National Fire & Marine Insurance Company

Omaha, Nebraska

MEDICAL DIRECTOR SERVICES APPLICATION

I. GENERAL INFORMATION

A. _____

Name of Individual Applicant (Last Name, First Name, Middle Name, Suffix)

_____ _____ _____ _____ _____

Mailing Address/Principal Practice Address **Suite** **City** **State** **Zip Code**

_____ _____/_____/_____ _____

Professional Designation (MD, DO, Other) **Date of Birth** (MM/DD/YYYY) **Gender** (M/F)

_____ _____-_____-_____ _____-_____-_____

Email Address **Phone** **Fax**

B. _____

Medical School & Date of Graduation

If foreign graduate, are you certified by the educational commission for foreign medical graduates? □ Yes □ No

C. _____ _____

Principal Medical Specialty **Sub-Specialty**

D. Please indicate states where you are licensed: _____

Are all these licenses active? □ Yes □ No

E. Are you American Board Certified? □ Yes □ No

If yes, list specialty boards: _____

F. Indicate number of CME credits in the last 12 months: _____

G. Number of years of experience working as a Medical Director: _____

Attach a copy of your resume or CV.

II. COVERAGE REQUEST

A. Requested Effective Date: _____

B. Prior Acts Date (Retroactive Date): _____

C. Limits Requested: □ $100,000/$300,000 □ $200,000/$600,000 □ $250,000/$750,000 □ $500,000/1,500,000
□ $1,000,000/$3,000,000 □ Other:_____

III. ENTITY/FACILITY INFORMATION

Provide the following information with respect to any entity where you act as, and are seeking coverage for your duties as, a Medical Director. If you are applying for coverage with respect to your duties as Medical Director for more than one entity or location, please attach additional pages. Note: Entities are not covered by the policy for which you are applying.

A. _____

Legal Entity/Facility Name, as per the articles of incorporation – include any DBA (doing business as) name

_____ _____ _____ _____ _____

Principal Office Address **Suite** **City** **State** **Zip Code**

B. Describe the type of facility and the medical services provided by the facility: _____

_____

C. Total number of employees in the organization for which you provide Medical Director services::_____

D. Does the entity provide long term care? □ Yes □ No

If yes, number of beds: _____

Type of long term care: □ Skilled □ Intermediate □ Assisted Living □ Residential

E. Does the entity provide overnight care? □ Yes □ No

If yes, number of beds: _____

Explain/describe type of overnight care: _____

F. Organization/service/facility annual receipts: _____

G. If known, which insurer provides medical professional insurance for the facility? _____

H. Has evidence of insurance been procured? □ Yes □ No

IV. MEDICAL DIRECTOR DUTIES/CONTRACT

Please provide a copy(s) of the Medical Director contract(s) between you and the facility(s) for which you are providing medical director services.

A. Please indicate below the medical services or responsibilities that you will be required to perform in your capacity as a Medical Director and for which you are seeking coverage:

□ **Administrative Services**
Duties include establishing general medical protocols, serving on a standards review, peer review or credentialing committee or similar professional board or committee.

Provide details if not specifically outlined in the contract between you and the facility: _____

□ **In-direct Patient Care**
Duties include rendering patient specific medical directives, medical direction, course of medical treatment or any other patient specific guidance to other healthcare professionals whom you oversee, manage or have collaborative agreements and collaborative responsibility. This includes any and all means of telecommunication or other forms of communication between you and another healthcare professional related to patient specific guidance.

Provide total number (by type) of health care providers (ie. CRNAs, NPs, PAs, CNMs, others) that you will supervise or assist in providing indirect patient care services: _____CRNAs _____NPs _____PAs _____CNMs _____Others (specify)_____

Provide details if not specifically outlined in the contract between you and the facility: _____

□ **Direct Patient Care**
Duties include rendering or failure to render medical professional services in the examination, diagnosis, testing and medical treatment to any patient.

Provide details if not specifically outlined in the contract between you and the facility: _____

B. Revenues/Receipts being paid to you by the facility for these services: _____

C. If you currently carry your own individual medical professional liability insurance policy please provide the information requested below:

Carrier name: _____

Liability limits: _____

Coverage dates: _____

Description of the professional services provided by your practice that are covered by this insurance**:** _____

_____

V. CLAIMS AND LICENSE SANCTIONS INFORMATION

A. Has any claim ever been made against you arising from your duties as a medical director? □ Yes □ No
If yes, complete the Supplemental Claim Information Form for each claim. Also please attach 5 years of currently valued carrier produced loss runs.

B. Are you aware of any circumstances, arising from your duties as a medical director, which may result in a claim against you? □ Yes □ No

If yes, please provide details: _____

C. Have you ever had your license, certification, or privileges revoked, suspended, or restricted or have you been subject to any disciplinary proceeding, been reprimanded by an administrative agency, professional association or peer review committee? □ Yes □ No

If yes, please provide details: _____

VI. NOTICES AND AGREEMENTS

Any person who knowingly and with intent to injure, deceive, or defraud any insurance company or other person files an application for insurance containing any materially false information or fails to provide complete information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may be prosecuted under state law and may be guilty of a felony and subject to criminal and civil penalties, fines, denial of insurance or confinement in prison.

I hereby declare 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 initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I 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 my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me 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 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.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

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, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also 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 my 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, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Applicant's Signature	Printed Name	Date Signed (MM/DD/YYYY)

National Fire & Marine Insurance Company
Omaha, Nebraska

Supplemental Claim Information Form

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at National Fire & Marine Company's discretion.

A. Patient/Claimant Information:

_____ _____ _____
Last Name First Name Age

B. Date of treatment and/or surgery which led, or could lead, to allegations against you. ____/_____
MM YYYY

C. Date of notice received, if applicable. ____/_____
MM YYYY

D. Has this mater 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: _____

_____

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

_____

F. 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: $ _____

G. Nature of allegations or potential allegations:

Condition Treated: _____
Treatment Provided: _____
Alleged Negligence: _____
Alleged Injury: _____

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

_____

_____

_____

_____