MedMal DIRECT
Insuring a Healthy Practice

Allied Healthcare Professional Liability Insurance Application

** Please provide a copy of: (1) Your Curriculum Vitae (CV); (2) Your Company Letterhead; and (3) Your Current Declarations Page

This application is for claims made coverage. Please read the policy carefully.

Applicant Information:

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Birthdate _____ Gender ◯ Female ◯ Male Professional Degree(s) _____

National Provider Identifier Number: _____ Medical License: Issuing State/Number _____

Additional Medical License: Issuing State/Number _____

Section I: Contact Information

Work Phone _____ Fax _____ Cell _____ Home _____

E-mail Address _____ Website _____

Primary Practice Address:

Number/Street _____ Suite _____

City _____ County _____ State _____ Zip Code _____

Home Address:

Number/Street _____ Unit _____

City _____ County _____ State _____ Zip Code _____

Preferred Method of Contact: ☐ Cell Phone ☐ Work Phone ☐ E-mail Other _____

Primary Contact Person _____

Preferred Mailing Address: ☐ Practice Address ☐ Home Address Other _____

Section II: Professional Practice Information

List all States and Counties where you practice _____

Corporation Name _____ Number of Physicians in Corporation: _____

Supervising/Protocoling Physician's Name _____

Please Provide Proof of Professional Liability Coverage for Supervising Physician

Scope of Duties:

☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Physicians Assistant

Do you perform any procedures outside of the specialty for which you are applying? ◯ Yes ◯ No

If yes, please fully explain: _____

Medical Procedures In Your Practice

- ☐ Assisting in Major Surgery
- ☐ Chelation Therapy
- ☐ Cosmetic Procedures
- ☐ Deliveries - Hospital
- ☐ Deliveries - Non-Hospital
- ☐ Epidurals/Blocks
- ☐ Experimental Procedures
- ☐ Laser Treatments
- ☐ Pain Management
- ☐ Permanent Fillers
- ☐ Sclerotherapy (deep vein)
- ☐ Shock Therapy
- ☐ Suction Lipectomy-list types/area
- ☐ Weight Control (non diet/exercise)
- ☐ None of Above - Not Applicable

Provide your *weekly* average hours of practice time: _____ Provide your *weekly* average patient load: _____

Part Time Applicants: When did you first begin working part-time? _____

Do you expect to continue part-time practice for the next year? ◯ Yes ◯ No

Section III: Insurance Coverage Information

Requested Effective Date _____ Please Provide Retroactive Date, if you would like prior acts covered: _____

If you do not want Prior Acts Coverage, did you purchase Tail (extended reporting coverage) from your prior carrier? ◯ Yes ◯ No

Requested Limits of Liability (per incident/annual aggregate)

- ☐ $100,000/$300,000
- ☐ $200,000/$600,000
- ☐ $250,000/$750,000
- ☐ $500,000/$1,500,000
- ☐ $1,000,000/$1,000,000
- ☐ $1,000,000/$3,000,000
- ☐ $2,000,000/$5,000,000
- ☐ $3,000,000/$6,000,000

Requested Deductible: ☐ None Other: _____

Do you wish to purchase: ☐ Shared limits with insured ☐ Separate limits from insured

Have you ever practiced without medical professional liability insurance? ◯ Yes ◯ No

if yes, on what date did you resume coverage? _____ or ☐ Still not covered

Current Malpractice Carrier _____ Current Premium: _____

PRIOR MALPRACTICE COVERAGE: (please provide 10 year history)(Use additional pages if necessary

Prior Carrier _____ Coverage Period _____ ◯ Claims Made ◯ Occurrence Tail? ◯ Yes ◯ No

Prior Carrier _____ Coverage Period _____ ◯ Claims Made ◯ Occurrence Tail? ◯ Yes ◯ No

Prior Carrier _____ Coverage Period _____ ◯ Claims Made ◯ Occurrence Tail? ◯ Yes ◯ No

Prior Carrier _____ Coverage Period _____ ◯ Claims Made ◯ Occurrence Tail? ◯ Yes ◯ No

LICENSURE ACTIONS: Have you ever had any of the following denied, revoked, suspended, placed on probation, subject to reprimand, voluntarily surrendered, limited in any manner or is it currently under investigation:

License to Practice Medicine? ◯ Yes ◯ No

DEA or State permit to dispense or prescribe drugs? ◯ Yes ◯ No

Privileges with a hospital, managed care organizations or other healthcare facility? ◯ Yes ◯ No

If yes to any of the above, please explain: _____
(For more space use additional remarks part)

CRIMINAL ACTIONS: Have you ever been charged with or convicted of a felony or misdemeanor other than a minor traffic violation?

◯ Yes ◯ No If yes, please explain: _____

MENTAL HEALTH/SUBSTANCE ABUSE: Are you or have you ever been evaluated for, diagnosed with, treated for, or hospitalized for: alcohol, narcotics, any other substance abuse (or central nervous system stimulants or depressants), sexual addiction, mental or emotional illness?

◯ Yes ◯ No If yes, please explain: _____

PRIOR SEXUAL MISCONDUCT: Have you ever been accused of sexual misconduct of any kind in your professional capacity?

◯ Yes ◯ No If yes, please explain: _____

CHRONIC IMPAIRMENT: Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?

◯ Yes ◯ No If yes, please explain:

PRIOR MALPRACTICE CLAIMS: Are you currently involved in or have you ever been involved in a malpractice claim or suit including any expression of intent by a third party (i.e. records request, incident reports, or notices of intent) even if a suit was never filed?

◯ Yes ◯ No If yes, please fully explain each case using the attached Incident/Claims form.

PRIOR POTENTIAL CLAIMS/INCIDENTS: Do you know of or is it reasonably foreseeable from the facts or circumstances regarding any procedure, treatment or diagnosis you have performed or made in the past that might reasonably lead to a claim or suit being brought against you?

◯ Yes ◯ No If yes, please fully explain each case using the attached Incident/Claims form.

UNREPORTED CLAIMS/INCIDENTS: Are there outstanding incidents, claims or suits, or potential incidents, claims or suits, regardless of merit (including cyber liability), pending against you?

◯ Yes ◯ No If yes, please fully explain each case using the attached Incident/Claims form.

REGULATORY ACTIONS: Have you been notified to respond to, appear before or been investigated by any regulatory agency on a complaint of any nature (i.e. alleged improper care of a patient, unprofessional conduct, unethical conduct, fraud, etc.)?

◯ Yes ◯ No If yes, please fully explain each case using the attached Incident/Claims form.

How did you hear about MedMal Direct? _____

ADDITIONAL REMARKS

Please use the space below to provide any further explanation to any of the previous responses.
Please also include any additional information or attach documentation as needed to best inform MedMal Direct Insurance Company of anything that would be useful in the underwriting of your application for insurance.
(i.e. common procedures/diagnoses, specialized trainings, CME coursework, Risk Management tools/programs, etc.)

Agreement and Authorization

I hereby agree that the information, contained within this document, is true and is an accurate representation made by me, the undersigned.

I hereby agree that this document and any attachments represent my full and complete application for insurance with MedMal Direct Insurance Company (MDIC).

MDIC may rely upon my representations in its evaluation of my background through this application.

If accepted, I understand that insurance is being issued upon reliance of the truth of my representations.

CLAIMS MADE COVERAGE NOTICE: Except to such extent as may otherwise be provided in the Policy and its endorsements, the coverage of the Policy is limited generally to liability only for those claims that are first reported in writing to the Company while the Policy is in force. Please review the Policy carefully and discuss the coverage with your legal advisor.

I understand that insurance coverage is subject to underwriting review and approval; I understand that no insurance will be afforded unless and until this application is accepted by MDIC and I am notified of said acceptance. If accepted by MDIC and an insurance policy is issued, this application becomes part of the policy on Form MDIC-HPLP-001.

I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by MDIC solely at its discretion.

I consent to any investigation/inquiry and authorize the release and exchange of information related to me, without limitation, including favorable or unfavorable results, state or hospital disciplinary actions/proceedings, medical malpractice coverage and claims, suits and performance records between any state medical licensing board(s), any state medical association(s), any county medical association(s), prior insurance carriers, any substance abuse treatment programs (including Physicians Recovery Network (PRN)), individuals and MDIC.

I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation or information so received from whatever source. I understand that, if insured by MDIC, re-verification of my credentials will be periodically required.

This authorization shall remain valid for so long as I maintain a business relationship with MDIC, and that any party furnishing information pursuant to this authorization is entitled to rely on the representation of MDIC that this authorization is currently valid. I may cancel this authorization, upon written notice to MDIC using the address listed below.

FLORIDA APPLICANTS:
"Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or any application containing false, incomplete or misleading information, is guilty of a felony of the third degree." Section 817.234(1)(b), Florida Statutes.

A misrepresentation, omission, concealment of fact or incorrect statement made in application for an insurance policy may prevent recovery where the misrepresentation is fraudulent or material to the acceptance of risk or if knowledge of the true facts would have altered the terms of the policy, the premium, or prevented the offering for coverage. Section 627.409, Florida Statutes.

GEORGIA APPLICANTS:
"Any person who knowingly or willfully: makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing: (a) in any written statement or certificate; (b) in the filing of a claim; (c)in the making of an application for a policy of insurance . . . for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer. Any natural person convicted of this Code section shall be guilty of a felony . . . ." Section 33-1-9 Georgia Code."
(a) All statements and descriptions in any application for an insurance policy or annuity contract or in negotiations for such, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. (b) Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless: (1) Fraudulent; (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or (3) The insurer in good faith would either not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the premium rate as applied for or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been known to the insurer as required either by the application for the policy or contract or otherwise" Section 33-24-7 Georgia Code.

Agreement and Authorization (Continued)

TEXAS APPLICANTS:
"A person commits an offense if, with intent to defraud or deceive an insurer, the person, in support of a claim for payment under an insurance policy:(1) prepares or causes to be prepared a statement that:(A) the person knows contains false or misleading material information; and (B) is presented to an insurer; or (2) presents or causes to be presented to an insurer a statement that the person knows contains false or misleading material information. (a-1) A person commits an offense if the person, with intent to defraud or deceive an insurer and in support of an application for an insurance policy: (1) prepares or causes to be prepared a statement that:(A) the person knows contains false or misleading material information; and (B) is presented to an insurer; or (2) presents or causes to be presented to an insurer a statement that the person knows contains false or misleading material information. . . .(c) An offense under Subsection (a) or (b) is: . . .(3) a Class A misdemeanor if the value of the claim is $500 or more but less than $1,500;(4) a state jail felony if the value of the claim is $1,500 or more but less than $20,000; (5) a felony of the third degree if the value of the claim is $20,000 or more but less than $100,000; (6) a felony of the second degree if the value of the claim is $100,000 or more but less than $200,000; or (7) a felony of the first degree if: (A) the value of the claim is $200,000 or more; or (B) an act committed in connection with the commission of the offense places a person at risk of death or serious bodily injury. (d) An offense under Subsection (a-1) is a state jail felony. . . ." Tex. Penal Code Section 35.01.
A false statement or misrepresentation in this application renders this policy void when the matter represented is/was material to the risk or contributed to the event on which the policy became due and payable. Texas Ins. Code Section 705.004.

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." – Ohio Revised Code 3999.21

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." O.R. 365:15-1-10(c)

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." 18 Pa C.S. 4117(k)(1)

Please note that if you are a Certified Nurse Midwife in Pennsylvania, shared policy limits are unavailable. If you selected "Shared Limits with Insured" above, you will be quoted for Separate Limits coverage.

Signature _____ Printed Name _____ Date _____

_____ _____
MDIC Authorized Representative License Number

INCIDENT/CLAIM INFORMATION FORM

This is a mandatory form that requires your signature at the bottom of the page. Please print, complete and sign a copy of this form for each medical malpractice claim, incident or regulatory action. If you do not have any claims to report, please initial and sign at the bottom of the page.

Date of Incident: _____ Name of Patient: _____

Location of Incident: _____ Insurance Carrier: _____

Conditions and Diagnosis at time of incident:

Dates and Description of Professional Services Rendered:

Condition of Patient Subsequent to Professional Services (and Dates and Follow-up Visits if known):

Provide a Summary of Defense Expert Witness support:

Present Status:

☐ Open ☐ Closed Date Closed _____

Total Paid: _____ Amount Paid on your behalf: _____

_____ **Initial here and sign below if you have NO CLAIMS to report.**

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE.

Signature _____ Printed Name _____ Date _____