TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
(hereafter, the "Underwriter")
A wholly owned subsidiary of The Doctors Company

Physicians Professional Liability Retroactive Coverage Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE AND REPORTED COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

For purposes of this Application, "Retroactive Period' means the period of time requested in question 9 of this Application, during which a "professional services wrongful act" must be committed or allegedly committed.

ACCOUNT INFORMATION

1.	Applicant Name			
	Other Names Used			
	Degree / Title			
	Birth Date (MM/DD/YYYY)			
	Federal DEA # National Practitioner ID Number (if available)			
2.	Home Address	Street:		
		City:	State:	Zip:
		County:	Email:	
		Phone:	Fax:	
3.	Principal Office Address	Street:		
		City:	State:	Zip:
		County:	Website	
		Phone:	Fax:	
		Email:		

4.	Other Office Address(s)	Street:
		City: State: Zip:
		County: Website:
		Phone: Fax:

5. List all locations where the Applicant practiced during the requested "Retroactive Period:" (please attach a separate sheet for additional locations)

a) Practice Name: ____ Period: ____
Practice Street Address: ____
City: ____ State: ____ County: ____ Zip: ____
Website Address: ____
Telephone Number: ____ Email Address: ____

b) Practice Name: ____ Period: ____
Practice Street Address: ____
City: ____ State: ____ County: ____ Zip: ____
Website Address: ____
Telephone Number: ____ Email Address: ____

c) Practice Name: ____ Period: ____
Practice Street Address: ____
City: ____ State: ____ County: ____ Zip: ____
Website Address: ____
Telephone Number: ____ Email Address: ____

6. Type of Practice (check all that apply during the requested "Retroactive Period"):

☐ Individual (solo) ☐ Partnership ☐ Professional Corporation

☐ Member of Multi-Person Corporation or Association ☐ Employee of: ____

☐ Other (describe): ____ ☐ Independent Contractor of: ____

7. **Training**

Medical School: ____ Dates: ____ to ____

City: ____ State: ____ Country: ____

Internship: ____

Hospital: ____ Dates: ____ to ____

City: ____ State: ____ Country: ____

Type of Residency: ______________________________

Hospital: ______________________ Dates: ____________ to ____________

City: ______________ State: __________ Country: ______________

Fellowship Training Type: ______________________________

Hospital: ______________________ Dates: ____________ to ____________

City: ______________ State: __________ Country: ______________

Additional Medical Specialty training: ______________ Dates: ____________
______________ Dates: ____________
______________ Dates: ____________
______________ Dates: ____________

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

If "Yes," please provide all information pertinent to the Applicant's ECFMG certification:

CURRENT AND REQUESTED COVERAGE

9. Retroactive Period: From: ____________ To: ______________

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

11. Requested effective date of coverage: ______________________

12. Duration of coverage: ☐1 Year ☐3 Years ☐5 Years ☐7 Years ☐Unlimited Other: ______

13. Limits requested: Each claim: Aggregate:

14. Limit Structure Requested:

☐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.

15. Retention requested: Each claim: Aggregate:

16. MISSOURI RESIDENTS - do not answer this question.

Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? ☐Yes ☐No

If "Yes," please provide details:

17. 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

18. List current and previous medical professional liability policies for the past seven (7) years:

Insurance Carrier	Policy Period MM/DD/YY – MM/DD/YY	Limits	Ded/SIR	Retroactive Date	Premium

FINANCIAL AND EXPOSURE DETAILS

19. List all states where the Applicant is licensed:

State: License #: ______________ ☐Active ☐Inactive

State: License #: ______________ ☐Active ☐Inactive

State: License #: ______________ ☐Active ☐Inactive

20. Medical Specialty: ______________ % of Practice: ______________

If Applicant's specialty is Pain Management, Neurosurgery or Bariatric Surgery Applicant will need to complete an additional procedure questionnaire.

Sub –Specialty: ______________ % of Practice: ______________

If Applicant's specialty is Pain Management, Neurosurgery or Bariatric Surgery Applicant will need to complete an additional procedure questionnaire.

21. Is the Applicant American board certified or board eligible? ☐Yes ☐No

If "Yes," Name of Specialty Board(s): ______________

Date of Certification: ____/____/____

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

If "Yes," please explain:

23. Did the Applicant perform any procedure that is outside the practice of his/her specialty or sub-specialty during the requested "Retroactive Period"? ☐Yes ☐No

If "Yes," please explain:

OPERATIONS AND ADMINISTRATION

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

    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:

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

    If "Yes," please explain:

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

    a. No surgery ☐ Yes ☐ No
    b. Minor surgery (including minor invasive procedures ☐ Yes ☐ No
    c. Major surgery ☐ Yes ☐ No

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

    a. Obstetrics? ☐ Yes ☐ No
    b. Weight loss/bariatric surgery? ☐ Yes ☐ No
    c. Pediatrics? ☐ Yes ☐ No
    d. Cosmetic surgery? ☐ Yes ☐ No
    e. Services for any professional sports organizations? ☐ Yes ☐ No

    If "Yes" to any of the above, please explain, and include the percent of practice:

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

    If "Yes," please explain:

29. 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:

30. 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 (describe):

CLAIMS HISTORY		
31.	During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed): **NOTE**: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 31 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No
32.	Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? If "Yes," please provide details: **NOTE**: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 32 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No

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.

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.

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.

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.

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

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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an 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.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS AND 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 civil fines and criminal penalties.

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.

MISSOURI APPLICANTS: Any person commits a “fraudulent insurance act” if such person knowingly 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 oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal 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 if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

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.

OKLAHOMA APPLICANTS: WARNING: 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.

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.

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.

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) no 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.

SIGNATURE AND AUTHORIZATION

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 or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or 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 us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy. The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we 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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITITES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)			
Insurance Agency			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:
Email Address			

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.