

REQUESTED EFFECTIVE DATE

Grid for effective date

12:01AM

POLICY NUMBER:

COMPANY USE ONLY

THE MEDICAL PROTECTIVE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

FOR FASTER SERVICE, PLEASE ENTER YOUR APPLICATION ONLINE AT WWW.MEDPRO.COM

I. GENERAL INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

PLEASE PRINT LEGIBLY, POLICY IS BASED ON READABILITY OF YOUR NAME. PLEASE ANSWER ALL QUESTIONS; IF A QUESTION IS NOT APPLICABLE, STATE "N/A"

A.

Grid for last name

LAST NAME

Grid for first name

FIRST NAME (FULL)

Grid for middle name

MIDDLE NAME

Grid for suffix

SUFFIX

Grid for degree

DEGREE

Grid for date of birth

DATE OF BIRTH MM/DD/YYYY

Grid for social security number

SOCIAL SECURITY NUMBER (OPTIONAL)

B. PRACTICE LOCATIONS (PLEASE LIST PRINCIPAL LOCATION FIRST)

(COMBINED PERCENTAGE OF PRACTICE FOR ALL LOCATIONS MUST TOTAL 100% AND CANNOT BE OF EQUAL VALUES)

% OF PRACTICE

1.

OFFICE

HOSPITAL:

ADMITTING

NON-ADMITTING

If Non-Admitting Please explain:

Grid for practice/hospital name

PRACTICE/HOSPITAL NAME

Grid for number & street

NUMBER & STREET

Grid for suite

SUITE

Grid for address 2

ADDRESS 2

Grid for city

CITY

Grid for state

STATE

Grid for zip code

ZIP CODE

Grid for county

COUNTY

% OF PRACTICE

2.

OFFICE

HOSPITAL:

ADMITTING

NON-ADMITTING

If Non-Admitting Please explain:

Grid for practice/hospital name

PRACTICE/HOSPITAL NAME

Grid for number & street

NUMBER & STREET

Grid for suite

SUITE

Grid for address 2

ADDRESS 2

Grid for city

CITY

Grid for state

STATE

Grid for zip code

ZIP CODE

Grid for county

COUNTY

% OF PRACTICE

3.

OFFICE

HOSPITAL:

ADMITTING

NON-ADMITTING

If Non-Admitting Please explain:

Grid for practice/hospital name

PRACTICE/HOSPITAL NAME

Grid for number & street

NUMBER & STREET

Grid for suite

SUITE

Grid for address 2

ADDRESS 2

Grid for city

CITY

Grid for state

STATE

Grid for zip code

ZIP CODE

Grid for county

COUNTY

I. GENERAL INFORMATION (CONTINUED)

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

C. RESIDENCE ADDRESS

NUMBER & STREET

APARTMENT #

ADDRESS 2

CITY

STATE

ZIP CODE

COUNTY

D. BILLING AND CORRESPONDENCE ADDRESS

LOCATION # (FROM I.B. ABOVE) _____ RESIDENCE OTHER (PLEASE ENTER BELOW)

NUMBER & STREET

SUITE

CITY

STATE

ZIP CODE

E. CONTACT INFORMATION

EMAIL ADDRESS

BUSINESS FAX

BUSINESS PHONE

RESIDENCE PHONE

F. IF WE NEED TO CONTACT YOU FOR ADDITIONAL INFORMATION, PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT:

EMAIL BUSINESS FAX BUSINESS PHONE RESIDENCE PHONE

G. DO YOU HAVE A WEB ADDRESS?

YES NO

IF YES, PLEASE PROVIDE THE WEBSITE ADDRESS (URL) _____

II. EDUCATIONAL BACKGROUND

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

A. MEDICAL SCHOOL

NAME OF SCHOOL

CITY

STATE

COUNTRY

DEGREE

COMPLETED FROM:

MM - YYYY

TO

MM - YYYY

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM?

YES NO

IF NO, PLEASE EXPLAIN: _____

II. EDUCATIONAL BACKGROUND (CONTINUED)

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS. (i.e., RESIDENCY SPECIALTY TRAINING, ANESTHESIA RESIDENCY TRAINING, etc.)

IF MORE THAN ONE SPECIALTY COMPLETED PLEASE ENTER EACH SPECIFIC SPECIALTY.

1.

NAME OF HOSPITAL/FACILITY

CITY

STATE

COUNTRY

SPECIALTY TYPE

COMPLETED ? YES NO

FROM MM - YYYY TO MM - YYYY

2.

NAME OF HOSPITAL/FACILITY

CITY

STATE

COUNTRY

SPECIALTY TYPE

COMPLETED ? YES NO

FROM MM - YYYY TO MM - YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., FELLOWSHIP, etc.)

YES NO

1.

NAME OF HOSPITAL/FACILITY

CITY

STATE

COUNTRY

SPECIALTY TYPE

COMPLETED ? YES NO

FROM MM - YYYY TO MM - YYYY

2.

NAME OF HOSPITAL/FACILITY

CITY

STATE

COUNTRY

SPECIALTY TYPE

COMPLETED ? YES NO

FROM MM - YYYY TO MM - YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN 6 MONTHS BETWEEN YOUR MEDICAL SCHOOL, RESIDENCY, OTHER TRAINING, OR FIRST TIME IN PRIVATE PRACTICE:

E. IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE:

MM - DD - YYYY

(YOUR POLICY MAY BE ISSUED FOR LESS THAN ONE YEAR IN ORDER TO HAVE THE POLICY EXPIRATION DATE EQUAL THE RESIDENCY ENDING DATE)

F. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME?

YES NO

G. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS?

YES NO

IF YES, HOW MANY CATEGORY 1 CREDIT HOURS?

H. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE LAST TWELVE (12) MONTHS?

YES NO

III. PRACTICE INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? YES NO

(IF THIS IS COVERED BY ANOTHER PROFESSIONAL LIABILITY INSURANCE POLICY, COMPLETE QUESTION I IN SECTION IV.)

IF YES, WHICH STATE(S): _____

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE: PLEASE CHECK THE APPROPRIATE BOX TO INDICATE THE STATUS OF YOUR LICENSE
(EXCLUDE STATE ABBREVIATION)

	STATE	LICENSE #	ACTIVE	INACTIVE	TEMPORARY	PENDING
1.	STATE	LICENSE #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	STATE	LICENSE #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	STATE	LICENSE #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	STATE	LICENSE #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING

IF NO PREVIOUS LOCATION(S), PLEASE INDICATE YOUR EARLIEST START DATE AT YOUR CURRENT LOCATION(S): MM - YYYY

1. _____
NAME OF PRACTICE

CITY

STATE

COUNTRY

SPECIALTY

FROM MM - YYYY **TO** MM - YYYY

2. _____
NAME OF PRACTICE

CITY

STATE

COUNTRY

SPECIALTY

FROM MM - YYYY **TO** MM - YYYY

3. _____
NAME OF PRACTICE

CITY

STATE

COUNTRY

SPECIALTY

FROM MM - YYYY **TO** MM - YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN ONE MONTH BETWEEN PRACTICE LOCATIONS: _____

E. TO WHICH MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG? _____

IF NONE, PLEASE EXPLAIN: _____

IV. RATING INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

**NOTE: ALL PERCENTAGES REQUESTED BELOW FOR SPECIALTIES, PROCEDURES AND SURGICAL ACTIVITIES ARE OF YOUR TOTAL PRACTICE
 PLEASE ENTER COMPLETE NAME OF SPECIALTY/SUB-SPECIALTY. COMBINED PERCENTAGES MUST EQUAL 100% **

A. WHAT IS YOUR PRESENT SPECIALTY? _____

--	--	--	--

% OF TOTAL PRACTICE

WHAT IS YOUR SUB-SPECIALTY? _____

--	--	--	--

% OF TOTAL PRACTICE

B. ARE YOU PERMANENTLY RETIRED FROM THE PRACTICE OF CLINICAL MEDICINE?

YES NO

C. AMERICAN BOARD CERTIFIED? YES NO

SPECIALTY BOARD

--	--	--	--	--	--	--	--

DATE CERTIFIED (MM/YYYY)

IF NO, ARE YOU BOARD ELIGIBLE? YES NO

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS?

MM		-					

IF NO, HAVE YOU EVER TAKEN A SPECIALTY BOARD EXAMINATION AND FAILED TO PASS?

YES NO

IF YES, HOW MANY TIMES? _____

IF YES, PLEASE EXPLAIN: _____

D. INDICATE THE AVERAGE WEEKLY NUMBERS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE. (IF YOU PRACTICE IN MULTIPLE STATES, PLEASE IDENTIFY THE FOLLOWING INFORMATION FOR EACH STATE.)

PLEASE PROVIDE WHOLE NUMBERS (NO RANGES i.e.. > <). IF "NONE" PLEASE ENTER "0" (ZERO) IN THE SPACE PROVIDED BELOW.

PATIENTS SEEN PER WEEK

--	--	--	--

HOURS PER WEEK

--	--	--	--

WALK-IN PATIENTS PER WEEK

--	--	--	--

E. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominoplasty - Tummy Tuck | <input type="checkbox"/> Cryosurgery (non-external lesions) | <input type="checkbox"/> Pacemakers - Epicardial |
| <input type="checkbox"/> Abortions- Elective _____% of total practice | <input type="checkbox"/> D & C | <input type="checkbox"/> Pacemakers - Endocardial |
| <input type="checkbox"/> Abortions- Therapeutic _____% of total practice | <input type="checkbox"/> Electromagnetic Therapy | <input type="checkbox"/> Pacemakers - Temporary |
| <input type="checkbox"/> Acupuncture - General Anesthetic | <input type="checkbox"/> Embolization | <input type="checkbox"/> Peritoneoscopy |
| <input type="checkbox"/> Acupuncture - Therapeutic/Local Anesthetic | <input type="checkbox"/> ERCP - Upper GI Endoscopy | <input type="checkbox"/> Phlebography |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal | <input type="checkbox"/> Face Lifts | <input type="checkbox"/> Pneumoencephalography |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Face Lifts Mini (done with laser) _____% of total practice | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Gastrointestinal Endoscopy | Prenatal /Gynecological Practice |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Gynecology - Major Surgery | <input type="checkbox"/> Prenatal Practice - 1st & 2nd Trimester |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Hair Transplants - Follicular Unit Transplantations | <input type="checkbox"/> Prenatal Practice - to term, no delivery |
| <input type="checkbox"/> Assisting in major surgery - own patients only | <input type="checkbox"/> Hair Transplants - Other | <input type="checkbox"/> Prenatal Practice - to term, and delivery |
| <input type="checkbox"/> Assisting in major surgery - own & other than own patients | <input type="checkbox"/> HVLA on the cervical spine on patients younger than 18 years of age | <input type="checkbox"/> Normal Deliveries - total per year _____ |
| <input type="checkbox"/> Bariatric Surgery - Laparoscopic | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Cesarean Deliveries - total per year _____ |
| <input type="checkbox"/> Bariatric Surgery - Non-Laparoscopic | <input type="checkbox"/> Laparoscopic Cholecystectomy | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Biopsy - Endoscopic | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Radial/Laser Keratotomy |
| <input type="checkbox"/> Blepharopigmentation - _____ % of total practice | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Radiation/X-Ray Therapy |
| <input type="checkbox"/> Blepharoplasty - Cosmetic _____ % of total practice | <input type="checkbox"/> Laser Therapy (Endoscopic) | <input type="checkbox"/> Radiopaque Dye - Non Ionic Only |
| <input type="checkbox"/> Blepharoplasty - Reconstruction _____ % of total practice | <input type="checkbox"/> Laser Therapy (Non-Endoscopic) | <input type="checkbox"/> Radiopaque Dye - Other than Non Ionic |
| <input type="checkbox"/> Botox _____ % of total practice | <input type="checkbox"/> Lipoinjection _____% of total practice | <input type="checkbox"/> Rectal Ozone Therapy |
| <input type="checkbox"/> Brachioplasty | Liposuction | <input type="checkbox"/> Rhinoplasty _____% of total practice |
| <input type="checkbox"/> Breast Implants - Cosmetic _____ % of total practice | <input type="checkbox"/> Other Than Tumescant Technique | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Breast Implants - Reconstruction _____ % of total practice | <input type="checkbox"/> Tumescant Technique Only _____% of total practice | <input type="checkbox"/> Sigmoidoscopy - 60 cm or less |
| <input type="checkbox"/> Breast Reduction - Cosmetic | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Sigmoidoscopy - Greater than 60 cm |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Silicone Injections _____ % of total practice |
| <input type="checkbox"/> Bronco-esophagology | <input type="checkbox"/> Mammograms | Skin Flaps/Grafts |
| <input type="checkbox"/> Buttock Implants | <input type="checkbox"/> Myelography | <input type="checkbox"/> Cosmetic _____% of total practice |
| <input type="checkbox"/> Calf Implants | Nerve Blocks | <input type="checkbox"/> Reconstruction _____% of total practice |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Facet | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Catheterization - Left Heart | <input type="checkbox"/> Intrathecal Pumps | <input type="checkbox"/> Tubal Ligations |
| <input type="checkbox"/> Catheterization - Right Heart (other than CVP lines) | <input type="checkbox"/> Lumbar Epidural Steroid | <input type="checkbox"/> Vasectomies - own patients only |
| <input type="checkbox"/> Catheterization - Swan-Ganz | <input type="checkbox"/> Myofascial | <input type="checkbox"/> Vasectomies - own & other than own patients |
| <input type="checkbox"/> Cheek/Chin/Lip Implants | <input type="checkbox"/> Occipital | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Chelation Therapy | <input type="checkbox"/> Paraspinal | <input type="checkbox"/> Weight Control Medication _____ % of total practice |
| <input type="checkbox"/> Chemical Peels - Superficial | <input type="checkbox"/> Paravertebral | <input type="checkbox"/> Other Medical Techniques |
| <input type="checkbox"/> Chemical Peels - Medium | <input type="checkbox"/> Peripheral | List Procedures (do not restate your specialty) |
| <input type="checkbox"/> Chemical Peels - Deep _____% of total practice | <input type="checkbox"/> Sciatic | _____ |
| <input type="checkbox"/> Cleft Lip Surgery - Reconstructive | <input type="checkbox"/> Spinal Cord Stimulators | _____ |
| <input type="checkbox"/> Cleft Palate Surgery - Reconstructive | <input type="checkbox"/> Triggerpoint Injection | |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Oxidation Therapy | |
| <input type="checkbox"/> Cryosurgery (Cervical) | | |

V. ADDITIONAL PROFESSIONAL INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

A. DO YOU PERFORM SURGERY ON OR ARE YOU A TEAM PHYSICIAN FOR ANY PROFESSIONAL OR COLLEGIATE ATHLETES?

YES NO

IF YES, WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED TO THIS ACTIVITY? (IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

B. DO YOU PARTICIPATE IN PHARMACEUTICAL TESTING PROGRAMS/CLINICAL INVESTIGATION STUDIES THAT ARE NOT FDA APPROVED?

YES NO

IF YES, INCLUDE A COPY OF THE INDEMNIFICATION AGREEMENT PROVIDED BY THE PHARMACEUTICAL COMPANY. (IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

C. DO YOU PRACTICE IN A NURSING HOME FACILITY?

YES NO

IF YES, WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED TO THIS ACTIVITY? (IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

D. DO YOU TREAT OR REVIEW TREATMENT OF FEDERAL PRISON INMATES?

YES NO

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

E. DO YOU TREAT NON-FEDERAL PRISON INMATES?

YES NO

IF YES, WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED TO TREATING NON-FEDERAL INMATES?

DOES THIS FACILITY HAVE A LAW LIBRARY? YES NO

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

F. DO YOU USE A COLLECTION AGENCY WHICH HAS THE AUTHORITY TO FILE COLLECTION SUITS WITHOUT YOUR KNOWLEDGE?

YES NO

G. DO YOU PRACTICE AS A MEDICAL DIRECTOR?

YES NO

TYPE AND NAME OF FACILITY: % OF TOTAL PRACTICE

BRIEFLY DESCRIBE YOUR RESPONSIBILITIES:

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

H. DO YOU DEVISE OR REVIEW PLANT/EMPLOYER SAFETY STANDARDS?

YES NO

1. WHAT PRODUCTS ARE MANUFACTURED BY THE COMPANY?

2. COMPANY NAME: LOCATION:

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION 1.)

I. HAVE YOU EVER BEEN INDICTED FOR, CHARGED WITH, OR CONVICTED OF, ANY ACT COMMITTED IN VIOLATION OF ANY LAW OR ORDINANCE OTHER THAN TRAFFIC OFFENSES OR HAD YOUR HOSPITAL PRIVILEGES, DEA LICENSE, MEDICAL LICENSE OR REIMBURSEMENT PRIVILEGES REFUSED, DENIED, REVOKED, SUSPENDED, RESTRICTED, SUBJECT TO A REPRIMAND, PLACED ON PROBATION OR VOLUNTARILY SURRENDERED?

YES NO

IF YES, PLEASE EXPLAIN AND INDICATE THE DATE(S): DATE -

J. HAS ANY PROFESSIONAL LIABILITY INSURANCE COMPANY EVER DECLINED, REFUSED, CANCELED, OR NON RENEWED YOUR COVERAGE, OR HAVE YOU EVER HAD AN INVOLUNTARY DEDUCTIBLE OR SURCHARGE ASSESSED AGAINST YOUR POLICY?

YES NO

IF YES, PLEASE INDICATE THE REASON AND THE DATE(S): DATE -

K. HAVE YOU EVER BEEN ACCUSED OF SEXUAL MISCONDUCT OF ANY KIND?

YES NO

IF YES, PLEASE EXPLAIN AND INDICATE THE DATE(S): DATE -

L. HAVE YOU INCURRED OR BECOME AWARE OF HAVING A CONDITION THAT IMPAIRS YOUR ABILITY TO PRACTICE YOUR MEDICAL SPECIALTY?

(i.e. CONVULSIVE DISORDERS, MENTAL ILLNESS, MULTIPLE SCLEROSIS, RHEUMATOID ARTHRITIS, ADDICTION OF ALCOHOL, NARCOTICS OR OTHER CONTROLLED SUBSTANCES, etc.)

YES NO

IF YES, STATE CONDITION, DATE(S) AND IDENTIFY YOUR TREATING PHYSICIAN 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. FURTHER STATEMENTS MAY BE REQUESTED AS NECESSARY BY THE COMPANY TO COMPLETE THE UNDERWRITING OF YOUR APPLICATION.

TYPE OF ILLNESS:

DURATION OF ILLNESS: MM - YYYY TO MM - YYYY

TREATING PHYSICIAN (NAME & ADDRESS):

VI. PRACTICE ORGANIZATION INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

A. INDICATE THE NUMBER OF EACH OF THE FOLLOWING WHO PROVIDE SERVICES IN YOUR OFFICE (PLEASE INCLUDE YOURSELF):

PHYSICIANS	<input type="text"/>	NURSE MIDWIFE ASSISTANTS	<input type="text"/>	PHYSICIAN ASSISTANTS	<input type="text"/>
DENTISTS	<input type="text"/>	NURSE PRACTITIONERS	<input type="text"/>	PHYSICIAN SURGICAL ASSISTANTS	<input type="text"/>
CASE MANAGERS	<input type="text"/>	NURSE SURGICAL ASSISTANTS	<input type="text"/>	PODIATRISTS	<input type="text"/>
CRNAs/ RNAs	<input type="text"/>	OCCUPATIONAL THERAPISTS	<input type="text"/>	PSYCHOLOGISTS	<input type="text"/>
CHIROPRACTORS	<input type="text"/>	PERFUSIONISTS	<input type="text"/>	RESPIRATORY THERAPISTS	<input type="text"/>
NURSE MIDWIVES	<input type="text"/>				

B. DO YOU OR ANY MEMBER OF YOUR GROUP CURRENTLY SUPERVISE ANY OF THE SPECIALISTS LISTED ABOVE WITH WHOM YOU DO NOT EITHER EMPLOY OR CONTRACT FOR SERVICES? YES NO

IF NO, DO YOU PLAN TO DO SO IN THE FUTURE? YES NO

IF YES, PLEASE PROVIDE AN EXPLANATION: _____

C. PRACTICE ORGANIZATION:

PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOUR PRACTICE AFFILIATION(S) AND "X" APPLICABLE BOXES UNDER EMPLOYMENT STATUS YOU MUST CHECK AT LEAST ONE BOX.

NOTE (1): TO SECURE SEPARATE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

SOLO UNINCORPORATED/SOLE PROPRIETOR

ENTITY NAME

EMPLOYMENT STATUS

SOLE PROPRIETOR EMPLOYEE SHAREHOLDER/PARTNER INDEPENDENT CONTRACTOR OTHER

DATE JOINED/FORMED
 -
MM YYYY

IF OTHER, PLEASE EXPLAIN: _____

SOLO INCORPORATED

ENTITY NAME

EMPLOYMENT STATUS

EMPLOYEE SHAREHOLDER/PARTNER INDEPENDENT CONTRACTOR OTHER

DATE JOINED/FORMED
 -
MM YYYY

IF OTHER, PLEASE EXPLAIN: _____

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? YES NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #:

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? YES (1) NO

IF YES, DO YOU HAVE ANY EMPLOYED OR CONTRACTED PHYSICIANS ASSOCIATED WITH YOUR PRACTICE? YES NO

IF NO, DO YOU WISH TO SHARE YOUR INDIVIDUAL POLICY LIMITS WITH YOUR SOLO CORPORATION? YES NO

IF YES, AND YOU DESIRE TO SHARE YOUR INDIVIDUAL POLICY LIMITS, PLEASE INITIAL HERE:

NOTE: TO QUALIFY FOR SHARED LIMIT SOLO CORPORATION COVERAGE, YOU MUST HAVE NO PHYSICIAN EMPLOYEES OR PHYSICIAN INDEPENDENT CONTRACTORS. INITIALS

**** IF YOU DESIRE SEPARATE POLICY LIMITS OR YOU DO NOT QUALIFY FOR "SOLO CORPORATION" COVERAGE, PLEASE CONTACT YOUR AGENT TO COMPLETE A SEPARATE ENTITY APPLICATION FOR CONSIDERATION. ****

C. PRACTICE ORGANIZATION: (CONTINUED)

PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOUR PRACTICE AFFILIATION(S) AND "X" APPLICABLE BOXES UNDER EMPLOYMENT STATUS YOU MUST CHECK AT LEAST ONE BOX.

NOTE (1): TO SECURE SEPARATE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

MULTI -SHAREHOLDER CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY

Entity name input field

ENTITY NAME

EMPLOYMENT STATUS

- EMPLOYEE, SHAREHOLDER/PARTNER, INDEPENDENT CONTRACTOR, OTHER

DATE JOINED/FORMED

MM - YYYY date input field

IF OTHER, PLEASE EXPLAIN:

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? YES NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #: input fields

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? YES (1) NO

HOSPITAL INDUSTRIAL GOVERNMENT - BRANCH: _____

Entity name input field

ENTITY NAME

EMPLOYMENT STATUS

- EMPLOYEE, SHAREHOLDER/PARTNER, INDEPENDENT CONTRACTOR, OTHER

DATE JOINED/FORMED

MM - YYYY date input field

IF OTHER, PLEASE EXPLAIN:

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? YES NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #: input fields

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? YES (1) NO

STATE LICENSED MEDICAL SURGERY CENTER: FOR USE BY OTHER PHYSICIANS YOUR PATIENTS ONLY

Entity name input field

ENTITY NAME

EMPLOYMENT STATUS

- EMPLOYEE, SHAREHOLDER/PARTNER, INDEPENDENT CONTRACTOR, OTHER

DATE JOINED/FORMED

MM - YYYY date input field

IF OTHER, PLEASE EXPLAIN:

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? YES NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #: input fields

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? YES (1) NO

VIII. CLAIM/SUIT INFORMATION FORM (PLEASE MAKE COPIES IF ADDITIONAL FORMS ARE NEEDED)

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION. ALL FIELDS MUST BE COMPLETED.

A. PATIENT/CLAIMANT INFORMATION

LAST NAME

FIRST NAME (FULL)

AGE: _____

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. (MM,YYYY)

____ - ____

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. (MM,YYYY)

____ - ____

D. HAS THIS CLAIM/INCIDENT BEEN REPORTED TO YOUR CURRENT OR FORMER INSURER?

YES NO

IF YES, DATE CLAIM REPORTED TO YOUR CURRENT OR FORMER INSURER. (MM,YYYY)

____ - ____

IF YES, PLEASE PROVIDE A COPY OF THE REPORT(S)

E. NAME OF OTHER DOCTOR(S), HOSPITAL(S) OR HEALTH CARE PROVIDER(S), IF ANY, INVOLVED IN THE CLAIM OR SUIT: _____

F. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT:

OPEN CLOSED

IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD (MM,YYYY)

____ - ____

G. INDICATE CASE VALUE ESTABLISHED BY CARRIER, IF KNOWN (IN \$) _____

H. DEFENDING INSURANCE CARRIER NAME: _____

I. WAS THIS MATTER CLOSED WITH YOUR CONSENT?

YES NO

WAS A CLAIM MADE OR A SUIT FILED?

YES NO

WAS PAYMENT MADE?

YES NO

IF NO, WAS CLAIM OR SUIT WITHDRAWN?

YES NO

IF YES, INDICATE TOTAL AMOUNT OF SETTLEMENT OR AWARD (IN \$)

AMOUNT PAID ON YOUR BEHALF (IN \$)

J. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: _____

TREATMENT PROVIDED: _____

ALLEGED NEGLIGENCE: _____

ALLEGED INJURY: _____

K. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY; YOUR INVOLVEMENT)

IX. COVERAGE INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING.

LIST CURRENT INSURER FIRST.

<p>1. _____ INSURER</p>	<input type="checkbox"/> OCCURRENCE <input type="checkbox"/> CLAIMS-MADE	MM - DD - YYYY TO MM - DD - YYYY
<p>2. _____ INSURER</p>	<input type="checkbox"/> OCCURRENCE <input type="checkbox"/> CLAIMS-MADE	MM - DD - YYYY TO MM - DD - YYYY
<p>3. _____ INSURER</p>	<input type="checkbox"/> OCCURRENCE <input type="checkbox"/> CLAIMS-MADE	MM - DD - YYYY TO MM - DD - YYYY

PLEASE EXPLAIN ANY GAPS IN COVERAGE BACK TO YOUR START DATE OF PRACTICE. _____

B. COVERAGE DESIRED

- 1. OCCURRENCE
- 2. CLAIMS-MADE COVERAGE WITHOUT PRIOR ACTS COVERAGE
- 3. CLAIMS-MADE COVERAGE WITH PRIOR ACTS COVERAGE

(A COPY OF CURRENT DECLARATION PAGE SHOWING CURRENT RETROACTIVE DATE MUST BE ATTACHED)

IF 1 OR 2 ARE SELECTED FROM THE ABOVE AND THE MOST RECENT PRIOR COVERAGE WAS ISSUED ON A CLAIMS MADE BASIS, PLEASE COMPLETE ONE OF THE FOLLOWING.

- AN EXTENDED REPORTING ENDORSEMENT (TAIL COVERAGE) HAS BEEN PURCHASED (COPY OF TAIL IS ATTACHED)
- AN EXTENDED REPORTING ENDORSEMENT HAS NOT AND WILL NOT BE PURCHASED.

I WILL NOT PURCHASE TAIL COVERAGE (REPORTING ENDORSEMENT) FROM MY CURRENT CARRIER WHERE I AM INSURED UNDER A CLAIMS-MADE POLICY. I REALIZE THAT MY FAILURE TO PURCHASE SUCH COVERAGE FROM MY CURRENT CARRIER WILL RESULT IN AN UNINSURED EXPOSURE FOR ANY CLAIMS WHICH MAY ARISE AS RESULT OF PROFESSIONAL SERVICES RENDERED WHILE INSURED BY MY CURRENT CARRIER'S POLICY. I UNDERSTAND THAT THE POLICY, FOR WHICH I AM APPLYING FOR WITH THE MEDICAL PROTECTIVE COMPANY, IF OFFERED WILL NOT PROVIDE PRIOR ACTS COVERAGE.

INITIAL HERE

CLAIMS-MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD, FOR SERVICES RENDERED BETWEEN THE RETROACTIVE DATE AND EXPIRATION DATE OF THE POLICY. PLEASE CONTACT YOUR AGENT SHOULD YOU HAVE ANY QUESTIONS PERTAINING TO THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE OR THE ADDITIONAL EXPENSE ASSOCIATED WITH AN "EXTENSION CONTRACT" OR "TAIL COVERAGE."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.

THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF YOUR CURRENT POLICY.

<p>FROM:</p>	MM - DD - YYYY	<p>12:01 A.M.</p>
<p>TO:</p>	MM - DD - YYYY	<p>12:01 A.M.</p>
<p>D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:</p>	MM - DD - YYYY	<p>12:01 A.M.</p>

ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY.

(NOTE: IF YOU ARE JOINING AN EXISTING INSURED/GROUP, YOUR COVERAGE MAY BE ISSUED TO A COMMON EXPIRATION DATE)

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:

(NOT REQUIRED FOR OCCURRENCE POLICIES OR CLAIMS-MADE WITHOUT PRIOR ACTS)

E. LIMITS DESIRED , , **PER OCCURRENCE/PER CLAIMS MADE**
, , **ANNUAL AGGREGATE**

NOTE: REQUESTED LIMITS MAY NOT BE AVAILABLE

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

BY INITIALING BELOW, I ASSIGN TO THE FOLLOWING EMPLOYER OR NAMED THIRD PARTY (INCLUDE NAME AND ADDRESS)

NAME: _____
ADDRESS: _____

INITIAL HERE

BOTH THE RIGHT TO CANCEL MY POLICY AND TO RECEIVE ANY UNEARNED PREMIUM. HOWEVER, I DO REQUEST THAT COPIES OF ALL CORRESPONDENCE, FORMAL NOTICES, etc., BE SENT TO ME AT THE LAST ADDRESS OF RECORD. THIS ASSIGNMENT MAY BE REVOKED BY ME AT ANY FUTURE TIME BY SENDING WRITTEN NOTICE TO THE MEDICAL PROTECTIVE COMPANY'S HOME OFFICE, P.O. BOX 15021, FORT WAYNE, INDIANA 46885-5021.

PLEASE NOTE: YOUR RIGHT TO CANCEL AND RECEIVE ANY PREMIUM REFUND WILL AUTOMATICALLY BE ASSIGNED:

- 1. TO THE FIRST NAMED INSURED IF YOU ARE COVERED UNDER A GROUP POLICY.
- 2. TO A THIRD PARTY FINANCE COMPANY IF IT PAYS YOUR PREMIUM ON YOUR BEHALF.

XI. STATE STATUTORY REQUIREMENT

MANDATORY: ALL MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY 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 ALSO PUNISHABLE BY CRIMINAL AND/OR CIVIL PENALTIES IN CERTAIN JURISDICTIONS.

INITIAL HERE

XII. PLEASE READ AND SIGN

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT I HAVE NOT KNOWINGLY SUPPRESSED OR MISSTATED ANY MATERIAL FACTS AND I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY. I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN MY PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY OTHER PHYSICIAN OR DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT I HAVE NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED MY COMPLETED APPLICATION; (2) OFFERED ME A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF I PAY MY PREMIUM OR FIRST INSTALLMENT BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS **I WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING MY CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REGARDING ME, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

DATE SIGNED

MM	-	DD	-	YYYY			

APPLICANT'S SIGNATURE

PRINT NAME

IF APPLICATION IS BEING SIGNED BY THE APPLICANT'S AGENT: BY MY SIGNATURE, I HEREBY REPRESENT THAT THE APPLICANT HAS GRANTED ME FULL AUTHORITY TO EXECUTE THIS APPLICATION ON HIS OR HER BEHALF. I ALSO REPRESENT THAT I HAVE REVIEWED THE RESPONSES CONTAINED IN THIS APPLICATION WITH THE APPLICANT, AND WE ARE IN AGREEMENT THEY ARE FULL AND COMPLETE TO THE BEST OF OUR COMBINED KNOWLEDGE AND BELIEF. IN ADDITION, I REPRESENT THAT I HAVE DISCUSSED THE REPRESENTATIONS PROVIDED THROUGHOUT THIS APPLICATION WITH THE APPLICANT AND THAT APPLICANT UNDERSTANDS AND AGREES THAT SUCH REPRESENTATIONS ARE BINDING UPON HIM OR HER, EVEN THOUGH I AM EXECUTING THIS APPLICATION ON THE APPLICANT'S BEHALF. I FURTHER ACKNOWLEDGE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY FORM THE BASIS FOR THE COMPANY TO TERMINATE MY AGENCY AGREEMENT WITH CAUSE.

DATE SIGNED

MM	-	DD	-	YYYY			

AGENT'S SIGNATURE

PRINT NAME

