

**SECTION A – APPLICANT INFORMATION**

Principal Office Phone Number		Fax Number	E-Mail Address
Mailing Address (for Risk Management seminar schedules, etc.)		Billing Address (if different)	
FORM OF PRACTICE		<input type="checkbox"/> Individual Do you have a Solo Professional Corporation or Association (no other stockholding members)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach copy of Articles of Incorporation.	
BUSINESS ACTIVITIES		Please describe any business activities other than Professional Health Care Provider.	
Home Address		Producer Name and Code <i>(To be completed by the Agent or Broker only)</i> <b>MED CHI AGENCY, INC.</b>	
Home Phone Number			
Home E-Mail Address			

**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"/> <b>Primary Professional Liability</b>		Per Medical Incident/Annual Aggregate <input type="checkbox"/> \$1,000,000 / \$3,000,000 <input type="checkbox"/> Other \$ _____ / \$ _____ (see note below)
<input type="checkbox"/> <b>Primary Business Liability</b> <input type="checkbox"/> For all professional office locations <input type="checkbox"/> Only for location # ___ (See Page 5)		<ul style="list-style-type: none"> <li>The Limits Option elected for Professional Liability will apply to Business Liability.</li> <li>Medical Payments Coverage is automatically included for limits of \$2,000 Per Person and a \$25,000 Annual Aggregate.</li> <li>Company approval required for Additional Insureds.</li> </ul>
<input type="checkbox"/> <b>Excess Liability</b> (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)
<b>Deductible -- check one</b> (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. Have you ever been denied a professional or prescription license, privileges at any medical institution, certification by a specialty board, or membership in any professional society or association?  Yes  No
7. Have you ever had a professional or prescription license, or certification by a specialty board suspended, revoked, or has probation or disciplinary action ever been invoked?  Yes  No
8. Has any medical institution ever restricted, suspended or revoked your privileges, or has probation or disciplinary action ever been invoked?  Yes  No
9. Have you ever voluntarily surrendered a professional or prescription license, board certification or your privileges at any medical institution to avoid suspension, restriction, probation or revocation?  Yes  No
10. Have you ever experienced any dependency upon alcohol, narcotics or other drugs?  Yes  No
11. Are you aware of any health impairment or disability that may affect your ability to perform professionally?  Yes  No
12. Have you ever been convicted of a felony?  Yes  No
13. Have you ever intentionally falsified patient records, or made any addition, correction or change to a patient record without clearly indicating it as such?  Yes  No

**SECTION E – PRACTICE CATEGORY**

Please indicate each occupational specialty/field in which you practice by putting an X in the applicable boxes below.

NOTE: No Surgery includes incising boils and superficial fascia, suturing minor lacerations and removing of superficial skin lesions.

ANCILLARY PROFESSIONAL

- CRNA
- CRNM
- Nurse Practitioner
- Physician's Assistant
- Surgeon's Assistant
- Other: \_\_\_\_\_

PHYSICIAN/SURGEON

- Abdominal Surgery
- Aerospace Medicine
- Allergy
- Anesthesiology - Other than OB
- Anesthesiology - Including OB
- Cardiovascular - Major Surgery
- Cardiovascular - Minor Surgery  
*(Coronary invasive procedures such as angiography, arteriography, or catheterization)*
- Cardiovascular - No Surgery
- Colon and Rectal Surgery
- Dermatology - Minor Surgery
- Dermatology - No Surgery
- Diabetes
- Emergency Medicine - Major Surgery
- Emergency Medicine - No Major Surgery
- Endocrinology
- Family or General Practice - Major Surgery
- Family or General Practice - Minor Surgery  
*(Procedures such as ERCP, colonoscopy, vasectomy, biopsies, myelography, or similar procedures)*
- Family or General Practice - No Surgery  
*(Limited to non-invasive office procedures such as sigmoidoscopy, treatment/removal of skin cysts, stress testing, thoracentesis or similar procedures)*
- Family or General Practice including OB - No Surgery  
*(No C-sections, no high risk pregnancy management and no more than 30 deliveries per year)*
- Forensic/Legal Medicine - except Psychiatry
- Gastroenterology
- General Preventive Medicine
- General Surgery - Not otherwise classified
- Geneticist
- Geriatrics

- Gynecology - Fertility Treatment
- Gynecology - Major Surgery - No OB, second trimester abortion or maternal/fetal medicine
- Gynecology - Minor Surgery - No OB  
*(Procedures such as D&C, IUD insertion, or vaginal cyst excision)*
- Gynecology - No Surgery
- Hand Surgery
- Hematology
- Hospitalist/House Staff
- Hypnosis
- Infectious Diseases
- Intensive Care Medicine
- Internal Medicine - Minor Surgery  
*(Procedures such as colonoscopy, vasectomy, ERCP, biopsies, myelography or similar procedures)*
- Internal Medicine - No Surgery  
*(Limited to non-invasive office procedures such as sigmoidoscopy, treatment/removal of skin cysts, stress testing, thoracentesis or similar procedures)*
- Neoplastic Diseases - Minor Surgery  
*(Includes biopsies other than needle or skin biopsies)*
- Neoplastic Diseases - No Surgery
- Nephrology - Minor Surgery  
*(Procedures such as nephrostomy tube replacement or nephro-lithotripsy)*
- Nephrology - No Surgery
- Neurology - Including Child - No Surgery
- Neurosurgery
- Nuclear Medicine
- Nutrition
- Obstetrics & Gynecology
  - ✓ In the past 12 months, how many live & still births were performed
    - By you? \_\_\_\_\_
    - Under your direct or indirect supervision? \_\_\_\_\_
- Occupational Medicine
- Ophthalmology - Major Surgery  
*(Procedures such as fluorescein angiography, intraocular lens implant, laser photocoagulation, laser trabeculectomy, refractive surgery)*
  - ✓ Number of refractive procedures (i.e., LASIK) per year: \_\_\_\_\_

- Ophthalmology - No Surgery
- Orthopedic Surgery
- Otorhinolaryngology - Major Surgery - No Plastic Surgery
- Otorhinolaryngology - Major Surgery including Plastic Surgery
  - ✓ Total number of procedures in the past 12 months: \_\_\_\_\_
- Otorhinolaryngology - No Surgery
- Pathology
- Pediatrics
- Pharmacology - Clinical
- Psychiatrist/Physical Medicine/Rehab.
- Psychiatrist/Physical Medicine/Rehab. - No Acupuncture
- Physician - Not otherwise classified - Minor Surgery  
*(Procedures such as ERCP, colonoscopy, vasectomy, biopsies, myelography or similar procedures)*
- Physician - Not otherwise classified - No Surgery  
*(Limited to non-invasive office procedures such as sigmoidoscopy, treatment/removal of skin cysts, stress testing, thoracentesis or similar procedures)*
- Plastic Surgery
- Psychiatry - Including Child
- Psychiatry - Extended  
*(Includes shock therapy)*
- Psychoanalysis
- Psychosomatic Medicine
- Public Health
- Pulmonary Diseases - Minor Surgery  
*(Procedures such as bronchoscopy)*
- Pulmonary Diseases - No Surgery
- Radiology - Diagnostic - No Surgery  
*(No invasive procedures)*
- Radiology - Interventional  
*(Coronary invasive procedures, intracranial procedures, similar procedures)*
- Radiology - Minor Surgery  
*(Percutaneous biopsies, or other diagnostic studies of organs, tissues or structures)*
- Rheumatology
- Thoracic Surgery
- Urgent Care Medicine  
*(No hospital emergency room)*
- Urological Surgery
- Vascular Surgery - Including Peripheral
- Other (Specify): \_\_\_\_\_

- ➔ 1. Do you perform any procedures that are outside of your primary specialty?  Yes  No  
If so, please specify: \_\_\_\_\_
- ➔ 2. Do you perform any operative procedure done under general, spinal or caudal anesthesia?  Yes  No
- ➔ 3. Do you assist in any operative procedure done under general, spinal or caudal anesthesia?  Yes  No

## SECTION F – ADDITIONAL PRACTICE DETAILS

1. Do you practice medicine in correctional facilities?  Yes  No If yes, how many hours per week? \_\_\_\_\_
2. Do you practice sports medicine for or perform surgery on professional athletes?  Yes  No
3. Do you perform weight reduction surgery?  Yes  No
4. Are you diagnosing, screening, prescribing for, or treating any patients without ever seeing them directly (i.e., by mail, teleconference, internet or other electronic means)?  Yes  No If yes, how many patients and by what means?
5. Are you employed by or contracted with a nursing home, assisted living facility or similar type of facility?  Yes  No If yes, provide details.

## SECTION G – CREDENTIALS

Professional School of Graduation				State/Country	Graduated (Month/Year)
Name of Facility and Location					(Month/Year)
Internship					From:
					To:
Residency					From:
					To:
Current Professional Licenses	State	License Number	State	License Number	Social Security Number:
	Attach Photocopy of Each License				
Are you Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Board:			
Are you Board Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Certification is Expected :			

## SECTION H – PRACTICE PATIENT LOAD AND HOURS (Based on past 12 months practice.)

*\* A patient "visit" is each time a patient is seen at a professional office, hospital outpatient department, emergency room, clinic or other health care location.*

*\* For physicians or dentists entering practice within the past 12 months, estimate amount for the next 12 months.*

State (or District of Columbia)	Annual No. of Patient "Visits" (Excluding Hospital Inpatients)	Annual No. of Hospital Patients Seen (Includes Admissions, Procedures or Consultations)	Avg. Hours Per Week in Each State Listed

1. Please indicate if you are employed exclusively by a government body.  Federal  State  County  No
2. Are you entering private practice for the first time after residency, fellowship, military service, public health or federal employment?  Yes  No
3. Are you applying for part-time coverage?  Yes  No If yes, please attach Application Supplement - Part-Time Practice.

## SECTION I – PRACTICE LOCATION & AFFILIATION HISTORY

Please provide a chronology of your practice subsequent to Internship/Residency. Attach current CV.

Name of Affiliated Organizations or Health Care Provider (If self-employed, show "Self.")	State	Affiliation Type (check one)			Start Date	Termination Date
		Member/Ptnr./ Stockholder	Employee	Independent Contractor		

**SECTION J – 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 K – AFFILIATED PROFESSIONALS**

Describe each Physician, Surgeon, Physician’s or Surgeon’s Assistant, CRNA, CRNM or Nurse Practitioner 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"/> Employee <input type="checkbox"/> Independent Contractor				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor				<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION L – 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 M – 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 N – CLAIMS HISTORY**

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

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2. If any person will be listed as an additional insured, 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.**

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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.**

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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.**

<b>Claim or Incident Number 1:</b>		
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

<b>Claim or Incident Number 2:</b>		
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



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## SECTION R – FRAUD WARNING

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**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.

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## SECTION S – APPLICANT’S STATEMENT

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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.

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Applicant’s/Insured’s Signature

Date

Producer’s Signature

Date