Professionals Advocate® Insurance Company
Home Office: 225 International Circle, Box 8016
Hunt Valley, MD 21030
410-785-0050 ◆ 1-800-492-0193

APPLICATION
MEDGUARD POLICY

SECTION A – APPLICANT INFORMATION

Applicant Name	
Current Professional Liability Policy Number	E-Mail Address
Principal Office Phone Number	Fax Number
Mailing Address	Billing Address (if different)
Form of Practice (select one) ❑ Individual ❑ Individual with a solo Professional Corporation or Association ❑ Professional Corporation ❑ Partnership ❑ Joint Venture ❑ Professional Association ❑ LLC ❑ Other (Describe) ____________	Business Activities - Please describe any business activities other than Professional Health Care Provider.
Home Address (if Individual)	**Producer Name and Code** ***(To be completed by the Agent or Broker only)*** MED CHI AGENCY, INC.
Home Phone Number (if Individual)	
Home E-Mail Address (if Individual)	

SECTION B – PROPOSED EFFECTIVE DATE

(List here: _____/_____/20_____)

SECTION C – MEDGUARD DEFENSE COVERAGE LIMITS: $50,000 Annual Aggregate

No increased limits are available.

SECTION D – PRACTICE CATEGORY

Please indicate the occupational specialty/field in which you practice: ____________________

SECTION E – GENERAL INFORMATION

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

1. Have any administrative or judicial proceedings ever been instituted against you or any of your employees? ☐ Yes ☐ No

2. Are you aware of any circumstances which may result in an administrative or judicial proceeding being instituted against you or any employees in the future. ☐ Yes ☐ No

3. 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

4. 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

5. Has any medical institution ever restricted, suspended or revoked your privileges, or has probation or disciplinary action ever been invoked? ☐ Yes ☐ No

6. 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

7. Have you ever received a notice of cancellation or a notice of nonrenewal for any professional liability policy? ☐ Yes ☐ No

SECTION F – 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 G – 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.
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.

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? ☐ Yes ☐ No	Date reported to Insurer	Has an actual request for compensation been made by or on behalf of the injured party? ☐ Yes ☐ No	
List Insurer name and policy period. Insurer Name		Has a final resolution, judgment or settlement been reached? ☐ Yes ☐ No	
Policy Period	From	To	Amount	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? ☐ Yes ☐ No	Date reported to Insurer	Has an actual request for compensation been made by or on behalf of the injured party? ☐ Yes ☐ No	
List Insurer name and policy period. Insurer Name		Has a final resolution, judgment or settlement been reached? ☐ Yes ☐ No	
Policy Period	From	To	Amount	Date

SECTION H – 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 I – CREDENTIALS

Professional School of Graduation	State/Country	Graduated (Month/Year)

	Name of Facility and Location	(Month/Year)
Internship		From:
		To:
Residency		From:
		To:

	State	License Number	State	License Number	
Current Professional Licenses					Social Security Number:
					Date of Birth:

SECTION J – 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 Signature | Date | Producer's Signature | Date