

I. General Information

E. Billing and Correspondence Address:

Location # (from Question D. above) Residence Other (Please enter below)

Number & Street _____ Suite _____

City _____ State _____ Zip Code _____

II. Professional Information

Note: All percentages requested below for specialties are of your total practice.

Please enter complete name of specialty/sub-specialty and formal training program. Combined percentages for specialties must equal 100%.

A. What is your present specialty? _____ % of total practice

What is your sub-specialty? _____ % of total practice

B. Education/Training:

Name of School _____ Credentials (CRNA, OD, RN etc.) _____

State _____ Country _____

Completed from: MM / YYYY To: MM / YYYY

C. To which Healthcare Professional Societies or Associations do you belong?

D. Are you required to be licensed in the state(s) where you practice? Yes No

If yes, states in which you hold a license to practice:
(Exclude state abbreviation from license number.)

Please check the appropriate box to indicate the status of your license.

	Active	Inactive	Temporary	Pending
1. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. Have you completed a risk management education course within the last twelve (12) months? Yes No

F. Indicate the estimated average hours per week for which you require Medical Protective coverage. _____ hrs

G. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates. _____ hrs None

H. Indicate the average hours per week devoted to treating non-federal prison inmates. _____ hrs None

I. Will you be performing activities which will be covered by another professional liability policy? Yes No

If yes, are you an: Employee Independent Contractor

Practice Name: _____

Location: _____

Name of Insurer: _____

J. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Yes No

If yes, please indicate the date(s) and explain: Date MM / YYYY _____

K. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage? Yes No

If yes, please indicate the date(s) and explain: Date MM / YYYY _____

II. Professional Information (continued)

L. Have you ever been accused of sexual misconduct of any kind?

Yes No

If yes, please indicate the date(s) and explain:

Date / /
MM YYYY

M. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty?

Yes No

(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s), date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: _____

Date(s) of treatment(s):

From / To /
MM YYYY MM YYYY

Currently in treatment

Name of treating physician(s): _____

Address(es): _____

N. Please check the box that best describes your practice affiliation:

Employed Self Employed

O. Do you work for an entity or employer currently insured with The Medical Protective Company?

Yes No

If yes, answer the following:

Employment Status: Employee Shareholder/Partner Independent Contractor Other: _____

Employer/Entity name:

Please provide The Medical Protective Company individual, corporation or partnership policy number or group number:

Policy #: Group #: Sub-group #:

III. Loss Information (Important! Please fully complete.)

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below that has **NOT** been covered by a Medical Protective policy.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? None

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to, the following:

▶ Amputation ▶ Death ▶ Loss of major organ function ▶ Loss of vision ▶ Permanent neurological injury

If **yes**, how many? None

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?

If **yes**, how many? None

IV. Coverage Information

Notes:

- 1. **Claims-Made coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**
- 2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage Desired:

- Claims-Made coverage without Prior Acts coverage
- Claims-Made coverage with Prior Acts coverage
- Occurrence coverage
- Occurrence coverage with Prior Acts coverage

B. Requested Coverage Period (12:01 am):

Annual policy term will begin and end on the same month and day.

From: / / **To:** / /

MM DD YYYY MM DD YYYY

C. The retroactive date shown on your current Claims-Made policy is:

(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.)

/ /

MM DD YYYY

D. Desired Limits:

Per Occurrence/Per Claim Filed

, ,

Annual Aggregate

, ,

E. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer:

- Occurrence
- Claims-Made

From: / / **To:** / /

MM DD YYYY MM DD YYYY

2. Previous Insurer:

- Occurrence
- Claims-Made

From: / / **To:** / /

MM DD YYYY MM DD YYYY

3. Previous Insurer:

- Occurrence
- Claims-Made

From: / / **To:** / /

MM DD YYYY MM DD YYYY

F. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been or will be purchased.
- An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying for with The Medical Protective Company, if offered, will not provide Prior Acts coverage.

Initial Here

V. Assignment of Right to Cancel Coverage

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

- Yes
- No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-800-398-6726 or sending a written notice to: The Medical Protective Company, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name: _____

Street: _____ Suite: _____

City: _____

State: _____ Zip Code: _____ Phone Number: _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

The Medical Protective Company

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

A. Is the matter related to: **A** **B** **C** **from the Loss Information section? (Check only one)**

- A. Current or prior claim.
- B. Complication, incident, or adverse outcome.
- C. Written request for records.

B. Patient/Claimant Information:

Last Name

First Name

Age

C. Date of treatment and/or surgery which led, or could lead, to allegations against you.

 /
MM YYYY

D. Date of notice received, if applicable.

 /
MM YYYY

E. Has this matter been reported to your current or former insurer?

Yes No

If yes, date reported to your current or former insurer:

 /
MM YYYY

Current or former insurer name: _____

If no, please explain: _____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

G. Current status: Open Closed

If open, indicate dollar value established by insurer:

\$ _____

If closed:

1. Date of closing:

 /
MM YYYY

2. Was a payment made?

Yes No

a. If yes, did you consent to the settlement?

Yes No

b. Total amount of settlement or award:

\$ _____

c. Total amount of settlement or award paid on your behalf:

\$ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

Virginia Cap on Malpractice Damages

The amount of damages which may be awarded against you in any one legal action for medical malpractice in Virginia are limited by statute. This is called a "cap" on damages. If the legal action falls within the statutory definition, you cannot be held liable for any amount in excess of this cap.

Recognizing that costs change over time, the statutory amount of the cap has also changed and is scheduled to continue to change. Since July 1, 2008, the cap has been \$2,000,000. Under the current legislation, the cap will increase effective July 1, 2012 and each July 1 thereafter by \$50,000 per year, until the cap is gradually increased to \$3,000,000 by July 1, 2031. Please see schedule below.

July 1, 2012, through June 30, 2013	\$2.05 million
July 1, 2013, through June 30, 2014	\$2.10 million
July 1, 2014, through June 30, 2015	\$2.15 million
July 1, 2015, through June 30, 2016	\$2.20 million
July 1, 2016, through June 30, 2017	\$2.25 million
July 1, 2017, through June 30, 2018	\$2.30 million
July 1, 2018, through June 30, 2019	\$2.35 million
July 1, 2019, through June 30, 2020	\$2.40 million
July 1, 2020, through June 30, 2021	\$2.45 million
July 1, 2021, through June 30, 2022	\$2.50 million
July 1, 2022, through June 30, 2023	\$2.55 million
July 1, 2023, through June 30, 2024	\$2.60 million
July 1, 2024, through June 30, 2025	\$2.65 million
July 1, 2025, through June 30, 2026	\$2.70 million
July 1, 2026, through June 30, 2027	\$2.75 million
July 1, 2027, through June 30, 2028	\$2.80 million
July 1, 2028, through June 30, 2029	\$2.85 million
July 1, 2029, through June 30, 2030	\$2.90 million
July 1, 2030, through June 30, 2031	\$2.95 million
July 1, 2031	\$3.00 million

Most health care providers in Virginia choose to carry limits equal to or greater than the cap as a means of protecting their personal and professional assets. Recognizing this, Medical Protective offers you the option of authorizing automatic increases in your policy limits at each renewal so that your policy limits will always meet or exceed the amount of the cap. If you select this option you will not need to take any further action at each renewal to match your policy limits to the then applicable cap. (The reason your policy limits may need to exceed the amount of the cap is to accommodate increases in the cap scheduled to occur during the term of your policy, depending upon your renewal date.) In the future, you may contact Medical Protective at 800-4MEDPRO if you would like to rescind your request and authorization. **If you want your policy limits to automatically increase to accommodate increases in the amount of the statutory cap, please select the option through which you state:**

"I request and authorize Medical Protective to select the policy limits which cover the cap and to automatically increase those limits at each renewal to match increases in the amount of the cap."

If you do not want Medical Protective to automatically increase your limits to accommodate increases in the amount of the statutory cap, and want to customize the policy limits available to you, please select the option through which you state:

"I would like to choose my policy limits at each renewal."

- I request and authorize the Medical Protective to select the policy limits which cover the cap and to automatically increase those limits at each renewal to match increases in the amount of the cap:
- I would like to choose my policy limits at each renewal