National Healthcare Medical Professional Liability Insurance Application

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ProAssurance
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ProAssurance Casualty Company/ProAssurance Indemnity Company, Inc.
PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 608.828.1100

With your fully completed, signed and dated application, please submit the following information:

1. Current insurance policy declaration page.
2. Loss runs from prior insurance companies or explanation as to why they are not available.

Note: Submission of a completed application confers no obligation upon the Company to bind coverage.

1. Organization Information

Name of Insured/Policyholder: _____

Federal Tax ID (FEIN): _____-_____

Primary Business Address: _____

Mailing Address (if different from above): _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Contact Name/Representative for Insurance Matters: _____

Title: _____ Phone: _____ Email: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership
☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other: _____

B. ☐ For-profit ☐ Non-profit

C. How long in operation? _____

D. Does the policyholder, or any entity for which coverage is requested, practice under any dba/fka names? Yes ☐ No ☐
If yes, please list the names (attach a separate sheet if necessary):

_____

E. Please list (attach a separate sheet if necessary) all wholly owned or majority owned (51% or more) entities for which coverage is requested. Please include FEIN and retro dates:

_____

F. If requesting coverage for partially owned (under 50%) or affiliated entities, please list (attach a separate sheet if necessary) and explain why:

_____

2. Coverage Information

A. Requested Effective Date: _____ / _____ / _____
MONTH DAY YEAR

B. Primary Limits:

i. Organizations: Per Claim: $_____ Annual Aggregate: $_____ ☐ Shared ☐ Separate

ii. Physicians: Per Claim: $_____ Annual Aggregate: $_____ ☐ Shared ☐ Separate
(Non-physician employees will automatically share in the limits available to the entity. If separate limits are requested, please request below).

C. ☐ CNM ☐ CRNA ☐ NP ☐ PA ☐ Other ☐ Per Claim: $_____ Annual Aggregate: $_____

D. Excess Limits (where available):

i. Per Claim: $_____ Annual Aggregate: $_____

ii. ☐ Corporation Only ☐ Physicians Only ☐ Group Shared
(Separate limits may be subject to an overall policy aggregate limit)

E. Does the organization have contracts that require limits different than above? Yes ☐ No ☐
If yes, please provide a list (attach a separate sheet if necessary):

_____

F. Does the organization (including physician and non-physician employees) maintain compliance with any state patient compensation funds or similar governmental plans? Yes ☐ No ☐
If yes, what state?

_____

G. Deductible/Self Insured retention (SIR):

i. Per Claim: $_____ Annual Aggregate: $_____ ☐ None

ii. ☐ Indemnity Only ☐ Indemnity & Expense

H. Does a single deductible/retention apply if multiple insureds are involved in the claim? Yes ☐ No ☐

I. Is the deductible/SIR collateralized? Yes ☐ No ☐
If yes, how?

_____

J. If a SIR, does a TPA or similar organization handle the claims? Yes ☐ No ☐
If yes, who is it? If no, please explain.

_____

3. Professional Liability Insurance and Claims History

Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.

A. List current and former professional liability information. (Please provide a minimum seven year history or indicate if none.)

Name of Insurance Company (current): _____

Practice/Employer: _____ Location: _____

Policy Type: ☐ Claims-Made ☐ Occurrence Policy Limits: $_____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____
MONTH DAY YEAR

Deductible/SIR (if different than requested above): $_____

Was the policy Admitted or Excess & Surplus Lines (E&S)? Admitted ☐ E&S ☐

Name of Insurance Company (first prior): _____

Practice/Employer: _____ Location: _____

Policy Type: ☐ Claims-Made ☐ Occurrence Policy Limits: $_____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____
MONTH DAY YEAR

Deductible/SIR (if different than requested above): $_____

Was the policy Admitted or E&S? Admitted ☐ E&S ☐

B. If on a claims-made form, are you purchasing an Extended Reporting Endorsement (tail) from your current carrier? Yes ☐ No ☐ N/A ☐

C. Upon termination/departure, the prior acts for physicians are handled by: Individual Extended Reporting Endorsement (tail) ☐ Rolling Incurred But Not Reported (IBNR) ☐

D. Have any claims or suits ever been filed against your organization, physicians, or employees/contractors as a result of professional services on your behalf? Yes ☐ No ☐

E. Is the Risk Manager or General Counsel of the policyholder aware of any conduct, circumstances, occurrences or incidents likely to give rise to a claim? Yes ☐ No ☐

F. If you answered "yes" to questions D and E above, have the claims, conduct, circumstances, occurrences or incidents been reported to a previous insurer? Yes ☐ No ☐

G. Has an insurance company, including Lloyds of London, ever cancelled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions including but not limited to services, procedures, previous/current patients, or locations? Yes ☐ No ☐

4. Practice Operations

A. The organization is:

i. ☐ Single Shareholder Medical Corporation *or* ☐ Multi-shareholder medical corporation

ii. ☐ Healthcare System *or* ☐ Hospital (single or multi-location)

iii. ☐ Inpatient Specialty Facility *or* ☐ Outpatient Specialty Facility

iv. ☐ Staffing Agency *or* ☐ Locum Tenens Firm

v. ☐ Independent Physician Association *or* ☐ Management Services Organization

vi. ☐ Other (please describe; i.e. Accountable Care Organization) _____

B. Within the next 12 months, does the organization plan to:

i. Make an acquisition? Yes ☐ No ☐

ii. Increase the number of locations/physicians? Yes ☐ No ☐
If yes, please estimate magnitude:

_____

C. Within the last three years, has the organization:

i. Made an acquisition? Yes ☐ No ☐

ii. Significantly (+/- 20%) increased/decreased the number of locations/physicians? Yes ☐ No ☐

iii. Began performing services/procedures recently introduced into the medical field? Yes ☐ No ☐

D. Is the organization or any of its physicians/employees engaged in, associated with, or controlled by an exclusive contract arrangement with an ACO, MSO, PMO, or similar organization? Yes ☐ No ☐

Regulatory

E. To the best of your knowledge, has the organization or any of its physicians, healthcare professionals, or employees:

i. Ever been investigated or audited by a governmental or regulatory agency? Yes ☐ No ☐

ii. Had a patient or insurance plan file a complaint of any kind with a medical society, foundation, or state/federal agency? Yes ☐ No ☐

iii. Ever been investigated, disciplined, censured, or reprimanded by a medical society, professional review board or licensing entity or board? Yes ☐ No ☐

iv. Ever been convicted of an act committed in violation of any law or ordinance other than a traffic offense? Yes ☐ No ☐

v. Ever had Medicaid, Medicare, or any health program authorities initiate an investigation for alleged billing fraud? Yes ☐ No ☐

If you answered yes to any of the questions above, please provide complete details at the end of the application or on a separate sheet.

Risk Management

F. Does/Has the organization or any of its physicians, healthcare professionals, or employees:

i. Signed any contracts with an indemnification/hold harmless provision? Yes ☐ No ☐

ii. Own, operate, or control any specialized, medically related unit, such as pharmacy, laboratory, physical therapy center, free standing surgery center, office based surgical suite, etc.? Yes ☐ No ☐

iii. Use electronic medical records? Yes ☐ No ☐

iv. Have an electronic medication contraindication system in place? Yes ☐ No ☐

v. Have any Medical Director responsibilities? Yes ☐ No ☐

vi. Implemented policies and procedures to comply with HIPAA privacy rules? Yes ☐ No ☐

vii. Have a formal quality assurance/risk management committee? Yes ☐ No ☐

viii. Have an ongoing quality assessment and/or improvement plan? Yes ☐ No ☐
If yes, how often is it updated?

_____

Credentialing

G. Are all foreign medical graduates certified by the Educational Council for Foreign Medical School Graduates or have they passed the Federal Licensure Examination (FLEX) or United States Medical Licensing Examination (USMLE)? Yes ☐ No ☐ N/A ☐

H. Who performs the credentialing services for your entity?

i. ☐ Internal department

ii. ☐ Outside credentialing entity

iii. ☐ Rely on contracted hospital

iv. Other? _____

I. How often are all physicians' and healthcare professionals' privileges reviewed?

_____

J. Are new physicians or healthcare professionals proctored or do they have a probationary period? Yes ☐ No ☐

K. Do the hiring and screening protocols for staff include the following:

i. Educational background checks Yes ☐ No ☐

ii. Criminal background checks Yes ☐ No ☐

iii. Personal reference checks Yes ☐ No ☐

iv. Previous employer checks Yes ☐ No ☐

v. Drug/alcohol screening Yes ☐ No ☐

vi. MPL claims history Yes ☐ No ☐

vii. Medical license verification Yes ☐ No ☐

L. Does any physician or healthcare professional have coverage independent of the group? Yes ☐ No ☐

i. If yes, are annual certificates of insurance required for proof of professional liability coverage and are specific limits required? Yes ☐ No ☐

ii. Limits required:

_____

M. Do you have specific criteria/protocols in place for employees with:

i. Substance abuse issues? Yes ☐ No ☐

ii. Adverse license actions? Yes ☐ No ☐

iii. Sexual misconduct allegations? Yes ☐ No ☐

N. Do you routinely screen employees for drugs and or alcohol use? Yes ☐ No ☐

To the best of your knowledge:

O. Has any physician ever had hospital privileges reduced, suspended, or revoked? Yes ☐ No ☐

P. Has any physician ever had a license to practice denied, revoked, suspended, placed on probation, or limited in any way? Yes ☐ No ☐

Q. Has any physician or healthcare professional ever been treated for any alcohol, narcotics, or any substance abuse? Yes ☐ No ☐

R. Are there any physicians or healthcare professionals in your group who are not licensed or who have restricted licensure or privileges? Yes ☐ No ☐

If you answered yes to any of questions O through R above, please provide complete details at the end of the application or on a separate sheet.

5. Exposure Information

A. Which areas of medicine do the organization, its physicians, and healthcare professionals specialize (check all that apply)?

☐ Anesthesia/Pain Management
☐ Addiction Medicine
☐ Behavioral Health/Psychiatry
☐ Cardiology
☐ Concierge Medicine
☐ Critical Care/Intensivists
☐ Dentistry
☐ Dermatology
☐ Emergency Medicine
☐ Gastroenterology
☐ General/Vascular/Thoracic Surgery
☐ Geriatric/Home Care
☐ Hospitalist
☐ Obstetrics – Gynecology
☐ Oncology – Radiation Therapy
☐ Ophthalmology
☐ Orthopedics
☐ Otorhinolaryngology
☐ Pathology
☐ Pediatrics/Neonatology
☐ Plastic/Cosmetic Surgery
☐ Pulmonary
☐ Primary Care
☐ Podiatry
☐ Radiology
☐ Telemedicine/Virtual Clinics
☐ Urgent Care
☐ Urology
☐ Weight Loss/Bariatric Surgery
☐ Other: _____

B. What percentage of the physicians are board certified? _____%

C. Does the organization, physicians, or healthcare professionals provide services in:

i. Nursing homes? Yes ☐ No ☐ % of Practice: _____

ii. Local/state/federal correctional facilities? Yes ☐ No ☐ % of Practice: _____

iii. Home health/mobile health services? Yes ☐ No ☐ % of Practice: _____

D. Has the organization, physicians, or healthcare professionals participated in a clinical trial in the last 5 years of practice? Yes ☐ No ☐

E. Has the organization, physicians, or healthcare professionals participated as a team physician for a professional or college sports team? Yes ☐ No ☐

F. Are contracted employees to be covered on this policy? Yes ☐ No ☐

G. Indicate below the number of each type of professional employed or contracted by the organization:

Type of Professional	# of Employed	# of Contracted	Type of Professional	# of Employed	# of Contracted
Aides/Orderlies			Oral Surgeons		
Audiologists			Paramedics or EMT's		
Chiropractors			Perfusionists		
Dental Hygienists/Technicians			Pharmacists		
Dietitians/Nutritionists			Pharmacy Technicians		
Electrologists			Physician Assistants		
Inhalation/Respiratory Therapists			Physicians/Surgeons/Podiatrists/Dentists		
Laboratory Technicians			Physiotherapists		
LPN's			Psychologists/Psychotherapists		
Medical Technicians			RN's		
Nurse Anesthetists			Social Workers		
Nurse Midwives			Speech Therapists		
Nurse Practitioners			Surgical Assistants		
Occupational/Physical Therapists			X-ray/Radiology Technicians		
Opticians			Other (please describe):		
Optometrists					

H. Schedule of physicians for whom coverage is requested (please attach a separate sheet with the following information):

Name	Retro Date	Specialty	Surgery Level	Hours Per Week or FTE	State/County

I. For departed physicians whom coverage is requested (please attach a separate sheet with the following information):

Name	Specialty	Start Date	Termination Date

J. For organizations that specialize in Emergency Medicine, Urgent Care, or Hospital Medicine, please list your number of patient visits/encounters by type and location (facility or state/county):

Type and Location (Facility or State/County)	# of Patient Visits/Encounters Last 12 Months	# of Patient Visits/Encounters Previous 12 Months

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant's Signature: _____ Title: _____

Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found at ProAssurance.com.

For Agent's Use Only (if applicable)

Agent's Name and License Number	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Please attach additional sheets as necessary.

PROASSURANCE.
Treated Fairly

Important Notice About the Policy of Insurance for Which You Have Applied

This Document Affects Your Legal Rights

Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

Applicant's Signature	Date	Time
Agent	Date	Time

Note: You will need to sign this notice to be considered for coverage.

Fraud Warning Notices

Please read the fraud warning notice for your state.

General Fraud Warning – 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.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arkansas Fraud Warning – Any person who knowingly presents a false or fraudulent claim for payment for 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.

Colorado Fraud Warning – 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.

District of Columbia Fraud 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.

Florida Fraud Warning – 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.

Kansas Fraud Warning – Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky Fraud Warning – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Fraud Warning – 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.

Maine Fraud Warning - 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 denial of insurance benefits.

Maryland Fraud Warning – Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New Mexico Fraud Warning – 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.

New York Fraud Warning – 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Fraud Warning – Any person who, with the 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.

Fraud Warning Notices

Oklahoma Fraud 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.

Oregon Fraud Warning – Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania Fraud Warning – 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.

Rhode Island Fraud Warning – 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.

Tennessee Fraud Warning – 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.

Vermont Fraud Warning - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia Fraud Warning – 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.

Washington Fraud Warning - 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.

West Virginia Fraud Warning - 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.