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NORCAL Insurance Company

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

ENTITY/ORGANIZATION

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.

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 the Entity's/Organization's most recent insurance policy.
- Articles of Incorporation of 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.

SECTION I: ENTITY/ORGANIZATION INFORMATION

GENERAL INFORMATION

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

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

1. 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
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No

2. 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 personnel (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 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, 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 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 that the foregoing statements contained in this application and any supplemental information are accurate, true, and complete. I also represent 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)