NORCAL MUTUAL®

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APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

ENTITY/ORGANIZATION

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

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.

☐ In addition to a completed application, please provide the following items:

- A copy of the Entity's/Organization's letterhead(s).
- Loss runs for the past 10 years.
- A copy of the Declarations page and endorsements from Entity's/Organization's most recent insurance policy.
- Articles of Incorporation or Partnership agreement.

☐ If the Entity/Organization employs, independently contracts with or otherwise maintains an association with health care professionals and desires coverage for them, a separate application is required.

☐ 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: ENTITY/ORGANIZATION INFORMATION

GENERAL INFORMATION

Entity/Organization Name				Federal Tax ID #
Authorized Representative for Insurance Matters: Name Email Address		Title 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

ENTITY DESCRIPTION

1. Type of Entity/Organization (Check all that apply):

   ☐ Professional Corporation ☐ Multi-Shareholder Corporation ☐ Limited Liability Company
   ☐ Partnership ☐ Non-Profit Organization ☐ Other (describe):

2. When was this Entity/Organization established or incorporated?

3. Do you practice under an unincorporated trade name (DBA or fictitious name)? ☐ Yes ☐ No

   If yes, please provide the name(s):

4. Are there any subsidiaries of this Entity/Organization that are involved in the delivery of health care or professional medical services to patients with a direct professional provider relationship? ☐ Yes ☐ No

   If yes, please describe below.

Subsidiary Name	Description	% of Ownership	Coverage Desired?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

5. Does the Entity/Organization have an Ambulatory Surgery Center (ASC)? ☐ Yes ☐ No

   If yes, please complete the following questions:

   a. Is the facility open to physicians not employed by the group? ☐ Yes ☐ No

   b. Does your recovery room have a dedicated nurse? ☐ Yes ☐ No

   c. What is the time in minutes to the nearest fully equipped hospital?

SECTION II: COVERAGE INFORMATION

COVERAGE DESIRED

1. 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

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

COVERAGE HISTORY

2. List below the professional liability insurance history of this Entity/Organization for the past 10 years, beginning with the most recent. Please include periods covered by a self-insurance program, governmental program, or no coverage. Use the Remarks Section if you need more space.

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

3. Does the Entity/Organization provide services covered by another professional liability policy? ☐ Yes ☐ No

   If yes, please provide proof of coverage and details of those services.

SECTION III: PRACTICE LOCATIONS

1. List all current practice locations. Use the Remarks section if you need more space.

Practice Name	**Location** (City, State, Zip)	**Description**	**% of Practice**

SECTION IV: MEDICAL STAFF

1. Do you currently employ, independently contract, or otherwise maintain an association with any other health care professionals?
   ☐ 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

2. Please identify below all health care professionals, including health care extenders, whom you are requesting to be insured under the Entity's/Organization's professional liability insurance; or attach a separate roster providing the following information.

Name	**Specialty**	**License #**	**State**	**Hours** (per week)	**Retroactive Date** (mm/dd/yyyy)	**Limit Type**
						☐ Shared ☐ Separate
						☐ Shared ☐ Separate
						☐ Shared ☐ Separate

3. Please provide the coverage information below for all health care professionals 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** (mm/dd/yyyy)
				☐ Employed ☐ Supervise ☐ Contracted ☐ Other:	
				☐ Employed ☐ Supervise ☐ Contracted ☐ Other:	
				☐ Employed ☐ Supervise ☐ Contracted ☐ Other:	

4. Has the number of the Entity's/Organization's physicians changed in the past year? ☐ Yes ☐ No

   If yes, provide an explanation or attach a historical roster.

SECTION V: MEDICAL DIRECTOR(S) AND RISK MANAGEMENT

1. Who is the Medical Director for the Entity/Organization?
2. Do other Entity/Organization personnel have medical director responsibilities? ☐ Yes ☐ No

   If yes, identify the personnel and provide details:

3. Does the Entity/Organization have a dedicated Risk Manager? ☐ Yes ☐ No

   Name: Title:
4. Is the Entity/Organization or any of its facilities certified or accredited by any of the following? ☐ Yes* ☐ No

   ASC Accreditation: ☐ AAHC ☐ ARC ☐ CAP ☐ JCAHO ☐ Other

   *If yes, please include a copy of the most recent survey, certification, or accreditation.
5. Does the Entity/Organization have a Peer Review Committee? ☐ Yes ☐ No
6. Does the Entity/Organization ever enter into arbitration or similar agreements with its patients? ☐ Yes ☐ No

   If yes, attach a copy of the agreement(s).
7. Does all biomedical equipment receive scheduled preventative maintenance annually by a qualified technician? ☐ Yes ☐ No

SECTION VI: CLAIMS INFORMATION

1. Within the past 10 years, has any claim or suit for alleged malpractice ever been brought against the Entity/Organization or its personal (EOP), 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 the Entity's/Organization's 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 the Entity's/Organization's medical professional liability insurance ever been surcharged, reduced, or issued with a deductible or other special terms? ☐ Yes ☐ No
3. Have any of the Entity's/Organization's personnel ever been charged or convicted of any crime other than minor traffic violations? ☐ Yes ☐ No
4. Has the Entity's/Organization's or any of its personnel's membership of any Professional Association or Society ever been refused, revoked, or limited in any way? ☐ Yes ☐ No

5. Has the Entity/Organization or any of its personnel ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society? ☐ Yes ☐ No

6. During the past year, have any of the Entity's/Organization's personnel incurred or become aware of having an illness or physical disability that impairs, or could impair, their ability to practice their medical specialty? ☐ Yes ☐ No

   If yes, a statement from their physician attesting to their fitness to practice their specialty must accompany this application.

7. Have any of the Entity's/Organization's personnel 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.

8. Have any of the Entity's/Organization's personnel ever been accused of sexual misconduct? ☐ Yes ☐ No

9. Have any of the Entity's/Organization's personnel ever had any contact of a sexual nature with a patient or former patient? ☐ Yes ☐ No

10. Do you know of any individual who works on behalf of the Entity/Organization that has a prior history or propensity for sexual misconduct? ☐ Yes ☐ No

11. Have any of the Entity's/Organization's personnel treated or will they treat celebrities or professional athletes? ☐ Yes ☐ No

12. Have any of the Entity's/Organization's personnel practiced or will they practice at a prison, correctional facility, or other similar facility, or have they provided or will they provide health care services to prisoners or inmates? ☐ Yes ☐ No

13. Does the Entity/Organization or any of its personnel enter into arbitration or similar agreements with patients? ☐ Yes ☐ No

    If yes, please attach a copy of the agreement(s).

14. Do any of the Entity's/Organization's personnel participate in clinical trials? ☐ Yes ☐ No

    If yes, please complete our clinical trials questionnaire.

15. Do any of the Entity's/Organization's personnel 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 that I make in this application that The Company relies on to its detriment could void coverage to which I would otherwise be entitled under any policy issued in reliance on the material misrepresentation in this application. 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.

New Hampshire Applicants:

Concealment, misrepresentation, or fraud will not void an entire policy because coverage will not be denied to any innocent co-insured.

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)