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NORCAL Insurance Company

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

MEMBERS OF LARGE GROUPS

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

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).

SECTION I: ENTITY/ORGANIZATION 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
National Provider Identification (NPI) Number			

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 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	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 choose 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; 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
☐ Cardiac Catheterization
☐ Chelation Therapy
☐ Cryosurgery (non-external lesions)
☐ D&C
☐ Dermatology Procedures
  ☐ Chemabrasion/Dermabrasion
  ☐ Chemical Peels
    ☐ Deep ☐ Superficial Only
  ☐ Hair Transplant
  ☐ Liposuction/Lipoinjection
  ☐ Silicone Injections
  ☐ Skin Flaps/Grafts
☐ 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
☐ 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

☐ 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
- ☐ Medication Only
- ☐ Nerve Block (Spinal, Paraspinal) Paravertebral, Epidural)

☐ Radiofrequency Procedures
- ☐ Spinal Stimulators

☐ Permanent Pacemakers
☐ Plastics
- ☐ Reconstructive % of Practice:_____
- ☐ Cosmetic % of Practice:_____

☐ Prolotherapy
☐ Radiology
- ☐ Interventional
- ☐ Radiopaque Dye

☐ Renal Dialysis
☐ Scleotherapy
☐ Spinal Surgery
☐ Thoracic Surgery % of Practice:_____
☐ Tonsillectomy/Adenoidectomy
☐ Transgender Surgery
☐ Trauma Surgery % of Practice:_____
☐ Tubal Litigations
☐ 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

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 with 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 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 ever 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
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 individuals 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 of 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, 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.