THE MEDICAL PROTECTIVE COMPANY APPLICANT NAME(S):_____

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

PODIATRIST SUPPLEMENTAL APPLICATION

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

A. Please indicate the number of each of the following who provide services in your office (please include yourself):

SPECIALTY	NUMBER OF DOCTORS IN YOUR PRACTICE ?	NUMBER OF DOCTORS REQUESTING MEDICAL PROTECTIVE COVERAGE? 1.
PODIATRIC PHYSICIAN		

1. MD/DO Physicians may apply separately for coverage at www.medpro.com.

OTHER SPECIALTIES	NUMBER OF OTHER PRACTITIONERS IN YOUR PRACTICE?	# OF OTHER PRACTITIONERS REQUESTING **SHARED LIMIT** COVERAGE? 2.	# OF OTHER PRACTITIONERS REQUESTING **SEPARATE LIMIT** COVERAGE?
Other (List Specialty):			

2. Shared limit coverage may be limited or not available in some states.

III.a. Individual Applicant Information: Each Podiatric Physician must complete the following additional questions specific to his/her specialty. (Please make copies if multiple applicants are applying.)

APPLICANT NAME:_____

A. School of Graduation: _____ _____ **Graduation Date:** ____ / ____
Name of School State MM YYYY

B. Did you complete a Podiatric Residency? □ Yes □ No □ Still in training

If Yes, Program Name: _____ From: ____ / ____ To: ____ / ____
MM YYYY MM YYYY

Type: □ Surgical □ Non-Surgical

City/State: _____

C. Did you complete a Preceptorship? □ Yes □ No □ Still in training

If Yes, Preceptor: _____ From: ____ / ____ To: ____ / ____
MM YYYY MM YYYY

Type: □ Surgical □ Non-Surgical

City/State: _____

D. Are you Board Certified? □ Yes □ No

Certification Board: □ ABPOPPM □ ABPS □ Other: _____ Date Certified: _____ / _____
MM YYYY

E. Type of practice: ____ Surgical ____ Assisting in Surgery ____ Non-Surgical*

* "Non-Surgical" excludes assisting in surgery and any surgery performed other than local anesthetic injections, therapeutic injections, surgical procedures involving the nails, excision of skin lesions, and the treatment of abscesses or ulcers.

III.b. Practice Information

A. Are you affiliated with any of the following:

□ Emergency Medicine
□ Healthcare Facility having bed and board accomodations
I am the owner of this facility □ Yes □ No
□ Laboratory
□ Locum Tenens Services
□ Nursing Home ____% of Practice
□ Wound Care Facility, other than your office
I am the owner of this facility □ Yes □ No
_____(**Type of Facility**)

B. Do you obtain your own informed consent from your patients? □ Yes □ No

If yes, what type of informed consent do you provide? □ Written □ Verbal □ Both Within: ____ Days prior to Surgery/Treatment

C. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including but not limited to, Telemedicine or Internet Medicine? □ Yes □ No

If yes, please indicate state(s):_____

III.c. Practice Activity

APPLICANT NAME: _____

A. Do you treat any professional sports athletes or professional dancers? □ Yes □ No

If yes, _____% of practice. Please explain (duties, team names and type of sport): _____

_____

B. Do you treat any amateur sports team athletes? □ Yes □ No

If yes, _____% of practice. Please explain (duties, team names and type of sport): _____

_____

C. Do you treat or consult on patients in any sovereign nation or territory, or other than the U.S., such as Native American or Alaskan Native lands? □ Yes □ No If yes, please indicate where: _____

D. Please check any of the following procedures you will perform:

- □ Ankle Surgery
  - □ Osseous Forefoot Surgery
  - □ Osseous Rearfoot Surgery
- □ Laser Surgery
- □ Excise Dermatological Lesions
- □ Implants
  - □ Ankle □ Forefoot □ Rearfoot
- □ Lower Leg Surgery
  - □ Soft Tissue
  - □ Osseous
- □ Minimal Incision Surgery
- □ Nail Surgery
- □ Sports Medicine
- □ Wound Care
  - ___ % of Practice
  - ___ % Devoted to Diabetic Patients

E. Do you provide procedures under neuroleptic-deep sedation or general anesthesia?* □ Yes □ No

If yes, is the anesthesia administered outside of a hospital or surgical center? □ Yes □ No

If yes, please complete the Anesthesia Supplemental Application

***General anesthesia** means a pharmacological or non-pharmacological method, or a combination thereof, intended to cause a controlled state of unconsciousness, accompanied by partial or complete loss of protective reflexes, including the inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.

Neuroleptic-Deep sedation means a pharmacological or non-pharmacological method, or a combination thereof, intended to cause a state of depressed consciousness, accompanied by a partial loss of protective reflexes, including the inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.

F. Have you completed a risk management program in the last 12 months? □ Yes □ No

G. In the last 10 years, have you discontinued major surgical procedures or any other medical activity? □ Yes □ No

If yes, list procedures/activities, reason for discontinuing and date discontinued: _____

_____

H. Will you be performing activities which will be covered by another professional liability contract? □ Yes □ No

1. If yes, are you a(n): □ Employee □ Independent Contractor/Self Employed □ Resident/Fellow □ Faculty

   Practice Name: _____

   Location: _____

   Name of Insurer: _____

2. If yes to Question H. above, are you requesting that Medical Protective exclude coverage for the practice listed above? □ Yes □ No

If previously covered with Medical Protective, or joining a current Medical Protective Healthcare Professional group policy, please enter the Policy Number: _____

THE MEDICAL PROTECTIVE COMPANY
HEALTHCARE PROFESSIONAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

APPLICATION INSTRUCTIONS

1. If additional space is needed, please complete Section IX. Supplemental Information with a reference to the question.
2. You must apply for coverage for each individual or entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture which you are requesting Medical Protective Company coverage. 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.
3. Please print legibly.
4. Please answer all questions; if a question is not applicable, state "N/A".

I. GENERAL INFORMATION

INDIVIDUAL APPLICANTS ONLY: Individuals with a Corporation or Partnership should apply below as a Group Applicant.

A. Please check all that apply:

□ Individual Sole Proprietor
□ Independent Contractor
□ Employed Practitioner
□ Individual joining a current Medical Protective Healthcare Professional Group, Corporation or Partnership: **Policy Number**: _____
□ Other, please explain: _____

B. _____
Name of Individual Applicant (Last Name, First Name, Middle Name, Suffix)

C. If we need to contact you for additional information, please indicate the preferred method of contact:

□ Email Address: _____ □ Phone: _____-_____-_____ □ Fax: _____-_____-_____

GROUP APPLICANTS/INDIVIDUALS WITH A CORPORATION OR PARTNERSHIP ONLY: Individual Applicants, please skip to Section II., General Practice Information.

A. Please check all that apply:

□ Professional Corporation: sole shareholder
□ Partnership or Professional Association
□ Limited Liability Company (LLC)/Partnership (LLP)
□ Professional Corporation: multiple shareholders
□ Other, please explain: _____

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) **Current Entity Retro Date** If claims-made (MM/DD/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
If Yes, please select one of the following:

□ Add this entity on a "Shared Limit" basis with the Scheduled Named Insured Providers. (Not available in some states.)
□ Add this entity with an additional "Separate Limit" to my policy for an Additional Charge.

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: _____-_____-_____

II. General Practice Information

A. 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 □ Hospital □ Surgical Center (Accredited Facility) □ Other, please explain: _____

Loc. #1 _____ % of Practice

_____ _____
Name of Primary Practice Location (All documents will be mailed to this location, unless a different mailing address is requested in Question B. below.) **County**

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

2. Type of Facility: □ Office □ Hospital □ Surgical Center (Accredited Facility) □ Other, please explain: _____

Loc. #2 _____ % of Practice

_____ _____
Name of Practice Location **County**

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

3. Type of Facility: □ Office □ Hospital □ Surgical Center (Accredited Facility) □ Other, please explain: _____

Loc. #3 _____ % of Practice

_____ _____
Name of Practice Location **County**

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

B. Does the group/entity require a mailing address other than the primary practice location address? □ Yes □ No

If yes, please select one of the following mailing preferences: □ **Billing only** □ **All Documents**

If yes, please provide the Location # or print the different mailing address: [redacted] □ **Other, please print below**:

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

III. Individual Applicant Information

Individual Applicants, please fill out Section 1. only. Group Applicants, please fill out each section for each applicant requesting coverage. (Attach a separate piece of paper, if needed.)

1. Please select your affiliation to the practice: □ Shareholder □ Partner □ Employee □ Independent Contractor □ Faculty

_____ _____/_____/_____ _____ _____
Name (Last, First, M.I., Suffix) **Date of Birth** **Degree** **Specialty**

Percentage of Practice: (Total must equal 100%.) □ **Loc.#1 _____%** □ **Loc.#2 _____%** □ **Loc.#3 _____%**

_____ _____ □ Active □ Inactive □ Pending/Temporary _____ _____ □ Active □ Inactive □ Pending/Temporary
License # **State** **License #** **State**

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

_____/_____ _____/_____ _____/_____/_____
Graduation Date (MM/YYYY) **First Date in Practice** (MM/YYYY) **Current Retro Date** (if claims-made)

_____ _____ _____-_____-_____
Current Prof. Assoc. Membership Name **National Provider Number** (Optional) **Soc. Security No.** (Optional)

2. Please select your affiliation to the practice: □ Shareholder □ Partner □ Employee □ Independent Contractor □ Faculty

_____ _____/_____/_____ _____ _____
Name (Last, First, M.I., Suffix) **Date of Birth** **Degree** **Specialty**

Percentage of Practice: (Total must equal 100%.) □ **Loc.#1 _____%** □ **Loc.#2 _____%** □ **Loc.#3 _____%**

_____ _____ □ Active □ Inactive □ Pending/Temporary _____ _____ □ Active □ Inactive □ Pending/Temporary
License # **State** **License #** **State**

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

_____/_____ _____/_____ _____/_____/_____
Graduation Date (MM/YYYY) **First Date in Practice** (MM/YYYY) **Current Retro Date** (if claims-made)

_____ _____ _____-_____-_____
Current Prof. Assoc. Membership Name **National Provider Number** (Optional) **Soc. Security No.** (Optional)

III. Individual Applicant Information (continued)

3. Please select your affiliation to the practice: □ Shareholder □ Partner □ Employee □ Independent Contractor □ Faculty

_____ _____ / _____ / _____ _____ _____
Name (Last, First, M.I., Suffix) **Date of Birth** **Degree** **Specialty**

Percentage of Practice: (Total must equal 100%.) □ **Loc.#1** _____**%** [redacted] □ **Loc.#3** _____**%**

_____ _____ □ Active □ Inactive □ Pending/Temporary _____ _____ □ Active □ Inactive □ Pending/Temporary
License # **State** **License #** **State**

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

_____ / _____ _____ / _____ _____ / _____ / _____
Graduation Date (MM/YYYY) **First Date in Practice** (MM/YYYY) **Current Retro Date** (if claims-made)

_____ _____ _____-_____-_____
Current Prof. Assoc. Membership Name **National Provider Number** (Optional) **Soc. Security No.** (Optional)

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

A. Have you, your entity, or any applicant requesting coverage above, 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 above, 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, your entity or any applicant requesting coverage above 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, your entity, or any applicant requesting coverage above, 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)

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)

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): _____

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? □ 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

If Occurrence Coverage is Desired:

A. Coverage desired: □ Occurrence coverage

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

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

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

D. List your current professional liability insurer(s) for the last 10 years, or back to your start date of practice. Please explain any gaps in coverage. (Attach a separate piece of paper, if necessary.)**:**

_____

Current Insurer: □ Occurrence □ Claims-made

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

If Claims-Made Coverage is Desired: If selecting Occurrence coverage above, skip to Extended Reporting Section on the following page.

Notes:

1. **Claims-made coverage is limited generally 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 an "extension contract(s)" or "tail coverage".**
2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage desired:
- □ Claims-made without Prior Acts Coverage
- □ Claims-made with Prior Acts Coverage
- □ Convertible claims-made: Step to Occurrence 4th-yr. if claim free

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

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

C. Current Claims-made policy retroactive date (Date is required for Claims-Made with Prior Acts.)**: ____ / ____ / ____** (MM/DD/YYYY)
Please attach a copy of your current Declaration Page(s).

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

E. List your current and previous professional liability insurer(s) for the last 10 years, back to your current retroactive date, or start date of practice. Please explain any gaps in coverage. (Attach a separate piece of paper, if necessary.)

_____

Current Insurer: □ Occurrence □ Claims-made

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

Extended Reporting Section:

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 extension contract endorsement (tail coverage) has been or will be purchased.
- □ An extension contract endorsement (tail coverage) has not 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, which I am applying from The Medical Protective Company, will not provide Prior Acts coverage.

Initial Here

VII. Fraud Notice

MANDATORY: ***ALL APPLICANTS must read and initial the following:***
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.

Initial Here

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.

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, or any applicant, understand and agree that a credit report and/or a credit score may be obtained, reviewed or used in connection with the submission of this application. I or any applicant understand and agree that the 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 this application or to assist in the development of a credit-based score.

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 warrant that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

I warrant 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.

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/Title	Printed Name	Date Signed (MM/DD/YYYY)
Agent/Producer Name	License Number	

IX. SUPPLEMENTAL INFORMATION

THE MEDICAL PROTECTIVE COMPANY APPLICANT(S) NAME: _____

HEALTHCARE PROFESSIONAL **PROFESSIONAL LIABILITY INSURANCE APPLICATION**

LOSS INFORMATION SUPPLEMENT

Please complete the following information for each applicant involved in each claim. Please make copies if additional forms are needed for multiple claims and/or each applicant.

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), surgery center(s) or healthcare provider(s), if any, involved: _____

_____

G. Current status: □ Open □ Closed
If open, indicate dollar value established by insurer: $ _____

If closed, date of closing: _____ / _____ (MM/YYYY)

Was a payment made? □ Yes □ No

1. If Yes, did you consent to the settlement? □ Yes □ No
2. Total amount of settlement or award: $ _____
3. 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:

_____

_____

_____

_____

THE MEDICAL PROTECTIVE COMPANY APPLICANT NAME(S): _____

HEALTHCARE PROFESSIONAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

ANESTHESIA SUPPLEMENT

Please make copies if additional forms are needed.

A. Number of Physician Anesthesiologists: ____ CRNA's: _____

B. Other than Physician Anesthesiologists or CRNA's, list anyone who administers anesthesia or conscious sedation:

_____

_____

C. Is the anesthesia provider currently licensed in your state? ☐ Yes ☐ No

If No, please explain: _____

D. Are all individuals who administer the sedation certified in one or more of the following?

☐ CPR ☐ ACLS ☐ ATLS ☐ PALS ☐ No

If No, please explain: _____

E. Are all anesthesiologists required to be board-certified/eligible in anesthesiology? ☐ Yes ☐ No

F. Please indicate who administers conscious sedation and/or general anesthesia:

☐ MD/DO ☐ RN/LPN

☐ AA/NA/CRNA

G. Where is conscious sedation and/or general anesthesia performed?

☐ Office ☐ Accredited Facility*

☐ Hospital ☐ Other (please specify): _____

For:

☐ Own patients ☐ Other than own patients

If administered outside of a hospital or accredited facility*, please answer questions H. through M.

H. How often does your staff participate in simulated emergency training?

Every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: _____

I. What American Society of Anesthesiology (ASA) physical status classifications categories are treated?

Check all that apply: **ASA:** _____ I. _____ II. _____ III. _____ IV. _____ V.

J. How often does your practice update health histories?

☐ Every_____months ☐ 3 months ☐ 6 months ☐ 12 months

K. Is a pre-anesthesia evaluation done by an anesthesiologist? ☐ Yes ☐ No

L. Is there a separate informed consent for anesthesia? ☐ Yes ☐ No

M. Please place an "x" next to the equipment utilized.

☐ Fail Safe Mechanism on Anesthesia Machine	☐ Sphygmomanometer/ Stethoscope	☐ Portable Suction
☐ Basic Airway Equipment	☐ Electrocardiographic Monitoring System	☐ Capnography
☐ Face Mask Resuscitator	☐ Pulse Oximeter	☐ Auxiliary Lighting
☐ Oral and Nasopharyngeal Airways	☐ Emergency Pharmaceutical Kit	☐ CO_2 Detector
☐ Endotracheal Tubes (Adult/Child size)	☐ Internal/External Temperature Monitor	☐ Cardiac Defibrillator
☐ Laryngoscopes	☐ Tracheostomy/Crycothyrotomy Equipment	☐ Emergency Tube Thoracostomy Equipment

If you do not utilize any of the above equipment, please explain:

_____

1. Who owns and maintains the oxygen equipment? _____

N. Do you treat children, 18 years of age or younger? ☐ Yes ☐ No

***Note:** *Accredited Facility* means approved by one of the following accrediting agencies: the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF), Accreditation Association for Ambulatory Health Care (AAAHC), Det Norske Veritas Healthcare (DNV Healthcare), Healthcare Facilities Accreditation Program (HFAP), The Institute for Medical Quality (IMQ), The Joint Commission: Hospital Accreditation Program (HAP), Critical Access Hospital Accreditation Program (CAH), Office-Based Surgery Accreditation Program (OBS), and Ambulatory Care Accreditation Program (AMB).

THE MEDICAL PROTECTIVE COMPANY
HEALTHCARE PROFESSIONAL

APPLICANT NAME(S):_____
PROFESSIONAL LIABILITY INSURANCE APPLICATION

AGENT SIGNING ON BEHALF OF APPLICANT SUPPLEMENTAL APPLICATION

If application is being signed by the applicant's agent: By my signature, I hereby represent that the applicant(s) has granted me full authority to execute this application on his, her or the entity's behalf. I also represent that I have reviewed the responses contained in this application with the applicant(s), and we are in agreement that 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 applicant and that applicant understands and agrees that such representations are binding upon him, her or the entity, even though I am executing this application on the applicant's behalf. I further acknowledge that any material misrepresentation or omission made on this application may form the basis for the Company to terminate my agency agreement with cause. **Not available in Alaska and Virginia.**

Agent's Signature

Printed Name

License Number

Date (MM/DD/YYYY)

THE MEDICAL PROTECTIVE COMPANY APPLICANT(S) NAME: _____

HEALTHCARE PROFESSIONAL **PROFESSIONAL LIABILITY INSURANCE APPLICATION**

ADDITIONAL INSURED SUPPLEMENT

III.b. Individual Applicant Information: Each applicant must complete the following additional questions specific to his/her specialty. (Please make copies if multiple applicants are applying.)

A. If you are an Independent Contractor or Business Entity, are you required to name an Additional Insured* to your Professional Liability policy? □ Yes □ No

1. Include only facilities required to be named under contract.

   Additional Insured Name: _____
   Designation (if applicable)

   Mailing Address: _____
   Street City State Zip Code

2. Please list each entity and individual applicant(s) affiliated with the Additional Insured listed above.

   a. Affiliated Applicant Name(s): _____

   b. □ Check here if all entity and individual applicants are affiliated with the above Additional Insured.

*Coverage limited to Additional Insured's vicarious liability based solely on professional services rendered, or which should have been rendered, by the Named Insured.