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NORCAL Insurance Company

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

HEALTH CARE EXTENDERS

Important Notice: This application is for claims-made and reported coverage. Please read the entire policy carefully. The application 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 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.

- 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 V, 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 current Curriculum Vitae (CV).

SECTION I: ENTITY/ORGANIZATION INFORMATION

GENERAL INFORMATION

First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	DEA License #	FEIN License #	☐ Male ☐ Female
Name of NORCAL Insured Entity/Organization/Physician		Relationship: ☐ Employee ☐ Independent Contractor ☐ Other:	
National Provider Identification (NPI) Number			
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

HEALTH CARE PROFESSIONAL LICENSE

State	License #	Expiration Date	% of Practice	Status of Licensure
				☐ 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 reported 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.			
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

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: 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
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No

SECTION III: SPECIALTY AND PRACTICE INFORMATION

SPECIALTY INFORMATION

1. Please indicate your specialty below:
   ☐ Certified Registered Nurse Anesthetist (CRNA) ☐ Midwife ☐ Nurse Practitioner
   ☐ Optometrist ☐ Perfusionist ☐ Physician Assistant
   ☐ Radiology Assistant ☐ Surgical Assistant ☐ Other:
2. Do you perform any procedures other than incisions of boils, cysts, circumcisions (newborns), or other superficial abscesses or suturing minor lacerations?
   ☐ Yes ☐ No

If yes, please list the procedures:

3. Do you have a collaborative agreement?
   ☐ Yes ☐ No Physician Name:
   If yes, please attach a copy of the agreement.

PRACTICE INFORMATION

4. Do you practice, or have practiced in the past 5 years, at any locations other than the primary office location listed previously?
   ☐ Yes ☐ No

Practice Name	Location (city, state, zip)	Hours (per week)	Start (mm/dd/yyyy)	Complete (mm/dd/yyyy)	Coverage Desired?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

5. Do you or will you work in an operating room?
   ☐ Yes ☐ No
   If yes, in what capacity?
   ☐ Observe Only ☐ Assist ☐ Other:
6. Do you or will you work in a labor and delivery room or birthing center?
   ☐ Yes ☐ No
   If yes, in what capacity?
   ☐ Observe Only ☐ Assist ☐ Other:
7. Have you seen or will you see patients in a nursing home?
   ☐ Yes ☐ No Hours per week:
   If yes, please explain:

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 ☐ Courtesy ☐ Other:	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No

		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No

*Comments

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, Claims Information.

	School/Facility	Location	Complete Date (mm/dd/yyyy)	Degree/Program
Professional School				
Additional Training				
Additional Training				

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

SECTION V: 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 VI: 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 license to practice as a health care professional or DEA license revoked, limited, refused, suspended, or denied?
   ☐ Yes ☐ No
5. Have your hospital privileges ever been surrendered, limited, or revoked, whether voluntarily or involuntarily?
   ☐ Yes ☐ No
6. Have your hospital privileges been expanded or reduced in the last 12 months?
   ☐ Yes ☐ No
7. Has your membership in any Professional Association or Society ever been refused, revoked, or limited in any way?
   ☐ Yes ☐ No
8. Have you ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society?
   ☐ Yes ☐ No
9. 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.
10. 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.
11. Have you ever been accused of sexual misconduct?
    ☐ Yes ☐ No
12. Have you ever had any contact of a sexual nature with a patient or former patient?
    ☐ Yes ☐ No
13. Do you know of any individual who works on your behalf that has a prior history or propensity for sexual misconduct?
    ☐ Yes ☐ No
14. Have you treated or will you treat celebrities or professional athletes?
    ☐ Yes ☐ No
15. 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
16. Do you enter into arbitration or similar agreements with your patients?
    ☐ Yes ☐ No
    If yes, please attach a copy of the agreement(s).
17. Do you participate in clinical trials?
    ☐ Yes ☐ No
    If yes, please complete our clinical trials questionnaire.

18. 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, as a condition precedent to approval for coverage, NORCAL Insurance Company, any of its subsidiaries or affiliates, or anyone acting on its or their behalf (collectively, "NORCAL") may perform a detailed inquiry and/or investigation of any applicant's background, training, experience, and qualifications by any legal means and I consent to any such inquiry and/or investigation. In addition, I understand that third-party information, records, or data regarding the applicant's practices, medical procedures, and/or prescribing practices may be used for informational or underwriting purposes. I authorize any individual or entity to which such inquiry and/or investigation is made to provide NORCAL or anyone acting on its behalf with all information within its possession or under its control that pertains to the applicant's background, training, experience, practices, procedures, and qualifications. I release and discharge any such individual or entity, including any such individual or entity's agents and representatives, from any and all liability that might arise out of any such inquiry and/or investigation.

I understand that all information provided by me or on my behalf as part of the application process is considered important and that it will be relied upon by NORCAL in the issuance of the coverage applied for herein and/or the calculation of the premium charged for the same. All information provided as part of the application process will be deemed attached to and made a part of the policy. I also understand that the policy could be void in its entirety or with respect to any Insured if any Insured: (1) attempts to defraud NORCAL or (2) conceals or misrepresents a material fact concerning such information or the risk insured. In addition, I understand that coverage for any claim; suit; or administrative, disciplinary, regulatory, or other type of proceeding may be unavailable if the circumstances for such claim; suit, or administrative, disciplinary, regulatory, or other type of proceeding were known before the effective date of coverage under any policy of insurance that may be issued by NORCAL. I understand that I must notify NORCAL immediately, in writing, of any changes in the information previously provided by me or on my behalf and that NORCAL may withdraw or modify any outstanding quotation(s) or authorization(s) or agreement(s) to bind insurance.

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

I represent and warrant that the foregoing statements contained in this application and any supplemental information are accurate, true, and complete. I also represent and warrant that I have not withheld any requested information.

I have read the fraud statement, and the state-specific notice(s), if any, applicable to the applicant on the attached State-Specific Notices Supplemental.

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 if 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 ☐ Judgement/Verdict for defense
   ☐ Judgement/Verdict for defense If closed, date closed (mm/dd/yyyy): _____
   Amount reserved for you: _____ Indemnity: $_____ Defense: $_____
   Amount reserved for other defendants : _____ Indemnity: $_____ Defense: $_____
   Amount reserved 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, please explain:

I understand this information is part of my Application.

Signature Printed Name Date (mm/dd/yyyy)