Tail APPLICATION FOR PHYSICIANS PROFESSIONAL LIABILITY RETROACTIVE COVERAGE POLICY

For the purposes of this Application, "Retroactive Period" means the period of time requested in Question 13. of this Application during which a "Professional Services Wrongful Act" must be committed or allegedly committed.

APPLICANT INFORMATION

1. Name of Applicant: ____

   License Number: ____________________ Date of Birth: _________________Federal DEA #: _______________

2. Mailing Address:

   Street: ____

   City: ________________________ County: ___________________ State: ________ Zip Code: __________

   Telephone #: __________________ Email Address: ____

3. Practice Location(s)
   List all locations where Applicant practiced or taught during the requested "Retroactive Period".
   Please attach a separate sheet for additional locations.

   (a) Practice Name: ___________________________________ Employment Period: ________________________

   Practice Street Address: ____

   City: _____________________ County: ___________________ State: _______ Zip Code: __________

   Telephone #: ___________Website: __________________ E-mail address: ___________________________

   (b) Practice Name: ___________________________________ Employment Period: ________________________

   Practice Street Address: ____

   City: ______________________ County: ___________________ State: ________ Zip Code: __________

   Telephone #: ______________ E-mail address: ____

   (c) Practice Name: ___________________________________ Employment Period: ________________________

Practice Street Address: ______________________________

City: ______________ County: ______________ State: ________ Zip Code: __________

Telephone #: ____________ E-mail address: ______________________________

4. Practice Type
   Check all applicable types of practice during the requested "Retroactive Period."

☐ Employed Physician ☐ Independent Contractor ☐ Solo Physician

☐ Professional Corporation ☐ Partnership ☐ Other: ______________

MEDICAL EDUCATION AND TRAINING

5. Applicant's Current Specialty: ______________________ Practice %: __________

   Applicant's Current Sub-Specialty: ______________________ Practice %: __________

6. (a) Medical School: ______________________ ______________ __________
   Name of School City State

   Year Graduated: ______________ Degree: ______________

   (b) Internship: ______________________ ______________ __________
   Name of School City State

   From: ______________ To: ______________

   (c) Residency: ______________________ ______________ __________
   Name of Hospital City State

   Year Completed: ______________ Specialty: ______________

7. Is the Applicant a foreign medical school graduate? ☐ Yes ☐ No

   If "Yes," please provide all information pertinent to your ECFMG certification: ______________________

   ____

8. Is the Applicant board eligible or certified by any board recognized by the American Board of Medical Specialties? ☐ Yes ☐ No

   If "Yes," please provide the name of the board, the date of certification and the expiration date of certification:

   ____

   ____

INSURANCE INFORMATION

9. List current and previous medical professional liability policies for the past seven (7) years (list additional policies on a separate sheet).

Company	Policy Period	Policy Limit	Deductible or SIR	Retroactive Date	Premium

10. Does the Applicant's current medical professional liability policy allow the Applicant to report known facts, circumstances, situations, transactions, events, acts, errors or omissions that could give rise to a claim that would fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "No," please explain: ____

____

11. MISSOURI RESIDENTS – DO NOT ANSWER
Has any insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant or any individual or entity proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide details: ____

____

REQUESTED COVERAGE STRUCTURE

The requested coverage is not automatically provided. The terms and conditions of the policy, if issued, will determine actual coverage.

12. Briefly describe the reason(s) why the requested coverage is needed: ______________________________

____

13. Retroactive Period: From: ____________ To: ______________

14. Duration of coverage: ☐ 1 year ☐ 3 year ☐ 5 year ☐ 7 year ☐ Unlimited ☐ Other: _______

15. Policy Effective Date: __________________

16. Limits Each Claim ________________ Aggregate________________

17. Limit Structure:

☐ Limits for insured physician only

☐ Separate limits for insured physician and separate limits for insured entity (if applicable)

☐ Shared limits for insured physician and insured entity (if applicable)

Note: In all cases, any non-physician insureds share in the insured physician or insured entity limits, as applicable, unless otherwise scheduled.

Separate limits may be subject to a Policy Maximum Aggregate Limit.

18. Deductible: Each Claim ________________ Aggregate ________________

19. Allied Health Care Providers
Please provide the number of healthcare professionals described below who were employed by or worked under the control of the Applicant during the requested "Retroactive Period."

_______Certified Registered Nurse Anesthetists _______Physician Assistants _______Nurse Practitioners
_______Physical/Occupational Therapists _______Surgical Assistants _______Psychologists
_______Registered Nurses/Licensed Practical Nurses _______Other (please describe: ________________)

PRACTICE INFORMATION

20. Has the Applicant or any individual or entity proposed for coverage under this insurance ever:

(a) been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐ Yes ☐ No

(b) been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐ Yes ☐ No

(c) been treated for any alcohol, narcotics or substance abuse? ☐ Yes ☐ No

(d) had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐ Yes ☐ No

(e) had hospital privileges reduced, suspended or revoked? ☐ Yes ☐ No

(f) had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐ Yes ☐ No

If "Yes" to any of the above, please explain: ____

____

21. Did the Applicant's specialty and/or types of procedures performed change during the requested "Retroactive Period"? ☐ Yes ☐ No

If "Yes," please explain:____

22. During the requested "Retroactive Period," did the Applicant work part-time? ☐ Yes ☐ No

If "Yes," please explain:____

23. Did the Applicant's practice during the requested "Retroactive Period" include the following?

☐ No Surgery ☐ Minor Surgery ☐ Major Surgery

24. Did the Applicant's practice during the requested "Retroactive Period" include any of the following:

Obstetrics?	☐ Yes	☐ No
Weight Loss/Bariatric Surgery?	☐ Yes	☐ No
Pediatrics?	☐ Yes	☐ No
Cosmetic Surgery?	☐ Yes	☐ No

If "Yes" to any of the above, please explain: ______________________________

25. Within the requested "Retroactive Period," did the Applicant use any locum tenens physicians? ☐ Yes ☐ No

If "Yes," please explain: ______________________________

26. During the requested "Retroactive Period," did the Applicant own, operate or control any specialized medically related unit including, but not limited to, a pharmacy, laboratory, physical therapy center or surgery center? ☐ Yes ☐ No

If "Yes," please explain: ______________________________

CLAIM HISTORY INFORMATION

27. During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against any individual or entity proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide a completed Claim Summary Supplement for each such claim.

28. Neither the Applicant nor any individual or entity proposed for coverage under this insurance is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is "none," so state:______________________________

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.
NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

NOTICE TO 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

NOTICE TO 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.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA, NEW MEXICO AND 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 civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND 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 may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO 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.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO 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.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If

aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

SIGNATURES AND AUTHORIZATIONS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments of information submitted with this Application (together referred to as the “Application”) are true and complete.

The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract.

The information contained in and submitted with this Application is on file with the Underwriter and, along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter’s acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant will immediately notify the Underwriter, and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

______________________________ ______________________ __________________

Signature Title Date

REQUIRED INFORMATION

ProducedBy:

Agent: ____________________ Agency: ____________________

Agency Taxpayer ID or SS No.:____________________ Agent License No.: ____________________

Address ____

City: ____________________ State: ____________ Zip Code: ____________

SubmittedBy:

Agency: ____

Agency Taxpayer ID or SS No.:____________________ Agent License No.: ____________________

Address ____

City: ____________________ State: ____________ Zip Code: ____________