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APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

MEMBERS OF LARGE GROUPS

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 INSURANCE 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.

☐ A copy of your current Curriculum Vitae (CV).

☐ Please download and print the NORCAL Insurance Business Associate Agreement at http://www.norcal-group.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 Insurance 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.

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 ☐ No	☐ Yes ☐ No
Sub Specialty			☐ Yes ☐ No	☐ Yes ☐ 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.

SECTION IV: CLAIMS INFORMATION

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:

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

If yes, please explain:

SECTION V: 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 your membership in 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 attach 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 Insurance (The Company).

I understand that the NORCAL Insurance 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.

Pennsylvania Applicants: 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.

Applicant Signature

Date (mm/dd/yyyy)

Printed Name

Title

This application is not valid without your complete signature.