



Agency/Broker: _____

Address: _____

Application for Coverage – Ancillary

This application is for claims made coverage. Please read the policy carefully.

I. Employer Information

Name of Employer _____

Office Address

Street _____ City _____ County _____ State _____ Zip Code _____

Office Phone: _____ Office Fax: _____ Office E-mail: _____

Location (s) at which you practice other than above: _____

Website(s): _____

II. Ancillary Information

Full Name

First

Middle

Last

Professional Designation:

CNM CRNA DPM LPN NP OD OT PA PhD PT RN

Profession

Specialty:

Certified Registered Nurse Anesthetist Nurse Practitioner Other _____
 Nurse Midwife Surgeons Assistant
 Physicians Assistant Psychologists

Home Address

Street _____ City _____ County _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Which is best way to contact you? Home Office Cell Phone

Date of Birth: _____ Social Security Number: _____

III. Limits of Liability

Shared Limits Separate Limits Same as Employer

Texas Only: \$200,000/\$600,000 \$500,000/\$1,000,000 \$1,000,000/\$3,000,000

Kansas Only: \$200,000/\$600,000

Indiana Only: \$250,000/\$750,000 \$1,000,000/\$3,000,000

Nebraska Only: \$500,000/\$1,000,000

Remainder of States: \$1,000,000/\$3,000,000

Requested Effective Date: _____ Requested Retroactive Date: _____

Are you purchasing tail coverage from your current carrier? Y N If yes, please provide Medicus with a copy.



IV. Medical Licensure

State: _____
License #: _____
Expiration Date: _____

State: _____
License #: _____
Expiration Date: _____

DEA License Number: _____

Have you ever had your license revoked, limited, refused, suspended or denied? Y N

If yes, give details _____

Please provide a copy of licensure and/ or certification.

V. Education/Training

School/ Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Degree: _____

VI. Certification

Certification(s) held: _____ Year _____ Recertified _____

Are you a member of an affiliated professional organization? Yes No

If so, please indicate _____

VII. Current Practices

Average number of hours worked per week? _____

Average number of patients seen per week? _____

VIII. Previous Insurance – Please provide ten (10) years of previous insurance information

Current Carrier	Effective Date _____	Limit of Liability _____
	Expiration Date _____	Type of Coverage _____
	Retroactive Date _____	Premium _____

IX. Claims Information

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? Y N

If yes, please complete a claim supplemental for each claim and provide prior carriers loss history.

Total Number of Claims: _____ Open/Reserved: _____ Closed: _____

Any change in your practice as a result of claims? _____



X. Additional Background

Do you moonlight (work outside control of employer)? Yes No If yes, where _____

Have you ever (check all that apply):

- Had your license or certification investigated, suspended, revoked, restricted or placed under probation in any state?
- Had your professional liability insurance declined, suspended, non-renewed or canceled? *(Not Applicable to Missouri Applicants.)*
- Had any complaints filed against you with a hospital, regulatory or certifying authority?
- Been treated or hospitalized for mental or emotional disorder?
- Been charged with or convicted of a felony or misdemeanor other than minor traffic violations?
- Been treated for (or recommended treatment for) alcoholism, sexual or drug addiction?

Do you treat patients at a nursing home, assisted living facility, jail or correctional facility? Yes No

Do you perform any cosmetic procedures? Yes No

If yes, to any of the above, please explain. If necessary please give details on additional sheet.

Warranty

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by Medicus Insurance Company (Company) as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations.

Further, I acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which 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.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

Acknowledged and Agreed:

Applicant Signature

Date

Signing this application does not bind the Company to complete the insurance. All information requested in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.



Fraud Warnings:

General Fraud Statement (not applicable in Arizona, Colorado, Georgia, Hawaii, Kansas, Kentucky, Nebraska, North Carolina, Ohio, Oklahoma, Oregon, Texas, Utah, Vermont and West Virginia)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia insurance benefits may also be denied.

Notice to Arizona and Oregon Applicants: All Statements and descriptions in any application for an insurance policy or in negotiations therefore, by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy unless: 1. Fraudulent; 2. Material either to the acceptance of the risk, or to the hazard assumed by the insured; 3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

Notice to Colorado Applicants: This Notice is A Part of Your Application for Professional Liability Insurance: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Georgia, Nebraska, North Carolina, and West Virginia Applicants: By statute, warranties are deemed representations.

Notice to Hawaii Applicants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Kansas Applicants: By statute, warranties are deemed representations. The definition of fraud is found in and complies with K.S.A. 40-2, 118.

Notice to Kentucky Applicants: By statute, warranties are deemed representations. Misrepresentations, omissions, and incorrect statements shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent; or 2) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required by the application for the policy.

Notice to Ohio Applicants: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Notice to Texas Applicants: Pursuant to Chapter 705 of the Texas Insurance Code, the company may void the policy only in the event of material misrepresentations in the application, and it must be shown at trial that such misrepresentations were material.

Notice to Utah Applicants: For your protection, Utah law requires the following to be included in this application: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature _____

Date _____

Printed Name _____

Title _____

This application is not valid without your complete signature, date, printed name, and title above.



Medicus Insurance Company SUPPLEMENT TO APPLICATION CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ Male Female

2. Date of Incident _____ Location of Incident _____
Insurance Carrier _____ Date Reported to Insurer _____

Suit Demand for Money Incident Only
 Notice of Intent to Sue Request for Records Other _____

3. Summary of condition/diagnosis at time of incident

4. Description of treatment rendered, including dates.

5. Allegation

6. Other physicians or entities involved

7. Status/Disposition of Claim:

- Closed without indemnity payment
 Settled
 Judgment/Verdict
 For the defense
 For the plaintiff

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendant(s)	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

Open—please provide current status and defense strategy: _____

8. Has there been a change in practice as a result of this claim(s)? Yes No

If yes, what has been the change? _____

I understand this information is part of my Application for Physician/Surgeon Medical Professional Liability Insurance.

Please print your name _____

Signature _____ Date _____