



Agency/Broker: _____

Address: _____

Corporate Application Non-Assessable Claims Made Coverage-Please read the policy carefully.

I. Organization Name _____ Federal Tax ID # : _____

Authorized Representative for Insurance Matters:

Name: _____ Title: _____ Phone: _____

II. Address

Office Address

Street _____ City _____ County _____ State _____ Zip Code _____

Phone: _____ E-mail: _____

Website(s): _____ Fax: _____

Which is best way to contact you? Phone Email Fax Other: _____

Billing Address-If same as Office Address, check here:

Street _____ City _____ County _____ State _____ Zip Code _____

Phone: _____ Fax: _____ E-mail: _____

III. Corporation Information

Name of Practice Manager _____ Phone Number _____

Type of Corporation: Professional Corporation Partnership Limited Liability Company
 Multi-Shareholder Corporation Non-Profit Organization Other (Describe)

Is there any other name under which you practice (i.e. DBA)? _____

Is your corporation requesting Shared or Separate Limits? _____

IV. Limits of Liability – Please check the limit you are requesting:

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.

V. Practice Information



List all current Practice Locations: (If more than 3, please attach information on a separate sheet of paper)

Location 1:

Office Name _____ Office Manager: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Location 2:

Office Name _____ Office Manager: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Location 3:

Office Name _____ Office Manager: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

VI. Medical Staff

Do you employ/contract/supervise any of the following personnel? Indicate the number of the following non-physician healthcare providers utilized by you or your group? Employ Contract Supervise N/A

| | | | | | | | |
|------------------------|--|-----------------------|--|------------------------|--|-----------------------|--|
| Other Physicians | | CRNA | | CNM | | Laboratory Technician | |
| Interns | | Nurse Practitioner | | Occupational Therapist | | Optician | |
| Residents | | Optometrist | | Orthodontist | | Pharmacist | |
| Fellows | | Physical Therapist | | Physician's Assistant | | Podiatrist | |
| Psychologist | | Respiratory Therapist | | Speech Therapist | | Social Worker | |
| Audiologist/Udiologist | | X-Ray Technician | | Other (please explain) | | | |

Are you requesting the above to be covered by Medicus Insurance Company? Y N
 If yes, should the ancillary be covered on a shared or separate limit of liability? _____

Are any of the above ancillary staff independent contractors? Y N
 If yes, please provide declarations page or certificate of insurance.

Does any of the ancillary staff have his/her own coverage? Y N
 If yes, please provide their declarations page or certificate of insurance to verify coverage.

VII. Practice Profile Questions – If needed, please attach information on a separate sheet of paper.

A. Has the Applicant's professional liability insurance ever been cancelled for non-payment of premium? Y N
 If yes, please describe. _____

B. Has the Applicant's professional liability insurance ever been declined, canceled, non-renewed or issued on special terms (Not Applicable for Missouri Applicants)? Y N
 If yes, please describe. _____

C. Does the Applicant through its employed physicians treat or intend to treat any patient by means of unconventional therapy which may be considered human experimentation, or conceivably be subject to regulatory approval? Y N
 If yes, please identify the physicians involved and provide details. _____

VII. Practice Profile Questions (continued) – If needed, please attach information on a separate sheet of paper.

- D.** Does the Applicant contract with any government facility including prison or correctional facilities? Y N
If yes, please identify the government agency, facility type and the relationship. _____
- E.** Does the Applicant ever enter into arbitration or similar agreements with your patients? Y N
If yes, please attach a copy of the agreement(s). _____
- F.** Does the Applicant own a subsidiary(ies)? Y N
If yes, disclose that subsidiary here and indicate its type of organization. _____
- G.** Has the Applicant or any of its employees ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital, or professional association? Y N
If yes, please identify the physicians involved and provide details. _____
- H.** Has the Applicant or any of its employees ever been indicted for, or convicted of any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges or medical licenses revoked, suspended, restricted, placed on probation, or voluntarily surrendered? Y N
If yes, please identify the physicians involved and provide details. _____
- I.** Has the Applicant or any of its employees ever filed for bankruptcy? Y N
If yes, please identify the physicians involved and provide details. _____
- J.** Does the Applicant maintain current certificates of insurance on file for all doctors and allied healthcare providers employed, contracted, or privileged at its facility(ies)? Y N
- K.** Does all biomedical equipment receive scheduled preventative maintenance annually by a qualified technician? Y N
If yes, is your biomedical equipment checked by your employees on a routine basis? Y N
If yes, are these check logs maintained in your practice? Y N
- L.** Is the entity certified or accredited by any of the following? AAAHC ARC CAP JCAHO Other (include a copy of the most recent survey, certification, or accreditation).
- M.** Does the Applicant have an Ambulatory Surgery Center? Y N
If yes, is the facility accredited? Y N
ASC Accreditation: JCAHO AAAHC Other _____
Does your recovery room provide for a dedicated nurse? Y N
What is the time in minutes to the nearest fully-equipped hospital? _____
- N.** Do you have a peer review committee? Y N
- O.** Does the Applicant obtain Certificates of Insurance from your independent contractors? Y N
- P.** Who is the Medical Director for the Group? _____
- Q.** Do any of the Group members have any other medical director responsibilities? Y N
If yes, please identify the physicians involved and provide details. _____
- R.** Does the Group perform activities covered by another professional liability policy? Y N
If yes, please provide proof of coverage, including name and address of entity. _____
- S.** Are informed consent forms used? Y N
- T.** Is the Medical Group a member of a national organization? MGMA AGPA Other _____
- U.** Has the Group ever been suspended by any government health program (e.g. Medicare or Medicaid)? Y N
If yes, please provide details below. _____
- V.** Has any Physician, patient, or insurance plan ever filed a complaint against the group with any medical association, society or foundation, consumer protection agency, chamber of commerce, or better business bureau? Y N
If yes, please provide details. _____



VII. Practice Profile Questions (continued) – If needed, please attach information on a separate sheet of paper.

W. Has the Group, its Physicians, or other employees ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency, or have its licenses to practice or its narcotics license ever been denied, revoked, suspended, or limited in any way? Y N

If yes, please provide copies of complaint and disposition documents. _____

X. Did you practice with other physicians in an employer-employee relationship, implied or formal partnership, professional association or Medical Corporation during the period for which you are requesting prior acts coverage? Y N

If yes, please list the full name of the entity(ies)/physician(s) with whom you practiced and the period of each such association.

| Name of Entity | Name of Physician | Dates: From - To |
|----------------|-------------------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Y. Please identify all Physicians and/or Ancillary personnel that will be insured under the Group's professional liability insurance program: If you have additional personnel, please attach information on a separate sheet of paper.

1. Name: _____ Specialty: _____ Date of Birth: _____

Medical Board License #: _____ State: _____ #Hrs/wk: _____ Retroactive Date: _____

2. Name: _____ Specialty: _____ Date of Birth: _____

Medical Board License #: _____ State: _____ #Hrs/wk: _____ Retroactive Date: _____

3. Name: _____ Specialty: _____ Date of Birth: _____

Medical Board License #: _____ State: _____ #Hrs/wk: _____ Retroactive Date: _____

4. Name: _____ Specialty: _____ Date of Birth: _____

Medical Board License #: _____ State: _____ #Hrs/wk: _____ Retroactive Date: _____

5. Name: _____ Specialty: _____ Date of Birth: _____

Medical Board License #: _____ State: _____ #Hrs/wk: _____ Retroactive Date: _____

VIII. Hospital Privileges Currently Held- List where Physicians have staff or courtesy Privileges

| <u>Hospital Name</u> | <u>Location</u> | <u>Privileges</u> |
|----------------------|-----------------|-------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If you need to list more, please attach information on a separate sheet.

Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily? Y N

If yes, please give details _____

Have your hospital privileges been expanded in the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or you Specialty Board? Y N

If yes, please explain. _____



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

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

X. Claims Information

Has any claim or suit for alleged malpractice ever been brought against the organization, 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? _____

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 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 _____