ProAssurance NORCAL GROUP

NORCAL Insurance Company

RENEWAL APPLICATION

INDIVIDUAL HEALTH CARE PROFESSIONAL

Please review and update the information below to reflect the current practice information for which coverage is requested. Any planned changes to your current practice must be included in your responses below along with proposed dates for those changes. Any practice changes indicated below that require a change to your policy, but that you have already made, will be changed as of the date this application is signed. ***If the application is not completed and returned, then your coverage may be subject to underwriting action.***

GENERAL INFORMATION

Insured Name: Policy#:

Agency: Producer:

Primary Phone:

Email Address:

Mailing Address: Billing Address: (if different than mailing)

Authorized Representative for Insurance Matters

Name: Title:

Email Address:

By providing your email address, you are agreeing to us contacting you via email to obtain follow-up information, if necessary.

Scope of Coverage:

Are you requesting coverage for your entire medical or health care practice as described in this application? Yes No

If no, in the Remarks Section please provide a detailed description of that part of the practice for which you are not requesting coverage, including confirmation of insurance you carry with another company for that portion of your practice.

Practice Location(s) For Which Coverage Is Required:

Practice Location Address	Percent of Practice *(Must total 100%)*

Insured Health Care Professionals

1. Insured Health Care Professionals
   a. Verify name, retroactive date, limit, and specialty information for all health care professionals listed below, who are active insureds on the policy.
   b. Add or delete health care professionals, if applicable. If you are requesting to add any health care professional, then in addition to providing the other information requested below, please provide the first practice date with the group or entity under the retroactive date column. An Application may be required before coverage is bound for any new health care professional; the first practice date will be the retroactive date unless otherwise requested and approved. If deleting, then provide the last date that the health care professional provided patient care on behalf of the group or entity under the total weekly practice hours column; the cancellation will be effective at 12:01 AM on the following day.
   c. Provide Average Weekly Patient Load and Total Weekly Practice Hours for each professional. (Hours include office hours, treating patients, charting, and consulting)

Insured	DOB	License	Retro date	Limits	Specialty	Practice County	Weekly Pt load	Weekly Practice Hours

Do you employ, independently contract with, supervise, or otherwise maintain an association with other health care professionals that are not listed above who provide patient care? If Yes, please use the free space in the chart above to enter the information, including the proposed effective date under the retro date column. An Application may be required before coverage is bound for any new health care professional; the proposed effective date will be the retroactive date unless otherwise requested and approved. Yes No

ENTITY/ORGANIZATION INFORMATION

The following entity(ies)/organization(s) are currently included as insureds on the policy identified on page 1. If you want to modify any of these listed entity(ies)/organization(s), or add a new one, then please indicate these changes, including the effective date for each modification or addition, in the Comments column.

Entity/Organization	Comments

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SPECIALTY AND PRACTICE INFORMATION

1. 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.
2. Please check each procedure or activity that you perform or render:
   If Not Applicable please check ☐ "N/A" Not applicable

   - ☐ Abortion – Beyond 1st Trimester
   - ☐ Addiction Medicine
   - ☐ Cryosurgery (Internal Lesions)
   - ☐ Fertility/Infertility Treatment
   - ☐ Hair Restoration Surgery
   - ☐ Liposuction/Lipoinjection
   - ☐ Pain Management
     Interventional ______%
     Non Interventional ______%
   - ☐ Needle Biopsy
     - ☐ Brain
     - ☐ Spine
     - ☐ Pancreas
     - ☐ Other
   - ☐ Prenatal Care – Beyond 1st Trimester
   - ☐ Radiology – Interventional
   - ☐ Skin Flaps/Grafts
   - ☐ Spinal Stimulators
   - ☐ Tubal Ligation
   - ☐ Vasectomy
   - ☐ Wound Care / Surgical Debridement
   - ☐ Prolotherapy
   - ☐ Stem Cell Therapy
   - ☐ Weight Loss ______% of practice
3. If you are not a plastic surgeon, dermatologist, ophthalmologist, or otolaryngologist, please answer (a) and (b) below:
   a. Do you perform aesthetic or cosmetic procedures? ☐Yes ☐No
   If yes, please list these procedures and provide proof of training:

   ____

   ____

   b. Do you supervise other individuals outside of your own practice who perform aesthetic or cosmetic procedures?
   ☐Yes ☐No
   If yes, please list these individual, procedures and indicate your professional association with them:

   ____

   ____
4. Do you currently have admitting privileges? ☐Yes ☐No
   If you do not or will not have admitting privileges, please describe your procedure for handling patients who may require immediate in-patient care.
5. Do you provide telemedicine/telehealth services? ☐Yes ☐No
   For purposes of this response, telemedicine is any type of patient care that involves telecommunication: video-

conferencing, transmission of still images and other data, e-health (patient portals, websites), m-health (mobile healthcare service), remote monitoring and medical call centers. In the Remarks Section, please include the state in which the patients are located, the percentage of practice for each state, and confirmation of licensure in the state.

6. Do you provide medical or health care professional services at any skilled nursing facility to patients other than your own? ☐Yes ☐No
7. Do you have any medical director, management or similar responsibilities at or on behalf of any entity(ies)/ organization(s) that are not an Insured under this policy? ☐Yes ☐No
8. Do you provide medical services or health care professional services to celebrities or professional athletes that make up more than 10% of the practice? ☐Yes ☐No
9. Do you provide medical or health care professional services at a prison, correctional facility, or other similar facility? ☐Yes ☐No
10. Do you manage any clinical trials that are not approved by an Institutional Review Board (IRB), and/or are not within your scope of training? ☐Yes ☐No
11. Do you use, administer, or prescribe any drug, pharmaceutical, or medical device disapproved or not yet approved by the United States Food and Drug Administration to treat human beings? ☐Yes ☐No

For each Yes response to questions 1 – 11 please provide additional information including, but not limited to, a description of the practice and the percentage dedicated to this portion of your overall practice in the Remarks Section.

ADDITIONAL INFORMATION

1. Have you ever been charged with, been convicted of, or plead guilty to a crime other than a minor traffic violation? ☐Yes ☐No
2. Has your license, certification, registration, or other authorization to provide medical or health care services ever been voluntarily or involuntarily suspended, put on probation, or restricted, or have you ever been denied such a license, certification, registration, or other authorization? ☐Yes ☐No
3. Have your medical staff membership or clinical privileges ever been voluntarily or involuntarily suspended, put on probation, or restricted? ☐Yes ☐No
4. Are you aware of any physical or mental impairment or illness, or any substance abuse problem that impairs, or could reasonably be expected to impair, your ability to practice as a health care professional? ☐Yes ☐No
   If yes, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.
5. Have you ever been treated for any substance abuse problems? ☐Yes ☐No
   If yes, please provide the details of the rehabilitation program including dates of treatment.
6. Have you been accused of sexual misconduct, as that term is defined in the policy? ☐Yes ☐No
7. Has any claim; suit; or administrative, disciplinary, regulatory, or other type of proceeding been brought against you that has not yet been reported under any insurance, self-insurance arrangement or trust, or risk transfer instrument of any kind? ☐Yes ☐No
8. Are you aware of any fact, circumstance, incident act, error, omission, breach of duty, inquiry, investigation, request for medical records, adverse patient outcome, or other matter, whether actual or alleged, that may reasonably give rise to or be the basis of a claim, suit, or other event specified in Question 7? ☐Yes ☐No

For each **Yes** response to questions 1 – 8, please provide additional information in the Remarks Section.

Remarks Section

AGREEMENTS & 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 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, 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 or investigation.

I understand that all information provided by me or on my behalf as part of the application process is considered material and important and 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 that 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.

Insured Signature

Date

Insured Printed Name

Please mail, email, or fax the completed application to:
NORCAL Insurance Company | [100 Brookwood Pl | Birmingham, AL 35209 844.4NORCAL customerservice@norcal-group.com