Agent Name: _HPSI If previously covered with Medical Protective, please enter the policy number: _________

Agent Number: #HCPS

THE MEDICAL PROTECTIVE COMPANY

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL PROFESSIONAL LIABILITY INSURANCE APPLICATION – OCCURRENCE GROUP

APPLICATION INSTRUCTIONS

1. If additional space is needed, please complete Section IX. Supplemental Information with a reference to the question.
2. Please complete this Application for each entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture or any applicant for which you are requesting Medical Protective Company coverage.
3. The Supplemental Specialty Application must also be completed and submitted with this Entity application. Additional documentation may be requested by the Company as necessary. For example: Articles of Incorporation, Declaration Page, copy of your most recent entity professional liability policy (including all endorsements), etc.
4. Please print legibly and answer all questions; if a question is not applicable, state "N/A".

I. ORGANIZATION INFORMATION

GROUP APPLICANTS/INDIVIDUALS WITH A CORPORATION OR PARTNERSHIP

A. Please check all that apply:

□ Professional Corporation: sole shareholder □ Professional Corporation: multiple shareholders

□ Partnership or Professional Association □ Other, please explain: ______________________________

□ Limited Liability Company (LLC)/Partnership (LLP)

B. ______________________________ ______________

Name of Group Applicant/Organization Entity Name (As stated in the Articles of Incorporation.) **State of Incorporation**

______________ ______________ _____ / ________

Federal Tax I.D. Number **National Provider Number** (optional) **Date Entity Formed** (MM/YYYY)

C. ______________________________

If the entity does business under any other name, list additional entity/clinic name(s), Doing Business As ("DBA"), fictitious name, etc.

D. Is this entity joining a current Medical Protective Insured's Policy? □ Yes □ No

If Yes, please provide the **Policy Number**: ____________________

E. If you are an owner of the entity identified in Question B. above, do you desire coverage for this entity? □ Yes □ No

F. If this group/entity has a web address, please provide the website address (URL): ______________________________

G. If we need to contact the group/entity for additional information, please indicate the primary contact name and preferred method of contact:

______________________________ ______________

Primary Contact Name (Last Name, First Name, Middle Name, Suffix) Title

□ Email Address: ______________________ □ Phone: _____-______-_______ □ Fax: _____-_____-_______

H. Practice Location(s): Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.

1. Type of Facility: □ Office □ Standalone Facility □ Staffing □ Other, please explain: ______________________

Loc. #1 _____ **% of Practice** ______________________________ ______________

Name of Primary Practice Location (All documents will be mailed to this location) **County**

______________ ______ ______________ ______ ______

Street Address **Suite** **City** **State** **Zip Code**

2. Type of Facility: □ Office □ Standalone Facility □ Staffing □ Other, please explain: ______________________

Loc. #2 _____ **% of Practice** ______________________________ ______________

Name of Practice Location **County**

______________ ______ ______________ ______ ______

Street Address **Suite** **City** **State** **Zip Code**

I. Organization Information (continued)

3. Type of Facility: ☐ Office ☐ Standalone Facility ☐ Staffing ☐ Other, please explain: ____________________

Loc. #3 ______ **% of Practice** ______________________________ ______________

Name of Practice Location **County**

______________________ ______ ______________ ______ ______

Street Address **Suite** **City** **State** **Zip Code**

II. practice Information (Attach a separate piece of paper, if needed.)

A. Type of Organization/Business Practices: (Please select all that are applicable. At least one must be selected .)

- ☐ Alternative Medicine (Integrative/ Complimentary)
- ☐ Anesthesia Administration (Deep Sedation and General Anesthesia)
- ☐ Behavioral Health Facility/Psychiatric Facility
- ☐ Colon Hydro Therapy
- ☐ Correctional Facility
  - ☐ ≤ 10 Hr/Wk ☐ > 10 Hr/Wk
- ☐ Cosmetic/Asthetic
- ☐ Dermatology
- ☐ Detox / Rehabilitation
- ☐ Family Practice/Primary Care
- ☐ Home Health Care/Hospice
- ☐ Intraoperative Neurophysiological Monitoring/IONM
- ☐ MRI/X-Ray Imaging
- ☐ Nurse Practitioner Group
- ☐ Orthopedics
- ☐ Physician Assistant Group
- ☐ Pain Management
- ☐ Physical Therapy/Occupational Therapy/ Speech/Hearing Therapy
- ☐ Perfusionists
- ☐ Sports Medicine
- ☐ Staffing—Healthcare
- ☐ Med Spa/Day Spa
- ☐ State/County Health Department
- ☐ Surgical Center
- ☐ Telemedicine
- ☐ Urgent Care Facility
- ☐ Weight Reduction/Bariatric/Liposuction
- ☐ Women's Health/Gynecology/Obstetrics
- ☐ Other: Please Explain ______________

III. Professional Information (Attach a separate piece of paper, if needed.)

A. Have you, your entity, or any applicant requesting coverage, or any of your employees, ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than minor traffic offenses? ☐ Yes ☐ No

If yes, please explain: ____________________

Applicant Name(s): ____________________ Date: ________ / __________ (MM/YYYY)

B. Have you, your entity, or any applicant requesting coverage, or any of your employees had hospital privileges, DEA/narcotics license, healthcare license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

If yes, please explain: ____________________

Applicant Name(s): ____________________ Date: ________ / __________ (MM/YYYY)

C. Have you or any applicant requesting coverage or any of your employees ever incurred or become aware of having a condition that impairs your ability to practice your specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics, or other controlled substances, etc. Note: Functional addiction is considered a reportable impairment.) ☐ Yes ☐ No

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

If yes, please explain: ____________________

Applicant Name(s): ____________________

Treating Physician(s) Name(s): ____________________ Date: ________ / __________ (MM/YYYY)

D. Have you or any applicant requesting coverage, or any of your employees ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

If yes, please explain: ____________________

Applicant Name(s): ____________________ Date: ________ / __________ (MM/YYYY)

CALIFORNIA and **MISSOURI APPLICANTS:** Do **NOT** answer the following question**:**

E. Have you, your entity or any applicant requesting coverage ever had any professional liability insurance refused, declined, canceled or non-renewed by an insurance company? ☐ Yes ☐ No

If yes, please explain: ____________________

Applicant Name(s): ____________________ Date: ________ / __________ (MM/YYYY)

III. Professional Information (Continued) Attach a separate piece of paper, if needed.

F. Will you, your entity or any applicant requesting coverage be treating or reviewing treatment of federal prison inmates? ☐ Yes ☐ No

If yes, how many hours per week? ______Hrs. Applicant Name(s): ______

G. Will you, your entity or any applicant requesting coverage be treating non-federal prison inmates? ☐ Yes ☐ No

If yes, how many hours per week? ______Hrs. Applicant Name(s): ______

IV. General Information

A. Does the entity contract or employ physicians as a Medical Director? ☐ Yes ☐ No
If yes, how many? ______

B. Does the Medical Director also provide direct patient care at the facility? ☐ Yes ☐ No

If yes, please describe**:** ______

C. How often is the Medical Director on-site at the facility? ☐ Daily ☐ Weekly ☐ Monthly ☐ Remotely Only

D. Does the entity own or operate any laboratory? ☐ Yes ☐ No
If yes, is the laboratory providing services solely for your patients? ☐ Yes ☐ No
If no, please explain: ______

E. When hiring professionals and support staff, does the Applicant have hiring/screening/credentialing employment procedures? ☐ Yes ☐ No

If yes, does the credentialling process for all facility providers include the following:

1. A verification of education, licensure and certification, if these are required for the job function? ☐ Yes ☐ No
2. Obtaining of references for providers and employees? ☐ Yes ☐ No
3. Doing background checks (including criminal history)? ☐ Yes ☐ No
4. Obtaining proof of malpractice insurance (if not obtained through this policy)? ☐ Yes ☐ No
5. Obtaining a copy of certificates of insurance? ☐ Yes ☐ No

F. Please include estimated annual numbers for this entity: Clinic Visits: ________Payroll: ________Gross Revenue: $____________

G. What is the applicant's percentage of receipts in each of the following categories: (total must equal 100%):

1. Health Insurance Plan/Marketplace: ________% 2. Medicare: ________% 3. Medicaid: ________%
4. Private Pay: ________% 5. Other: ________% If Other, please explain: ____________

H. Has the entity performed any contract for or entered into any contract or agreement (written or oral) with any entity/city/county/state/federal agency/clinic including providing care at correctional facilities, prisons, mental health facilities, Veteran's Administration, university, military or indigent care, etc.? ☐ Yes ☐ No

If yes, please explain: ______

V. Loss Information

Please complete a Loss Information Supplement for each written request, incident, claim or suit (A, B or C) in which the group, entity and/or individual's policy was triggered and that has NOT been covered by a Medical Protective policy.

Report professional liability, malpractice and related matters for each applicant (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 the group, entity, and/or anyone from your practice, even if it is believed the claim or suit would be without merit.

A. Has your entity or any individual applicant now, or ever been, involved in a claim or suit arising out of the rendering or failure to render professional services, or related to any other coverage requested from Medical Protective (e.g. CGL, EPLI, etc.)? ☐ Yes ☐ No

If yes, how many? _____ Applicant Name(s): ______

B. Is your entity or any individual applicant from the practice aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against an applicant, entity or anyone from the practice? This includes, but is not limited to, the following:

◇ Amputation ◇ Permanent Neurological Injury ◇ Loss of Major Organ Function ◇ Death ◇ Loss of Vision. ☐ Yes ☐ No
If yes, how many? _____ Applicant Name(s): ______

C. In the last 12 months, has your entity, or any individual applicant or anyone from the practice received a written request from an attorney for treatment records concerning any current or former patient(s) which might reasonably result in a claim or suit against an applicant, entity or anyone from the practice? ☐ Yes ☐ No
If yes, how many? _____ Applicant Name(s): ______

VI. Coverage Information - Occurrence Coverage Only

A. Current Insurer: ____________________ ☐ Occurrence ☐ Claims-made

From: _____ / _____ / _____ **12:01 AM** **To:** _____ / _____ / _____ **12:01 AM**
(MM/DD/YYYY) (MM/DD/YYYY)

B. Please provide the applicant's insurance history for the last five years and explain any gaps in coverage. (Attach a separate piece of paper, if necessary.) ____________________

____

POLICY PERIOD	MOST RECENT YEAR	1 YEAR PRIOR	2 YEARS PRIOR	3 YEARS PRIOR	4 YEARS PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

C. Requested Coverage Effective Date: Annual policy terms will begin and end on the same month and day.

From: _____ / _____ / _____ **12:01 AM** **To:** _____ / _____ / _____ **12:01 AM**
(MM/DD/YYYY) (MM/DD/YYYY)

D. Desired Limits: Per Occurrence/Per Claim Filed: $ _____ , _____ , _____ Annual Aggregate: $ _____ , _____ , _____

Extended Reporting Section: ONLY COMPLETE IF YOUR EXPIRING POLICY IS CLAIMS MADE

If the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

☐ An extension contract endorsement (tail coverage) has been or will be purchased.
☐ An extension contract endorsement (tail coverage) has not been and will not be purchased.

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

VII. Fraud Notice

MANDATORY: ***ALL APPLICANTS must read the following statement carefully unless in a state listed below:***
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim 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 such person to criminal and civil penalties, which may include voiding of the policy if allowed by state law.

ALL ALABAMA APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALL ARKANSAS APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL COLORADO APPLICANTS:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an 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 policyholder 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.

ALL DISTRICT OF COLUMBIA APPLICANTS:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

ALL FLORIDA APPLICANTS:
Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of a claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

ALL GEORGIA APPLICANTS:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

ALL 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.

ALL KANSAS APPLICANTS:
An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

ALL KENTUCKY APPLICANTS:
Any person who knowingly and with intent to defraud any insurance company or other 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.

ALL MAINE APPLICANTS:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

ALL MINNESOTA APPLICANTS:
No oral or written misrepresentation made by the insured, or in the insured's behalf, in the negotiation of insurance, shall be deemed material, or defeat or avoid the policy, or prevent its attaching, unless made with intent to deceive and defraud, or unless the matter misrepresented increases the risk of loss.

ALL NEW HAMPSHIRE APPLICANTS:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in Section 638.20.

ALL NEW JERSEY APPLICANTS:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ALL NEW MEXICO APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

ALL OHIO APPLICANTS:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

ALL OREGON APPLICANTS:
Any person who knowingly files an application for insurance or a statement of a claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

ALL PENNSYLVANIA APPLICANTS:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 such person to criminal and civil penalties.

ALL RHODE ISLAND APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL TENNESSEE APPLICANTS:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

ALL VERMONT APPLICANTS:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

ALL VIRGINIA APPLICANTS:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, or denial of insurance benefits.

ALL WASHINGTON APPLICANTS:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, or denial of insurance benefits.

ALL WEST VIRGINIA APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

VIII. Notices and Agreements

By my signature, I hereby represent that all applicants have granted me full authority to execute this application on his, her or the entity's behalf and I am authorized to represent and sign on behalf of anyone from my practice. I also represent that I have reviewed the responses contained in this application with the applicants, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicants and that they understand and agree that such representations are binding upon him, her or the entity, even though I am executing this application on the applicants' behalf.

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my, or any applicants' initial or renewal application, are true and that I, nor any applicant, have not knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare professional, facility, firm or professional association.

Where allowed by state law, I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I, OR ANY APPLICANT, FAIL TO COMPLY WITH THESE TERMS WE **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

I, or any other applicant, understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me or any applicant, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

By signing this application on behalf of a group, or an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

I represent that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

If Arizona: I understand that, to the extent permitted by law, the Company reserves the right to deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the 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 Company as required either by this application for the policy, subsequent notice, or otherwise.

If California: I understand that if I cancel or terminate any coverage that may be provided by the Company, earned premium shall be computed in accordance with the standard short rate tables and procedures with a maximum penalty of up to 11%. Premium adjustments shall be made within a reasonable period of time after cancellation or termination. However, payment or tender of unearned premium shall not be a condition of cancellation.

If Delaware: Misrepresentations, omissions, concealment of facts 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 either by the application for the policy or contract or otherwise.

If Georgia: I understand that any material misrepresentation or omission made by me on this application may provide the Company with the right to cancel the policy and/or deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the 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 Company as required either by this application for the policy, subsequent notice, or otherwise. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Illinois: I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, my policy shall not be deemed to have been issued or delivered and shall not be applicable to any matter which may have been covered under the policy if the payment is later dishonored by the bank.

If Kansas: An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

If Maine: I understand that any material misrepresentation or omission made by me on this application may cause coverage to be cancelled and/or denied. However, we maintain the right to request a ruling from the Maine Courts on voidance or rescission of this policy. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If New Hampshire: I understand that any material misrepresentation or omission made by me on this application may provide the Company with the right to cancel my policy pursuant to state law and pursue further legal action against me. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Vermont: I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to cancel it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

If Washington: I understand that any intentional concealment or material misrepresentation made by me, or someone acting on my behalf, on this application may act to render any contract of insurance null and without effect. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

The Delaware Civil Union & Equality Act of 2011

The Medical Protective Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 including the following:

Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

Compliance with Illinois Bulletin 2011-06 and The Religious Freedom Protection and Civil Union Act

The Medical Protective Company recognizes the rights afforded to individuals under The Religious Freedom Protection and Civil Union Act which states:

"The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married." or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA INSURANCE GUARANTY ASSOCIATION LAW

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
7600 Parklawn Ave # 460
Edina, MN 55435-5137
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to $300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Application must be signed by the Individual Applicant, a President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

________________________	________________________		________________________
Authorized Representative Signature	Printed Name	Title	Date Signed (MM/DD/YYYY)

________________________	________________________
Agent/Producer Name	License Number

Agent Name & License Number:____
(Signature)

IX. Supplemental Information

THE MEDICAL PROTECTIVE COMPANY

NAME OF INDIVIDUAL OR GROUP APPLICANT(S):______________________________

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL

MULTI-SPECIALTY SUPPLEMENTAL APPLICATION

I.a. General Information: Applicants must complete the following additional general information questions.

1. Please indicate the number of Employed or Self-Employed providers who provide services in each of the following specialties in your practice that are requesting coverage. (Please include yourself).

SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers	SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers
Acupuncturist			Community Health Assistant		
Anesthesia Assistant			Community Health Technician		
Anesthesia Technician			Community Health Technologist		
Anesthesia Technologist			Corrective Therapist		
Art Therapist			Counselor – Alcohol/Drug		
Athletic Trainer			Counselor – Clinical		
Audiologist (Excluding IONM)			Counselor – Marriage/Family		
Audiologist (Including IONM interpretation/non-supervisory)			Counselor – Not Otherwise Classified		
Autotransfusionist			Counselor – Pastoral		
Biomedical Technician			Counselor – Rehabilitation		
Biomedical Technologist			Counselor – School		
Blood Bank Technician			CPR Trainer		
Blood Bank Technologist			Dance Therapist		
Cardiology Technician			Dental Assistant		
Cardiology Technologist			Dental Hygienist		
Caregiver/Home Healthcare Professional			Diagnostic Medical Sonographer		
Case Manager			Dialysis Technician		
Chiropractic Assistant			Dialysis Technologist		
Circulation Technician/Technologist			Dietician		
Clinical Laboratory Technician			Drama Therapist		
Clinical Laboratory Technologist			EEG/Electroneurodiagnostic Technologist/Technician		
Clinical Nurse Specialist – Administrator			EKG/Electrocardiograph Technician/ Technologist		
Clinical Nurse Specialist – Consultant			Electrologist		
Clinical Nurse Specialist – Cosmetic Procedures			EMT– Basic Certified		
Clinical Nurse Specialist – Educator			EMT– Intermediate Certified		
Clinical Nurse Specialist – No Prescriptive Authority			EMT– Paramedic Certified		
Clinical Nurse Specialist – Not Otherwise Classified			EMT– Volunteer		
Clinical Nurse Specialist – Researcher			Enterostomal Therapist/Colon Hydrotherapist		
Clinical Research Associate			Esthetician		
Clinical Research Coordinator			Evoked Potential (EVT) Technologist		

SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers	SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers
Exercise Physiologist			Medical Assistant – Certified		
Fitness Professional			Medical Dosimetrist		
Geriatric Nursing Assistant			Medical Laboratory Technician/ Technologist		
Health Educator/Wellness Counselor			Medical Records Administrator		
Healthcare Aide (Licensed) - Not Otherwise Classified			Medical Records Technician		
Healthcare Aide (Non-Licensed) - Not Otherwise Classified			Medical Technician		
Healthcare Specialty Assistant – Not Otherwise Classified (Excluding Labor & Delivery, Surgical)			Medical Technician Assistant		
Hearing Therapist			Medical Technician Assistant – Not Otherwise Classified		
Heller Worker			Medical Technologist		
Histologic Technician			Medical Technologist Assistant		
Histologic Technologist			Medical Technologist Assistant – Not Otherwise Classified		
Home Health Aide			Mental Retardation Worker		
Horticulture Therapist			Music Therapist		
Intensive Care Unit/Continuous EEG (ICU/cEEG) Specialist			Naturopath		
Intraoperative Neuromonitoring (IONM) Technologist, Supervised			Navigator		
Intraoperative Neuromonitoring (IONM) Technologist, Unsupervised			Nerve Conduction Studies (NCS) Technologist		
Interpreter for the Deaf			Nuclear Medical Technician		
Kinesiologist			Nuclear Medical Technologist		
Kinesiotherapist			Nurse Educator/RN/LPN		
Lab Technician – Certified			Nurse Surgical Assistants (Excluding NP's & DNP's)		
Lab Technologist – Certified			Nurses Aide		
Laboratory Aide			Nursing Assistant		
Lactation Consultant/IBCLC			Nutritionist		
Lactation Counselor			Occupational Therapist		
Legal Nurse Consultant/RN/LPN			Occupational Therapist Assistant		
Licensed Practicing Nurse – Cosmetic Procedures			Occupational Therapist Assistant – Certified		
Licensed Vocational Nurse – Cosmetic Procedures			Optometric Technicians		
Life Care Planner			Opticians		
Long-Term Monitoring for Epilepsy (LTME) Specialist			Ophthalmic Technician		
Massage Therapist			Orthopedic Assistant		
Medical (Office) Assistant			Orthopedic Technician		

SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers	SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers
Orthotist/Prosthetist			Registered Nurse – Cosmetic Procedures		
Pathology Assistant			Registered Nurse/Licensed Practical Nurse/Licensed Vocational Nurse—Not Otherwise Classified (Excluding Labor & Delivery & Surgical)		
Pedorthist			Rehabilitation Assistant		
Perfusionist			Rehabilitation Therapist		
Personal Trainer – Certified			Respiratory Care Provider		
Pharmacist			Respiratory Therapist		
Pharmacy Technician/Technologist			Respiratory Therapy Assistant/ Technician/Technologist		
Phlebotomist			Retail Druggist		
Physical Rehabilitation Therapist – Not Otherwise Classified			Rolfer		
Physical Therapist			Social Worker – Clinical		
Physical Therapy Aide			Sonographic Technician/Technologist – Not Otherwise Classified		
Physical Therapy Assistant			Speech Pathologist		
Podiatric Assistant			Speech Therapist		
Polysomnographic Sleep Technician			Sports Medicine Instructor		
Postpartum Care Provider/Doula			Sports Medicine Therapist		
Psychologist			Structural Body Worker		
Psychotherapist			Student– Acupuncturist		
Radiation Therapist			Student (Excluding Acupuncturist, CRNA, Nurse Practitioner, Physician or Surgical Assistants)		
Radiation Therapy Technologist			Surgical Technician/Technologist		
Radiological Technician/Technologist – Not Otherwise Classified			X-Ray Technician/Technologist		
Radiology Assistant – Registered			Other, please describe:		
Recreation Therapist					

2. Are there any medical doctors or other specialties listed below, employed and/or contracted by the entity? ☐ Yes ☐ No

If Yes, please indicate the numbers below. A copy of their policy or certificate of insurance indicating limits of coverage will be required. *(Please note, Physicians will not be included in coverage afforded by this policy.)

SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers	SPECIALTY	Number of Employed Providers	Number of Self-Employed/ Contracted Providers
Chiropractors			Physician Assistants		
CRNA's			Podiatrists		
Dentists			Physicians Specialty: ____________________		
Nurse Practitioners			Medical Director: (No Patient Contact) Specialty: ____________________		
Optometrists			Supervising Physician (Provides services to your Patients) Specialty: ____________________		

MANDATORY: ALL DISTRICT OF COLUMBIA APPLICANTS must read the following:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

MANDATORY: ALL FLORIDA APPLICANTS must read the following:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

MANDATORY: ALL MAINE APPLICANTS must read the following:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

THE MEDICAL PROTECTIVE COMPANY APPLICANT NAME: ___________________________

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL

OCCURRENCE COMMERCIAL GENERAL LIABILITY SUPPLEMENTAL APPLICATION

If you are a practice owner or independent contractor, do you desire Commercial General Liability coverage? □ Yes □ No
If yes, please select coverages, limits and complete the following questions.

A. Desired Limits: Per Occurrence/Annual Aggregate:
□ **$1,000,000/$3,000,000** □ $1,000,000/$6,000,000 □ $2,000,000/$4,000,000

^The Commercial General Liability Limits cannot be greater than your selected Medical Protective Company Professional Liability Limits.

B. Do you own, rent or lease premises from others? □ Yes □ No

If yes, please provide the number of locations: __________

C. Do you rent or lease equipment from others? □ Yes □ No

If yes to Questions B or C above, please answer the following:

D. Are you required by contract to name an Additional Insured to your Commercial General Liability policy? □ Yes □ No

1. If yes, please provide the Additional Insured(s) Name and Address. Include only Lessors required to be named under contract.

   Additional Insured Name: ____

   Mailing Address: ____
   Street City State Zip Code

2. Is the Additional Insured a:

   □ Lessor of Premises:

   Description of Leased Premises: ____

   Address: ____
   Street City State Zip Code

   □ Lessor of Equipment:

   Description of Equipment: ____

Please be advised that if you do not purchase tail coverage (an extended reporting endorsement) from your current insurer where you are insured for Commercial General Liability under a Claims-Made policy, this will result in an uninsured exposure for any claims which may arise as a result from an event while insured by your current insurer's policy. If you do not purchase tail coverage from your current insurer, understand that the policy for which you are applying with The Medical Protective Company, if offered, will not provide prior acts Commercial General Liability coverage.

MANDATORY: ALL DISTRICT OF COLUMBIA APPLICANTS must read the following:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

MANDATORY: ALL FLORIDA APPLICANTS must read the following:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

MANDATORY: ALL MAINE APPLICANTS must read the following:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

The Medical Protective Company®
A STOCK INSURANCE COMPANY
5814 Reed Road, Fort Wayne, Indiana 46835
Strength. Defense. Solutions. Since 1899.

DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

THIS DISCLOSURE IS ATTACHED TO AND MADE PART OF YOUR COVERAGE IN RESPONSE TO THE DISCLOSURE NOTICE REQUIREMENTS OF THE TERRORISM RISK INSURANCE ACT OF 2002. THIS NOTICE DOES NOT GRANT ANY COVERAGE OR CHANGE THE POLICY TERMS AND CONDITIONS OF ANY COVERAGE UNDER THE POLICY.

Coverage for acts of terrorism is included under your coverage. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your coverage may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is $0, and does not include any charges for the portion of losses covered by the United States government under the Act.

This constitutes notice, as required under the federal Terrorism Risk Insurance Act of 2002 Section 102(1), as extended on December 22, 2005, and amended on December 31, 2007 and January 12, 2015 ("TRIA Act"). Any losses resulting from certified acts of terrorism under the coverage to which this notice applies may be partially reimbursed by the United States Government, subject to a $100 billion cap as set forth in the TRIA Act. Application of the $100 billion TRIA Act cap may reduce the amount of coverage available to you. This disclosure also constitutes notice as required pursuant to the TRIA Act of the amount of your premium attributable to the coverage under the TRIA Act.

<u>This coverage is automatically included in your coverage. In order to decline this coverage, you must notify the company in writing that you DO NOT want to include this coverage. If you decide to decline the terrorism coverage you must notify us of your decision at the time of binding the remainder of your coverage.</u>