  - ☐ Hair Transplants
  - ☐ Liposuction/Lipoinjection
  - ☐ Silicone Injections
  - ☐ Skin Flaps/Grafts
- ☐ Endoscopic Procedures
  - ☐ Sigmoidoscopy only
  - ☐ Other than Sigmoidoscopy
  - ☐ Laser Therapy
- ☐ Fertility/Infertility Treatment
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ General Surgery
- ☐ Hysterectomy
- ☐ Lithotripsy
- ☐ Laparoscopy
- ☐ Needle Biopsy
  - Type:
- ☐ Pain Management
  - ☐ Implants (incl. Intrathecal Pumps)
  - ☐ Medication only
  - ☐ Nerve Block (Spinal, Paraspinal, Paravertebral, Epidural)
  - ☐ Nerve Block (Other)
- ☐ Radiofrequency Procedures
  - ☐ Spinal Stimulators
- ☐ Prenatal Care
  - ☐ Including 1st Trimester only
  - ☐ Including 1st and 2nd Trimesters
  - ☐ Prenatal to term, no delivery
  - ☐ Prenatal to term, incl. delivery
- ☐ Obstetrics ☐ *Performing* ☐ *Assist only*
  - ☐ C-Sections # Per Year:
  - ☐ Vaginal Births # Per Year:
  - ☐ VBACs # Per Year:
- ☐ Orthopedics
  - ☐ Including Spine
  - ☐ No Spine
- ☐ Permanent Pacemakers
- ☐ Plastics
  - ☐ Reconstructive % of Practice:
  - ☐ Cosmetic % of Practice:
- ☐ Prolotherapy
- ☐ Radiology
  - ☐ Interventional
  - ☐ Radiopaque Dye

☐ Radiation/X-Ray Therapy
☐ Renal Dialysis
☐ Sclerotherapy
☐ Spinal Surgery
☐ Thoracic Surgery % of Practice:
☐ Tonsillectomy/Adenoidectomy
☐ Transgender Surgery
☐ Trauma Surgery % of Practice:
☐ Tubal Ligations
☐ Vascular Surgery % of Practice:
☐ Vasectomies
☐ Wound Care
☐ Hyperbaric Medicine
☐ Surgical Debridement

☐ Other Medical/Procedural Techniques not listed above (please describe):

5. Do you perform or provide any of the following services as a part of your practice?

If so, please describe.

| Type | Offered | % of Practice | Description |
|---|---|---|---|
| **Experimental Surgery** | ☐ Yes ☐ No | | |
| **Independent Medical Exams** | ☐ Yes ☐ No | | |
| **Weight Control Medication** | ☐ Yes ☐ No | | |
| **Telemedicine*** | ☐ Yes ☐ No | | |

*If you are practicing telemedicine, please complete and return the Telemedicine Supplemental Questionnaire.

## PRACTICE INFORMATION

6. Do you currently practice at any additional locations other than the primary office location listed in Section I: General Information? ☐ Yes ☐ No

If yes, please describe:

| **Practice Name** | **Location** (City, State, Zip) | **Hours** (per week) | **Specialty** (if different than above) | **Start Date** (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

7. Have you changed medical specialties, hours, or location within the last 5 years? ☐ Yes ☐ No

If yes, please explain:

| **Location** (City, State, Zip) | **Hours** (per week) | **Specialty** (if different than the current) | **Period** (mm/dd/yyyy) | **Tail Purchased?** |
|---|---|---|---|---|
| | | | From:<br>To: | ☐ Yes<br>☐ No |
| | | | From:<br>To: | ☐ Yes<br>☐ No |
| | | | From:<br>To: | ☐ Yes<br>☐ No |

8. Do you currently have Hospital Privileges? ☐ Yes ☐ No

If yes, please list all locations below.

| **Hospital** | **Location** (City, State, Zip) | **Type of Privileges** | **Current Restrictions?** If yes, please comment* |
|---|---|---|---|
| | | ☐ Staff<br>☐ Courtesy<br>☐ Other: | ☐ Yes<br>☐ No |
| | | ☐ Staff<br>☐ Courtesy<br>☐ Other: | ☐ Yes<br>☐ No |
| | | ☐ Staff<br>☐ Courtesy<br>☐ Other: | ☐ Yes<br>☐ No |

*Comments:

9. Do you work as an emergency room physician, other than for maintaining hospital privileges? ☐ Yes ☐ No

If yes, do you have separate coverage for this exposure? ☐ Yes ☐ No

If yes, how many hrs per month?:

10. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director, or attending physician at any of the following:

☐ Hospital ☐ Sanitarium ☐ Nursing Home ☐ Surgery Center
☐ Birthing Clinic ☐ Clinic ☐ Laboratory ☐ Blood Bank
☐ Prepaid Health Plan ☐ HMO ☐ Other:

If yes, do you have separate coverage for this exposure? ☐ Yes ☐ No

Do you practice medicine at the above institutions? ☐ Yes ☐ No

## SECTION IV: EDUCATION AND TRAINING

1. Please describe your medical professional education and training.

   ☐ Check this box if you have attached a current Curriculum Vitae (CV) and continue with Section V, Entity/Organization Information.

| | School/Facility | Location | Specialty | Start (mm/dd/yyyy) | Complete (mm/dd/yyyy) |
|---|---|---|---|---|---|
| **Medical School** | | | | | |
| **Internship** | | | | | |
| **Residency** | | | | | |
| **Fellowship** | | | | | |
| **Other Training** | | | | | |

2. Please explain any gaps in training:

3. Are you a Foreign Medical School Graduate? ☐ Yes ☐ No

   If yes, please provide a copy of your USMLE.

4. Are you certified in: ☐ ACLS ☐ ATLS ☐ PALS ☐ Other:

5. Are you entering private practice for the first time following your residency, training, military services, or an academic position?
   ☐ Yes ☐ No

## SECTION V: ENTITY/ORGANIZATION INFORMATION

### ENTITY/ORGANIZATION STRUCTURE

1. Indicate which practice organization applies to you:

   ☐ Solo Unincorporated ☐ Partner or Partnership ☐ Corporate Shareholder ☐ Government Employee
   ☐ Solo Corporation ☐ Independent Contractor ☐ Employee ☐ Other:

2. Name of Entity/Organization:

3. Do you wish for coverage for this Entity/Organization? ☐ Yes ☐ No Limit Type: ☐ Shared ☐ Separate

   If yes, a separate Entity/Organization application is required. **Note:** Separate limits are not available in all states.

4. Is there any other name under which you practice (i.e. DBA, unincorporated name, trade name)? ☐ Yes ☐ No

   If yes, please provide all names:

| Name | Description |
|---|---|
| | |
| | |
| | |

## MEDICAL STAFF

5. Do you currently employ, independently contract, or otherwise maintain an association with any other health care providers? ☐ Yes ☐ No

   If yes, please provide the number of each below. If coverage is desired, a separate application is required for each provider.

   ☐ Check this box if you have included a current roster in place of completing the table below.

| | # Employed | # Contracted | # Supervise Only | Coverage Desired |
|---|---|---|---|---|
| Physicians and Surgeons | | | | ☐ Yes ☐ No |
| Dentists | | | | ☐ Yes ☐ No |
| Podiatrist | | | | ☐ Yes ☐ No |
| Fellows | | | | ☐ Yes ☐ No |
| Residents | | | | ☐ Yes ☐ No |
| Interns | | | | ☐ Yes ☐ No |
| CRNAs | | | | ☐ Yes ☐ No |
| Midwife | | | | ☐ Yes ☐ No |
| Nurse Practitioner | | | | ☐ Yes ☐ No |
| Optometrist | | | | ☐ Yes ☐ No |
| Perfusionist | | | | ☐ Yes ☐ No |
| Physician Assistants | | | | ☐ Yes ☐ No |
| Radiology Assistants | | | | ☐ Yes ☐ No |
| Surgical Assistants | | | | ☐ Yes ☐ No |

6. Please provide the coverage information below for all health care providers you employ, contract or otherwise associate with, for which coverage is **NOT** desired or attach a copy of their current Declarations page or Certificate of Insurance.

| Name | Specialty | Insurer | License # | Association | Start Date |
|---|---|---|---|---|---|
| | | | | ☐ Employed<br>☐ Supervise<br>☐ Contracted<br>☐ Other: | |
| | | | | ☐ Employed<br>☐ Supervise<br>☐ Contracted<br>☐ Other: | |
| | | | | ☐ Employed<br>☐ Supervise<br>☐ Contracted<br>☐ Other: | |

## SECTION VI: CLAIMS INFORMATION

1. Within the past 10 years, has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No

   If yes, complete the following and a claim/suit/incident supplemental form for each claim, suit, or incident and provide loss runs for the past 10 years, or since the date you began practicing medicine if you began within the past 10 years.

   Total Number of Claims and Suits: # Open/Reserved: # Closed:

   Total Number of Incidents: # Open/Reserved: # Closed:

2. Have you made any changes to your practice as a result of any claims, suits, or incidents? ☐ Yes ☐ No

   If yes, please explain:

## SECTION VII: ADDITIONAL INFORMATION

**For each question below that you answer "Yes," please provide a complete explanation in the Remarks Section.**

1. Has your medical professional liability insurance ever been declined, non-renewed or cancelled including cancellation for nonpayment of premium? (Not applicable to Missouri applicants) ☐ Yes ☐ No
2. Has your medical professional liability insurance ever been surcharged, reduced, or issued with a deductible or other special terms? ☐ Yes ☐ No
3. Have you been charged or convicted of any crime other than minor traffic violations? ☐ Yes ☐ No
4. Have you ever had your medical license or DEA license revoked, limited, refused, suspended, or denied? ☐ Yes ☐ No
5. Have you ever failed to pass a Board Examination? ☐ Yes ☐ No
6. Have your hospital privileges ever been surrendered, limited, or revoked, whether voluntarily or involuntarily? ☐ Yes ☐ No

7. Have your hospital privileges been expanded or reduced in the last 12 months? ☐ Yes ☐ No
8. Has membership of any Professional Association or Society ever been refused, revoked, or limited in any way? ☐ Yes ☐ No
9. Have you ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society? ☐ Yes ☐ No
10. During the past year, have you incurred or become aware of having an illness or physical disability that impairs, or could impair, your ability to practice your medical specialty? ☐ Yes ☐ No

    If yes, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.
11. Have you ever been treated for alcoholism, narcotic addiction, or mental impairment? ☐ Yes ☐ No

    If yes, please provide the details of the rehabilitation program including dates of treatment.
12. Have you ever been accused of sexual misconduct? ☐ Yes ☐ No
13. Have you ever had any contact of a sexual nature with a patient or former patient? ☐ Yes ☐ No
14. Do you know of any individual who works on your behalf that has a prior history or propensity for sexual misconduct? ☐ Yes ☐ No
15. Have you treated or will you treat celebrities or professional athletes? ☐ Yes ☐ No
16. Have you practiced or will you practice at a prison, correctional facility, or other similar facility, or have you provided or will you provide health care services to prisoners or inmates? ☐ Yes ☐ No
17. Do you enter into arbitration or similar agreements with your patients? ☐ Yes ☐ No

    If yes, please attached a copy of the agreement(s).
18. Do you participate in clinical trials? ☐ Yes ☐ No

    If yes, please complete our clinical trials questionnaire.
19. Do you use any non-FDA approved devices, drugs, or procedures? ☐ Yes ☐ No

## REMARKS SECTION

Please provide any additional information/explanations for your application below.

## AGREEMENTS AND NOTICES

I understand that any claims whose circumstances were known before the effective date of coverage are specifically excluded from coverage under any policy of insurance that may be issued by NORCAL Mutual (The Company).

I understand that the NORCAL Mutual policy requires any disputes arising from it to be submitted to binding arbitration unless specifically prohibited by applicable law.

I understand that, as a condition precedent to approval for coverage, The Company may perform a detailed inquiry and investigation of the applicant's background, competence, and qualifications. I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to The Company and its duly authorized agents and representatives. I further expressly authorize all individuals and entities to whom such legal inquiry is made by The Company and its duly authorized agents and representatives to provide the same with all information within their possession or under their control that pertains to the applicant's background, competence, and qualifications. I expressly release and discharge the aforesaid entities and individuals and their agents and representatives from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation, as well as in the evaluation of information so received from whatever source.

All information requested in this application is considered material and important. I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of The Company in considering this application for insurance. I understand that any material misrepresentation in this application that The Company relies on to its detriment could void coverage. I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to me by The Company.

I understand that I must notify The Company immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf and that The Company may withdraw or modify any outstanding quotations or authorization or agreement to bind insurance.

I understand that this application is subject to acceptance by The Company and does not bind coverage.

Applicant Signature

Date (mm/dd/yyyy)

Printed Name

Title

*This application is not valid without your complete signature.*

# CLAIM | SUIT | INCIDENT SUPPLEMENTAL FORM

Attach a detailed narrative, which includes at least the information requested below, or complete this form, for each claim, suit, or incident within the past 10 years. Provide adequate detail to allow proper evaluation. Additional information may be requested.

| Patient Name | Age | ☐ Male ☐ Female |
|---|---|---|
| Date of Incident (mm/dd/yyyy) | Location of Incident | |
| Name of Insurer | Date Reported to Insurer (mm/dd/yyyy) | |

Type: ☐ Suit ☐ Demand for Money ☐ Incident Only ☐ Notice of Intent to Sue
☐ Request for Records ☐ Other:

1. Summary of condition/diagnosis at time of incident:

2. Description of treatment rendered, including dates:

3. Allegations:

4. Other persons and entities involved:

5. Status/Disposition:

   ☐ Open Describe current status and defense strategy:

   ☐ Closed without indemnity payment ☐ Settled ☐ Judgment/Verdict for defense ☐ Judgment/Verdict for plaintiff

   If closed, date closed (mm/dd/yyyy):

| | | |
|---|---|---|
| Amount reserved for you: | Indemnity: $ | Defense: $ |
| Amount reserved for other defendants: | Indemnity: $ | Defense: $ |
| Amount paid on your behalf: | Indemnity: $ | Defense: $ |
| Amount paid on behalf of other defendants: | Indemnity: $ | Defense: $ |

6. Has there been a change in practice as a result of this claim, suit, or incident? ☐ Yes ☐ No If yes, explain below:

*I understand this information is part of my Application.*

Signature Printed Name Date (mm/dd/yyyy)