

DOCTORS PROFESSIONAL LIABILITY

Medical Professional Liability Policy Application

- APPLICATION MUST BE SIGNED AND DATED AT TIME FIRST COMPLETED AND SENT BACK TO US.

- Please provide your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.

- Please provide copies of any applicable current policy endorsements that affect basis of coverage so that we are able to try and obtain coverage aspects equal to or better than what you currently have in place.

- Please provide a copy of an Up-to-date CV (curriculum vitae - also known as a resume).

- Please provide current (*i.e. obtained within 60 days of requested effective date*) Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years – WE WILL BE GLAD TO TRY AND HELP YOU OBTAIN THESE IF NECESSARY.



Medical Professional Liability Policy Application

I. PERSONAL INFORMATION

Full Name of Applicant: _____
FIRST MIDDLE LAST SUFFIX

Professional Designation: MD DO Date of Birth: _____ Gender: Male Female
MONTH DAY YEAR

Place of Birth: _____ Social Security Number: _____

II. OFFICE INFORMATION

Principal Office Address: _____
City County State Zip

Office Phone Number: _____ Office Fax Number: _____

Email Address: _____ Office Manager: _____

Secondary Office _____

Locations (If any): _____
City County State Zip

III. COVERAGE REQUEST

Requested Effective Date: _____ Retroactive Date: _____
MONTH DAY YEAR MONTH DAY YEAR

**If retroactive coverage is requested, please complete the attached No Known Loss Form.
 **If you do not want retroactive coverage, please complete the attached Waiver of Prior Acts Form.

Please indicate your desired level of coverage in the appropriate box.

- \$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000
- \$500,000/\$1,500,000 \$1,000,000/\$3,000,000 \$1,300,000/\$3,900,000 (New York Only)

IV. CLASSIFICATION, LICENSING AND BOARD CERTIFICATION INFORMATION

- A. What is your present specialty? _____
- B. What is your present sub-specialty? _____
- C. What percentage of your practice is devoted to your specialty? _____ Sub-specialty? _____
- D. Indicate the average number of: Patients seen per week: _____ Hours practiced per week: _____
 If working 20 hours or less, reason for being part-time? _____
 How long have you been part-time? _____



E. Licensing (List all states in which you are currently licensed.) _____

State	Medical License Number	% of Practice	Federal DEA License Number & Status	Member of State Medical Association?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

F. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates? Yes No N/A

G. Are you American Board Certified? Yes No

a. If "yes," list Specialty Board(s): _____ (Indicate allopathic or osteopathic)

b. If "yes," list date of initial Board Certification: _____

H. Please indicate the number of Continuing Medical Education (CME) credit hours you have attained over the past 12 months: _____

V. MEDICAL PROCEDURES

<input type="checkbox"/> Abortion, elective <input type="checkbox"/> Acupuncture <input type="checkbox"/> Anesthesia <input type="checkbox"/> Caudal <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> Other _____ <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Assist in Major Surgery <input type="checkbox"/> On own patients <input type="checkbox"/> On patients of others <input type="checkbox"/> Bariatric Surgical procedures <input type="checkbox"/> Gastric banding <input type="checkbox"/> Gastric bubble <input type="checkbox"/> Gastric bypass <input type="checkbox"/> Gastric stapling <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Brazilian Butt Lift / Miami Thong Lift <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implants <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Cardiac surgery <input type="checkbox"/> Cataract surgery <input type="checkbox"/> Chelation therapy <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Circumcision <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryosurgery, other than external lesions <input type="checkbox"/> Dermatological procedures <input type="checkbox"/> Botox injection <input type="checkbox"/> Chemical peels	<input type="checkbox"/> D & C <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Echocardiography <input type="checkbox"/> Endoscopic laser therapy <input type="checkbox"/> Endoscopy <input type="checkbox"/> Cystoscopy <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> EGD <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> Proctoscopy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Other _____ <input type="checkbox"/> ERCP/ERC <input type="checkbox"/> Exchange transfusion <input type="checkbox"/> Facial plastic surgery <input type="checkbox"/> Elective cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reduction <input type="checkbox"/> Closed <input type="checkbox"/> Open <input type="checkbox"/> Hand surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia repair <input type="checkbox"/> Hip nailing <input type="checkbox"/> Hospitalist Please complete the Hospitalist supplement. <input type="checkbox"/> Hyperbaric medicine <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Intensive care for newborns <input type="checkbox"/> Intensive care medicine for adults <input type="checkbox"/> Infertility treatment <input type="checkbox"/> Medical <input type="checkbox"/> In vitro fertilization <input type="checkbox"/> Other surgical <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> LASIK <input type="checkbox"/> Left heart catheterization <input type="checkbox"/> Liposuction	<input type="checkbox"/> Organ transplantation <input type="checkbox"/> Orthopedic surgery <input type="checkbox"/> Including spinal surgery <input type="checkbox"/> Without spinal surgery <input type="checkbox"/> Osteopathic manipulative medicine <input type="checkbox"/> Pain management <input type="checkbox"/> Cordotomy <input type="checkbox"/> Dorsal root gangliotomy <input type="checkbox"/> Facet blocks <input type="checkbox"/> Medication only <input type="checkbox"/> Nerve root blocks <input type="checkbox"/> Pump implantation and removal <input type="checkbox"/> Rhizotomy <input type="checkbox"/> Sphenopalatine lesioning <input type="checkbox"/> Spinal injections <input type="checkbox"/> Thoracic sympathectomy <input type="checkbox"/> Trigeminal lesioning <input type="checkbox"/> Other _____ <input type="checkbox"/> Percutaneous vertebroplasty <input type="checkbox"/> Pacemaker placement <input type="checkbox"/> Polypectomy <input type="checkbox"/> Prenatal care – 1st Trimester <input type="checkbox"/> Prenatal care – 2nd Trimester <input type="checkbox"/> Prenatal care – 3rd Trimester <input type="checkbox"/> Prolotherapy <input type="checkbox"/> Provertin retinal therapy <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Radiopaque dye injection <input type="checkbox"/> Roux-en-Y <input type="checkbox"/> Sclerotherapy <input type="checkbox"/> Spinal fusion <input type="checkbox"/> Spinal surgery, other <input type="checkbox"/> Thoracic surgery %_____ <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy/adenoidectomy <input type="checkbox"/> Transgender surgery/hormonal gender conversion <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vascular surgery %_____ <input type="checkbox"/> Vasectomy
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<input type="checkbox"/> Chemabrasion <input type="checkbox"/> Collagen injection <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Fat transfer <input type="checkbox"/> Hair transplant <input type="checkbox"/> Laser hair removal <input type="checkbox"/> Laser skin resurfacing <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Silicone injection <input type="checkbox"/> Other _____	<input type="checkbox"/> Tumescant <input type="checkbox"/> Other _____ <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Mammography <input type="checkbox"/> Mesotherapy <input type="checkbox"/> Myelography <input type="checkbox"/> Myomectomy % _____ <input type="checkbox"/> Neonatology	<p>None of the above apply to my practice (Initial) _____</p> <p>Other procedures not listed above (Please list)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<input type="checkbox"/>	No Surgery	This category allows the suturing of minor lacerations; the incision of sebaceous cysts and boils; incision and removal of foreign body(ies) from superficial or subcutaneous tissue; needle aspiration of cysts limited to subcutaneous tissue; the localized treatment of 2 nd and 3 rd degree burns; umbilical and urethral catheterization.
<input type="checkbox"/>	Minor Surgery	The following procedures as performed by all general practitioners or specialists except those performing major surgery or anesthesiology. However, this category allows no procedures performed on a patient while under general anesthesia. Endoscopic procedures including endoscopic retrograde cholangiopancreatography; colonoscopy; sigmoidoscopy; pneumatic or mechanical esophageal dilation (not with bougie or olives); arteriography; angiography; arterial cardiac or diagnostic catheterization - if by internists, only to those who have completed appropriate cardio-vascular subspecialty training; radiopaque dye injections into blood vessels, lymphatic system, sinus tracts or fistulae; needle biopsy-including lung, prostate, breast, superficial and subcutaneous tissue.
<input type="checkbox"/>	Major Surgery	This category involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of the patient, the length, or circumstances of the operation(s). This includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography, radiation therapy(ies), the removal of tumors (except skin tumors), the liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, removal of any organ or gland, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation performed under general anesthesia.

- A. If applying for Obstetrical coverage, indicate:
- a. Average number of deliveries per year _____
 - Percentage of high-risk deliveries _____
 - b. Average number of VBAC deliveries per year _____
 - What induction agents do you use on VBAC patients? _____
 - c. Do you have privileges to perform C-sections at each hospital staff? Yes No
 - d. If you employ a Nurse Midwife, how many deliveries does that individual perform annually? _____ N/A
- B. Do you or will you staff an emergency room?
- a. If “yes,” how many hours per week? _____
 - b. If “yes,” in what facilities or for what staffing company? _____
 - c. Is this emergency room practice required solely to maintain hospital staff privileges? Yes No

VI. ADDITIONAL PROFESSIONAL INFORMATION - If you answer “yes” to any of these questions please provide details.

- A. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? Yes No
- B. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? Yes No
- C. Have you ever been refused hospital privileges? Yes No
- D. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? Yes No
- E. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committees? Yes No
- F. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? Yes No

G. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? Yes No

H. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? Yes No

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.

Type(s) of Illness: _____

Date(s) of treatment(s): _____

Name of treating physician(s): _____

I. Have you ever been accused of sexual misconduct of any kind? Yes No

J. Have you or your practice been the subject of any billing or reimbursement inquiry Or investigation by any governmental agency, private health insurance payors or public Health insurance payors, including, but not limited to, Medicare or Medicaid? Yes No

K. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years? Yes No
If YES, please provide details: _____

L. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year? Yes No
If YES, please provide details: _____

M. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? Yes No

N. Do you provide medical services within the confines of any state, local or federal correctional facility, jail or prison? Yes No

- O. Do you treat patients in a nursing home or similar facility? Yes No
 If YES, how many patients do you treat there per month, on average? _____
 Are you contracted with a facility or are these your own private practice patients? _____
- P. Do you serve as a medical director of a hospital, nursing home, or other facility? Yes No
 If YES, please complete a medical directorship supplement. _____
 Do you wish to have coverage for this exposure? Yes No
 If yes, please complete a Medical Director Supplement.
 If yes, does the entity have coverage? Yes No
- Q. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (i.e. teleradiology, telemedicine or internet medicine)? Yes No
 If YES, please complete the telemedicine supplement form.
- R. Do you treat patients in an addiction facility, sober living facility or similar facility? Yes No
- S. Do you treat patients for Addiction Medicine - Outpatient Only? If yes, please complete Addiction Medicine supplement Yes No
- T. Do you provide IV ketamine treatment to patients? Yes No
- U. Do you provide Esketamine treatment to patients? Yes No
 If yes, are these services provided in a healthcare setting and are patients monitored for at least two hours prior to being discharged? Yes No
- V. Do you prescribe ketamine lozenges? Yes No
 If yes, are ketamine lozenges prescribed via Telemedicine? Yes No

VII. EDUCATIONAL INFORMATION (Complete Below or Attach CV)

MEDICAL SCHOOLS

NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING

INSTITUTION	LOCATION	SPECIALTY OR DEPARTMENT	DATES (MONTH/YEAR)		WAS THE TRAINING FULLY COMPLETED?
			START	END	
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

VIII. PRACTICE LOCATIONS HISTORY

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY

LOCATIONS	DATES (MONTH/YEAR)	
	START	END

IX. ENTITY COVERAGE

If a Solo Practice: Name of your Corporate entity and/or DBA name: _____

Do you want coverage for the above entity? _____

What is the retroactive date for this current coverage? _____

When was the entity formed? _____

If a Member of a partnership or multi-shareholder corporation / Partnership/Group Name: _____

Work as an Employee or Independent Contractor for Other - please explain and provide name of Entity/Practice you are working for: _____

X. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any Ancillary or Allied Health Care Professionals associated with your practice:

Name	Specialty	Status	Shared Limits Coverage	Additional Information
1		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	DOB _____ Year of Graduation _____ Years at Current Company _____ Years of Professional Experience _____ Hours Worked Per Week _____ Number of Patients seen Per Week _____
2		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	DOB _____ Year of Graduation _____ Years at Current Company _____ Years of Professional Experience _____ Hours Worked Per Week _____ Number of Patients seen Per Week _____
3		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	DOB _____ Year of Graduation _____ Years at Current Company _____ Years of Professional Experience _____ Hours Worked Per Week _____ Number of Patients seen Per Week _____
4		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	DOB _____ Year of Graduation _____ Years at Current Company _____ Years of Professional Experience _____ Hours Worked Per Week _____ Number of Patients seen Per Week _____
5		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	DOB _____ Year of Graduation _____ Years at Current Company _____ Years of Professional Experience _____ Hours Worked Per Week _____ Number of Patients seen Per Week _____



B. Do any of your employees practice at a location geographically separate from yours? Yes No
 If “yes”, please explain. _____

Had any of the above Allied Health Care Professional:		
1	Named in a suit or subject of disciplinary or investigatory proceeding or reprimand by an administrative or governmental agency?	<input type="checkbox"/>
2	Had their insurance canceled, declined or refused to renew?	<input type="checkbox"/>
3	Have been convicted of a felony?	<input type="checkbox"/>
4	Have sought treatment for drug or alcohol addiction?	<input type="checkbox"/>
5	Are aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any other named insured?	<input type="checkbox"/>
6	Administer any anesthesia?	<input type="checkbox"/>
7	Perform or assist in any surgical procedure?	<input type="checkbox"/>
8	Work at any other company or location other than the one applying for this coverage?	<input type="checkbox"/>

XI. HOSPITAL AFFILIATIONS AND PRIVILEGES

HOSPITALS WHERE YOU HAVE, OR HAD, ACTIVE PRIVILEGES OR WHERE YOU HAVE APPLIED

HOSPITAL DATA		DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE
NAME	MAILING ADDRESS	START	END		
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

XII. PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

INSURANCE COMPANY NAME	# OF CLOSED CLAIMS	# OF PENDING CLAIMS	POLICY DATES		RETROACTIVE DATE	TALL COVERAGE PURCHASED?
			FROM	TO		

A. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes No

B. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? (THIS INCLUDES ANY WHICH HAVE BEEN CLOSED or DISMISSED) Yes No
 If "yes," how many? _____

C. Other than the claims/suits indicated in 12B, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? If you respond YES to any of the below questions, then you must provide additional information.

- i. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
- ii. A letter from an attorney regarding your medical treatment of a patient? Yes No
- iii. Intra-operative or post-operative complications or any other type complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? Yes No
- iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? Yes No
- v. Any other incidents or circumstances that might reasonably lead to a claim or suit? Yes No

D. HAVE ALL INCIDENTS & CIRCUMSTANCES THAT MIGHT REASONABLY LEAD TO A CLAIM OR SUIT (even if you believe the possible claim or suit would be without merit) BEEN REPORTED TO YOUR CURRENT OR PREVIOUS PROFESSIONAL LIABILITY INSURANCE CARRIER? N/A Yes No

IMPORTANT!!! Please note that a NO answer to question D indicates that you are aware of a potential CLAIM OR SUIT but have not yet reported it to your current insurance company. Using a separate page, please provide the name of the patient you are referring to along with a detailed narrative as to what transpired and the date that the incident in question took place.



I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT MY ANSWERS AND STATEMENTS WILL BE THE BASIS FOR DETERMINING MY INSURABILITY AND PREMIUM FOR THE PROFESSIONAL LIABILITY INSURANCE BEING APPLIED FOR. I FURTHER UNDERSTAND THAT THE COMPLETION AND SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

ANY PERSON WHO KNOWINGLY OR WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

ACKNOWLEDGED AND AGREED:

Applicant Name (Printed)	Applicant Signature (Required)	Date Signed

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING – THANKS!

If you have the need to provide additional info or to elaborate on previous YES responses please do so in the space provided below:



Supplemental Claims Information

- 1. Patient's name: _____
- 2. Date reported to insurance company: _____
- 3. Name of Insurance Company: _____
- 4. Date of incident and your treatment: _____
- 5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, Yes No
medical or otherwise, or were allegations made that you did so, pertaining to this claim?

8. Status of claim (check applicable answer):

- | | | |
|---|---|--|
| <input type="checkbox"/> Suit threatened, no action taken | Court outcome in your favor: | Unresolved/Open Claim: |
| <input type="checkbox"/> Suit filed but dropped by claimant | <input type="checkbox"/> Jury verdict | <input type="checkbox"/> Awaiting mediation |
| <input type="checkbox"/> Summary judgment in your favor | <input type="checkbox"/> Directed verdict | <input type="checkbox"/> Awaiting court action |
| | | |
| <input type="checkbox"/> Suit settled out of court | Court outcome in favor of | Reserve Amount: |
| a. Date claim paid: _____ | plaintiff: | _____ |
| b. Amount paid: _____ | Jury verdict | |
| c. Did you want to settle this claim? | Directed verdict | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Amt. of loss payment: | |
| | _____ | |

9. Name and address of the attorney assigned to your case: _____

10. To your knowledge, was any settlement paid by another party involved Yes No
(i.e., your P.A., P.C., partners, employees, etc.)?
If "yes", amount was _____

11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

Signature: _____ Date: _____

Name(Printed): _____



Statement of No Claims / Losses

(This statement must be completed, signed and returned with the completed application)

My signature below confirms that:

1. The Insured has reviewed, or has had an opportunity to review, the proposed insurance Policy from the Company. All capitalized terms referenced herein shall have the same meaning afforded to them in the Policy.
2. The Insured has conducted a diligent search and investigation as part of completing this Statement of No Claims/Losses and represents and warrants to the Company the following:
 - a. No Claims, Occurrences, facts, circumstances, or situations exist that have not been previously reported to the Insured's prior insurance carrier;
 - b. No requests for medical records have been made to any Insured, which refer to a potential lawsuit, medical malpractice action, or pre-suit proceedings;
 - c. No requests for medical records have been made to any Insured about which any Insured knew (or should have known) and could have reasonably foreseen that such request might be expected to be the basis of a Claim; and
 - d. No prior insurance carrier has refused or denied coverage for any Claims made against any Insured for the previous five (5) years.
3. To the extent ANY of the above statements or representations contained in Section 2 are untrue or inaccurate, the Insured acknowledges and agrees that the Company may seek to rescind or cancel the Policy and/or that the Policy may not afford coverage for any Claim, Occurrence, fact, circumstance, or situation based on, arising out of, or in any way involving such untrue statements or representations, whether or not any Insured knew that the Application contained an untruthful or inaccurate disclosure.
4. The person signing this Statement of No Claims/Losses further represents and warrants to the Company the following:
 - a. He / She is an authorized agent of the entity(ies) and/or individual(s) seeking insurance from the Company; and
 - b. He / She is authorized to complete this Statement of No Claims/Losses on behalf of the entity (ies) and/or individual(s) seeking insurance from the Company.

Signature

Date

Name



Waiver of Prior Acts Coverage, DPLRRG

This form must be completed ONLY if you are requesting 1st year/no prior acts coverage.

I acknowledge the need to purchase tail coverage (reporting endorsement) from my previous carrier where I was insured under a claims-made policy. I realize that my failure to purchase such coverage from my previous carrier will result in an uninsured exposure while insured by my previous carrier's policy. I understand that the policy which I am purchasing from Doctors Professional Liability, RRG will not provide prior acts coverage.

Signature

Date

Printed Name



Application for Additional Insureds

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on a separate page. Submit this form with a copy of state license, CV and signed No Known Loss.

Effective Date	Additional Insured Name	Date of Birth
Professional Degree	School of Professional Degree	Year of Graduation
Social Security Number	License Number	Email Address

Primary Insured

Additional Insured Questions: (Please explain all "Yes" answers on separate page)

- Have you ever been named in a suit or subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
- Have you ever had any insurance canceled, declined or refused to renew? Yes No
- Have you ever been convicted of a felony? Yes No
- Have you ever sought treatment for drug or alcohol addiction? Yes No
- Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any other named insured? Yes No
- Do you administer any anesthesia? Yes No
- Do you perform or assist in any surgical procedures? (List All) Yes No
- Years at current company? _____
- Years of professional experience? _____
- Number of hours worked per week? _____
- Number of patients seen per week? _____
- Do you work at any other company or location other than the one applying for this coverage? Yes No

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I FURTHER ACKNOWLEDGE ANY MISREPRESENTATION OR LACK OF NOTIFYING THE CARRIER OF CHANGES IN MY PRACTICE MAY RESULT IN COVERAGE BEING VOIDED.

_____ Authorized Representative Signature	_____ Date
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Printed Name

23276 S. Pointe Dr. Suite 204 Laguna Hills , California 92653 * P 888-959-9456 * F 888-600-6280 * W www.DPLRRG.com