

**Medical Mutual Liability
Insurance Society of Maryland**
Home Office: 225 International Circle, Box 8016
Hunt Valley, MD 21030
410-785-0050 ♦ 1-800-492-0193

**APPLICATION – CLAIMS-MADE
ORGANIZATION
PROFESSIONAL LIABILITY POLICY
(For Professional Organizations)**

SECTION A – APPLICANT INFORMATION

Organization Name	
Authorized Representative	Title
Principal Office Phone Number	Fax Number
E-Mail Address	
Mailing Address (for Risk Management seminar schedules, etc.)	Billing Address (if different)
FORM OF PRACTICE	Please attach a copy of the Articles of Incorporation. <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Professional Association <input type="checkbox"/> LLC <input type="checkbox"/> Other (Describe) →
State your business activities. <input type="checkbox"/> Professional Health Care provider <input type="checkbox"/> Other: Please describe	Producer Name and Code (To be completed by the Agent or Broker only) <p style="text-align: center;">MED CHI AGENCY, INC.</p>

SECTION B – PROPOSED EFFECTIVE DATE (List here: ____/____/20__)

SECTION C – COVERAGE REQUESTED

NOTE: IF ANY REQUESTED RETROACTIVE DATE PRECEDES THE PROPOSED EFFECTIVE DATE, PLEASE ATTACH A COPY OF THE CURRENT POLICY DECLARATIONS.

COVERAGE	RETROACTIVE DATE	LIMITS OF INSURANCE
<input type="checkbox"/> Primary Professional Liability (for the Organization)		Per Medical Incident/Annual Aggregate <input type="checkbox"/> \$1,000,000 / \$3,000,000 <input type="checkbox"/> Other \$ _____ / \$ _____ (see note below)
<input type="checkbox"/> Primary Business Liability <input type="checkbox"/> For all professional office locations <input type="checkbox"/> Only for location # ___ (See Page 2)		<ul style="list-style-type: none"> The Limits Option elected for Professional Liability will apply to Business Liability. Medical Payments Coverage is automatically included for limits of \$2,000 Per Person and a \$25,000 Annual Aggregate. Company approval required for Additional Insureds.
<input type="checkbox"/> Excess Liability (Not available for all programs)		Per Medical Incident/Annual Aggregate <input type="checkbox"/> \$1,000,000 / \$1,000,000 <input type="checkbox"/> Other \$ _____ / \$ _____ (see note below)
Deductible -- check one (applies to both Professional Liability and Business Liability)		<input type="checkbox"/> None <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000

NOTE: PRIOR COMPANY APPROVAL REQUIRED FOR ALL OTHER LIMITS EXCEPT THOSE REQUIRED BY ANY PATIENT COMPENSATION FUND OR CATASTROPHE LOSS FUND.

SECTION D – GENERAL INFORMATION

Please provide an explanation below for any "yes" answer to the following questions.

1. Have you ever failed to provide complete and accurate information on any application for insurance? Yes No
2. Has any insurer ever canceled, declined, refused to renew, or only accepted on special terms or with restrictions your professional or business liability insurance? Yes No
3. Have you ever failed to give notice of an incident or claim or failed to fully cooperate in the settlement or defense of a claim in accordance with the terms of an insurance contract? Yes No
4. Do you own or operate any hospital, nursing home, sanitarium, clinic or other outpatient facility, laboratory or other business enterprise? Yes No
5. (a) Has any administrative or judicial proceeding ever been instituted against you or any of your employees to examine allegations of improper conduct, competence or utilization of professional services? Yes No
- (b) Are you aware of any circumstances that may result in such proceedings being instituted in the future? Yes No
6. Has any owner, member, shareholder, employee, independent contractor or anyone for whom you are legally liable ever had their professional or prescription license, or certification by a specialty board suspended, revoked or has probation or disciplinary action ever been invoked? Yes No

SECTION E – LOCATIONS

List every professional office location.

Location #1 Address

County:

Square Feet:

Describe any use of this location other than by you, your partners or your employees.

Location #2 Address

County:

Square Feet:

Describe any use of this location other than by you, your partners or your employees.

SECTION F – ADDITIONAL ORGANIZATION INFORMATION

If you are doing business as or trading as a name other than that which is listed in SECTION A – APPLICANT INFORMATION, please list the other name(s) below.

SECTION G – AFFILIATED PROFESSIONALS

Describe each Physician, Surgeon, Dentist, Physician’s or Surgeon’s Assistant, CRNA, CRNM, Nurse Practitioner or Dental Hygienist you engage by employment or contract.

Name and Affiliation Type	Occupational Specialty	Professional License Registration or Certification Number	Affiliation Start Date	Separately Insured By Us?
<input type="checkbox"/> Member, Stkhldr., Prtnr. <input type="checkbox"/> Employee <input type="checkbox"/> Indpt. Cont.				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Member, Stkhldr., Prtnr. <input type="checkbox"/> Employee <input type="checkbox"/> Indpt. Cont.				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Member, Stkhldr., Prtnr. <input type="checkbox"/> Employee <input type="checkbox"/> Indpt. Cont.				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Member, Stkhldr., Prtnr. <input type="checkbox"/> Employee <input type="checkbox"/> Indpt. Cont.				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Member, Stkhldr., Prtnr. <input type="checkbox"/> Employee <input type="checkbox"/> Indpt. Cont.				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Member, Stkhldr., Prtnr. <input type="checkbox"/> Employee <input type="checkbox"/> Indpt. Cont.				<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION H – INSURED AFFILIATED PROFESSIONALS

For any affiliated professionals who will share your limits of insurance (i.e., RNs, LPNs, Technicians, etc.), please list each occupational specialty/field and the number of professionals in that specialty/field.

Occupational Specialty/Field	Number of Professionals	Occupational Specialty/Field	Number of Professionals

SECTION I – PROFESSIONAL ORGANIZATION DESCRIPTION

Name any stockholders not previously listed under SECTION G – AFFILIATED PROFESSIONALS. _____

Are any of your services, equipment or offices provided to or used by any of the following?

- Any health care professional not listed on this application? Yes No
- Any other individual or entity who is not your employee? Yes No
- Any patient other than your own? Yes No

If the answer to any of the above is “yes,” please describe below. _____

SECTION J – PRIOR INSURANCE

Past 5 years or back to the proposed Retroactive Date, whichever is longer.

Policy Expiration Date	Prior Insurance Company	Policy Retroactive Date	Was a Tail Purchased?	Specialty Practiced
			<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	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION K – CLAIMS HISTORY

1. How many claims have been made or suits have been filed against the organization (including any claims closed without indemnity payment)? If none, please state "0." _____
If any, describe below or attach separate Application Supplement – Claims History.

2. If any person will be listed as an additional insured and is not submitting a separate application, how many claims have been made or suits have been filed against that person? _____
If any, describe below or attach separate Application Supplement – Claims History.

3. Do you know of any pending claims, suits, incidents or activities, including any request for patient records, that might give rise to a claim in the future other than those described above?
 Yes No **If yes, describe below or attach separate Application Supplement – Claims History.**

4. Have you reported all claims, suits, incidents or activities described above to your prior insurer?
 N/A Yes No **If no, explain the reason they have not been reported.**

If you need additional space to describe further claims, suits, incidents or activities,
 please attach a separate Application Supplement – Claims History
 or attach a separate sheet of paper which includes all of the information shown below.

Claim or Incident Number 1:		
Date of Incident	Date Claim Made	Name of Claimant or Allegedly Injured Party
Alleged Injury or Damage		

Alleged Cause of Injury or Damage

Reported to your Insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date reported to Insurer	Has an actual request for compensation been made by or on behalf of the injured party? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Insurer name and policy period. Insurer Name		Has a final resolution, judgment or settlement been reached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Policy Period	From	To	Date

Claim or Incident Number 2:		
Date of Incident	Date Claim Made	Name of Claimant or Allegedly Injured Party
Alleged Injury or Damage		

Alleged Cause of Injury or Damage

Reported to your Insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date reported to Insurer	Has an actual request for compensation been made by or on behalf of the injured party? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Insurer name and policy period. Insurer Name		Has a final resolution, judgment or settlement been reached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Policy Period	From	To	Date

SECTION O – FRAUD WARNING

For Arkansas, Louisiana 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 fines and confinement in prison.

For 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For 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.

For 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.

For Kentucky and 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.

For Maine 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.

For New Jersey applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to civil and criminal penalties.

For New Mexico 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.

For Ohio applicants: Any person, who, with intent to defraud or knowing that he 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.

For Oregon 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.

For Virginia 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 include imprisonment, fines and denial of insurance benefits.

SECTION P – APPLICANT’S STATEMENT

I certify (and warrant where permitted by law to do so) that the information contained in this Application and any Supplements or additional written documents are complete and true. I understand that this Application is subject to acceptance by the Company and does not bind coverage, that, where permitted by law, it will be made a part of any policy issued to me, and that any misrepresentation or omission of material facts will void the policy. I hereby authorize any hospital, health care provider, medical association or society, board of medical examiners, governmental agency, insurance carrier, attorney or any other person or entity having such information to release to the Company any claims or other information which in the judgment of the Company may have a bearing on my acceptability to the Company as a liability risk. I hereby release and agree to hold harmless, any releasing party, its agents, servants and employees, as well as the Company, its directors, officers, employees or agents, from any liability arising out of the release or use of the released information notwithstanding that there may be errors or omissions in such information.

Applicant’s/Insured’s Signature

Date

Producer’s Signature

Date