HALLMARK PROFESSIONAL LIABILITY



# HALLMARK SPECIALTY INSURANCE COMPANY
# HALLMARK NATIONAL INSURANCE COMPANY (OKLAHOMA)
# MEDICAL DIRECTOR'S PROFESSIONAL LIABILITY APPLICATION
## CLAIMS MADE AND REPORTED COVERAGE

**Please type or print all answers in ink. All questions require a response. If space is insufficient, please attach additional pages.**

## I General Information

**A.** Full Name of Applicant:____________________________

**B.** Mailing Address: ____________________________

____________________________

**C.** Location Address: ____________________________

____________________________

**D.** Telephone Number: ________________ Fax Number: ________________

**E.** Medical License # and State of Issuance: ________________________

**F.** Date of Birth: ________________ US Citizen: _______Yes _______No

If no, what is your current status in the U.S., and where is your current citizenship? ________________

**G.** Desired Effective Date: ____________ Desired Limits of Liability: $____________/$____________
Desired Deductible: ____________ Desired Retroactive Date: ____________

## II Medical Training

**A.** Medical Specialty: ________________________ % of practice ________
**B.** Sub-Specialty: ________________________ % of practice ________

| Training | Hospital/School | City & State | Completed? | Dates From/To |
|---|---|---|---|---|
| Medical School | | | □ Yes □ No | |
| Internship/1st Year Residency | | | □ Yes □ No | |
| Residency | | | □ Yes □ No | |
| Additional Residency | | | □ Yes □ No | |
| Fellowship | | | □ Yes □ No | |

**C.** Are you a Foreign Medical School Graduate? ____ Yes ____ No

If Yes, please provide the date of ECFMG certification ________________________

**D.** Are you currently certified by the American Board of Medical Specialties?

If Yes, please provide Name of Board ________________________

Expiration date of Certification/Recertification ________________________

If No, do you plan to take the Board examination? ____ Yes ____ No

**E**. Are you a member of any medical association? ____ Yes ____ No If "Yes", please list memberships:

**F**. How many hours of continuing medical education have you taken in each of the past two years?

## III Entity Information

**A**. Name & Location of Facility where Medical Director Services are Performed:

**B**. Your relationship to this entity:
_____ owner/partner _____ contractor _____ employee
_____ other. Provide Details:

**C**. When was this facility established? ____________________________________________

**D**. Type of Facility – describe in detail medical services provided:

**E**. Does this entity have any beds for overnight occupancy? ___ Yes ___ No

If Yes, how many licensed beds? ____________________________________________

**F**. What is the total number of outpatient visits and/or tests per year at this facility?

**G**. Is surgery performed at this facility? ___ Yes ___ No

If Yes, how many surgeries per year? ____________________________________________
***PLEASE ATTACH A LIST OF THE TYPES OF SURGERIES PERFORMED AT THIS FACILTY.**

**H**. Are obstetrics practiced at this facility? ___ Yes ___ No

If Yes, how many deliveries per year? ____________________________________________

**I**. What is the estimated revenue of the facility for the next 12 months? ______________________

**J**. Is the facility currently covered by a Medical Malpractice policy? ___ Yes ___ No

If Yes, who is the medical malpractice insurance carrier? ______________________________

If Yes, what are the Limits of Liability? ____________________________________________

**K**. Does the facility have a website? ___Yes ___No,
If yes what is the web address?____________________________________________

**L**. Are all physicians, whether employed or contracted, required to carry medical malpractice insurance?
___ Yes ___ No If Yes, at what limits of liability?

## IV Medical Director Services Information

**A**. How many hours per week are dedicated to medical director services only? __________________

**B.** Do you also provide direct medical services at this facility? ___ Yes ___ No

If yes, how many hours per week are dedicated to direct medical services only? ____________________

Are you seeking coverage for direct medical services? ___ Yes ___ No

Describe, in detail, the medical services you provide:

**C.** How long have you worked as medical director at this facility? _________________________________

**D.** Please describe your duties as medical director:

**E.** Could the applicant be called upon to act within his/her capacity as a physician to treat, intervene in the treatment, direct the treatment or consult in the treatment of any patient/client? Yes _____ No _____

If yes, please provide details including how often such circumstances occur:

If yes, is this exposure covered by another policy?: ___ Yes ___ No

Carrier: ________________________ Effective Dates: __________________ Limits: _______________

## V Prior Insurance/Claims Information

**A.** Do you currently carry Professional Liability Insurance for your medical directors services?___ Yes ___ No
If Yes, please complete the following:

| Policy Period | Insurer | Policy Limits | Deductible | Policy Type | Premium | * Total # of Claims |
|---|---|---|---|---|---|---|
| | | | | □ CM □ Occ | | |
| | | | | □ CM □ Occ | | |
| | | | | □ CM □ Occ | | |
| | | | | □ CM □ Occ | | |
| | | | | □ CM □ Occ | | |

**B.** Has any claim ever been made against you solely as respects your duties as a medical director? If Yes, Complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs. ___ Yes ___ No

**C.** Are you aware of any circumstances, solely as respects your duties as a medical director,which may result in a claim against you? ___ Yes ___ No

**D.** Have you had any losses or claims that have not been reported to a prior insurance carrier or any other source from which payment could be made? ___ Yes ___ No

**E.** Are you aware of any specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim that has not been reported to a prior insurance carrier? ___ Yes ___ No

**F.** Have you had any requests for medical records by a patient or his/her attorney which might result in a claim? ___ Yes ___ No

**G.** Do you have any information relating to service(s) on a Board which may result in a claim? ___ Yes ___ No

**H.** Have you had any prior professional liability carrier refuse coverage for, or decline to accept a report of a specific act, omission or circumstance involving a particular and specific professional service(s) that may result in a claim, threat of a claim, letter of intent, adverse result notice or attorney contact? ___ Yes ___ No

**I.** Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend non-renew or revoke your privileges? ___ Yes ___ No

**J.** Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ___ Yes ___ No

**K.** Have you ever been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? ___ Yes ___ No

**L.** Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ___ Yes ___ No

**M.** Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse? If "Yes", complete the **Substance Abuse Supplement.** ___ Yes ___ No

**N.** Have you ever been evaluated, treated or hospitalized for mental or emotional disorders? ___ Yes ___ No

**O.** Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation would limit your ability to safely practice in your medical specialty? ___ Yes ___ No

If "Yes" to any of the above, please provide details:

## VI Notice to the Applicant – Please Read Carefully

If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy.

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom, shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is assigned and the effective date of the policy, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

The policy for which application is made applies only to “Claims” first made during the “Policy Period”.

Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by “Claim Expenses” and, in such event, the Company will not be liable for “Claim Expenses” or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy.

Unless amended by endorsement, “Claim Expenses” shall be applied against the “Deductible”.

## VII Fraud Statements

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV**
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

**Applicable in CO**
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.

**Applicable in FL and OK**
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)*. *Applies in FL Only.

**Applicable in KS**
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, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or 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 commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA**
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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*.
*Applies in NY Only.

**Applicable in ME, TN, VA and WA**
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 and denial of insurance benefits. *Applies in ME Only.

**Applicable in NJ**
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Applicable in OR**
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**Applicable in PR**
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

## VIII Warranty

I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

| ______________________________ | ______________________ |
|---|---|
| Name of Applicant | Title |
| ______________________________ | ______________________ |
| Signature of Applicant | Date |

**Signing this form does not bind the Applicant or the Company to complete the Insurance.**

**Notice to 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 the person to criminal and civil penalties.