MEDICAL PROFESSIONAL LIABILITY

ENTITY APPLICATION

The Applicant agrees that any coverage issued will be contingent upon the truth of the information provided in this application. If a policy is issued, this application will become a part of the policy, as if physically attached thereto.

Please fully complete this application as an incomplete application cannot be evaluated. Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply. Provide any supporting information on a separate sheet and reference the applicable question number. This application must be completed, dated and signed by an authorized representative of the Applicant.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the policy, if and when issued.

APPLICANT GENERAL INFORMATION

1. Full Legal Name of Applicant: _____

   Doing Business As (D/B/A): _____

   FEIN/Tax ID: _____ State of Incorporation _____

   Year Operations Began: _____ Number of Years Under Present Management: _____

   ☐Corporation ☐Limited Liability Corp. ☐Partnership ☐Other _____

2. Principal Business Address: ☐ Administrative ☐ Patient Practice ☐ Both

   Street _____City _____ County _____

   State _____ Zip _____

   Corporate Medical Director: _____ Email: _____

   Website: _____Office Telephone: _____Fax: _____

3. If patient services are performed at this location, is this the *only* location where patient services are performed? ☐ Yes ☐ No ☐ N/A

   If No, list additional patient practice locations:

   Name/Address _____

   Name/Address _____

PROFESSIONAL SERVICES

4. Applicant's Annual Gross Revenue:
   Estimated for the next 12 months: $ _____
   Actual for the last 12 months: $ _____

5. Applicant's Healthcare Accreditation Organization(s)/Professional Association(s):

_____

6. Does the above Applicant meet the definition of a "Covered Entity" according to current Healthcare Insurance Portability and Accountability Act/HIPAA requirements? ☐ Yes ☐ No
   a. Is the Applicant in full compliance with HIPAA privacy rules? ☐ Yes ☐ No
   b. List the Applicant's HIPAA Privacy Officer: _____

7. Practice statistics:
   Patient Visits/Encounters reflect the count each time a patient visits or is tested, not the number of patients

	Last 12-months	Projected/Estimated Next 12-Months
Total Patient Visits/Encounters		
Total Patient Tests Completed		

8. Is there planned expansion or growth in the next 12 – 18 months? ☐ Yes ☐ No
   If Yes, please explain: _____

ENTITY INSURANCE INFORMATION

9. Requested Effective date: _____ Requested Retroactive date: _____

10. Requested limits of insurance: Per Claim: _____ Aggregate: _____

11. Beginning with your most recent or current insurer, list all professional liability insurers for the past 5 years:

Name of Insurer	Occurrence or Claims-Made	Limits of Liability	Policy Period	Premium	Deductible	# of Claims*

**Please provide a total number of claims reported regardless of status and indemnity or expense payment*

12. Has the Applicant ever had Professional Liability insurance cancelled, declined, rescinded, or non-renewed? (Missouri Applicants do not answer) ☐ Yes ☐ No
    If Yes, please provide details: _____

13. Has the Applicant ever operated without Professional Liability insurance? ☐ Yes ☐ No
    If Yes, when and provide details: _____

EMPLOYEE, CONTRACTOR & VOLUNTEER HEALTHCARE PROVIDERS

14. Please list all current Healthcare Providers or attach a current roster that contains the following information:

-- physicians/surgeons -- allied health professionals

-- physician extenders -- other licensed healthcare providers

Name	Professional Designation	Practice Specialty	Join Date	Full-Time /Part-Time (FT/PT)	Current Carrier (if separately insured)	Current Carrier Limit of Liability (if applicable)

15. Total number of current employed, contracted and volunteer Healthcare Providers:

Physicians/Surgeons _____ Non-Physician/Surgeon providers _____

16. List all ***terminated*** Healthcare Providers whose association with the Applicant has terminated within the past 5 years or attach a roster which includes the following information:

Name	Professional Designation	Practice Specialty	Join Date	Termination Date

17. Does the Applicant desire coverage for terminated Physicians/Surgeons? ☐ Yes ☐ No

18. Does the Applicant desire coverage for terminated non-Physician/Surgeon providers? ☐ Yes ☐ No

CREDENTIALING PROTOCOLS

19. Does the Applicant have and follow established, written & documented protocols, procedures and criteria for Physician, Surgeon and Non-Physician/Surgeon Healthcare Provider Credentialing? ☐ Yes ☐ No
If Yes, please describe the process and frequency, or attach appropriate documentation of the policy.

RISK MANAGEMENT PROTOCOLS

20. Does the Applicant have and follow an established, formalized Risk Management program? ☐ Yes ☐ No
If Yes, please describe the program or attach the appropriate documentation describing the program.

21. Does the Applicant have a dedicated Risk Manager? ☐ Yes ☐ No
If Yes, is this person ☐ On-Staff or ☐ under contract.
Please include a copy of the Risk Manager's CV and job description

UNDERWRITING INFORMATION

For the following questions, explain any "Yes" response on a separate sheet of paper.

22. Has the Applicant ever had or been involved in any professional liability Claim or suit? If Yes, complete an ***Aspen Claim Information Supplement*** for each. ☐ Yes ☐ No

23. Has the Applicant ever had any claim(s), suit(s) or loss(es) that have not been reported to and accepted by any prior insurance carrier or any other source from which coverage and/or payment could be made? ☐ Yes ☐ No

24. Is the Applicant or any employed, contracted or volunteer Physician/Surgeon or Non-Physician Healthcare Provider aware of any circumstance, specific act or omission involving particular or, specific professional service(s) that may result in a claim or suit, that has not been reported to a prior insurance carrier? ☐ Yes ☐ No

25. Is the Applicant or any employed, contracted or volunteer Physician/Surgeon or Non-Physician Healthcare Provider aware of, or has received a request or demand for medical records by a patient or his/her legal representative(s) or attorney which might result in a claim or suit? ☐ Yes ☐ No

26. Has the Applicant ever had any current or prior professional liability carrier refuse coverage for, or declined to accept a report of a specific act, error, omission or circumstance involving a particular and specific professional service or act that may result in a claim, suit, threat of claim or suit, letter of intent, adverse act outcome or result notice or attorney contact? ☐ Yes ☐ No

27. Does the Applicant or any employed, contracted or volunteer Physician/Surgeon or Non-Physician/Surgeon Healthcare Provider use any non-FDA approved devices, drugs, or procedures? ☐ Yes ☐ No

28. Does the Applicant or any employed, contracted or volunteer Physician/Surgeon or Non-Physician/Surgeon Healthcare Provider provide services on behalf of any sovereign Indian nation? ☐ Yes ☐ No

FRAUD WARNING

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, FLORIDA, KANSAS, KENTUCKY, LOUISIANA, MAINE, MARYLAND, MINNESOTA, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits. **NOTICE TO 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. **NOTICE TO 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. **NOTICE TO 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. **NOTICE TO NOTICE TO KANSAS APPLICANTS:** an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto. **NOTICE TO KENTUCKY APPLICANTS:** 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. **NOTICE TO LOUISIANA 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. **NOTICE TO MAINE AND WASHINGTON 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. **NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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. **NOTICE TO MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NOTICE TO 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. **NOTICE TO NEW YORK 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 is subject to a civil penalty not to exceed

$5,000.00 and the stated value of the claim for each such violation. **NOTICE TO 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. **NOTICE TO OKLAHOMA APPLICANTS:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law. **NOTICE TO 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 material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. **NOTICE TO PUERTO RICO APPLICANTS:** The Entity understands that according to the Insurance Code of Puerto Rico (Article 27.320): "Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, it will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with a pain of no smaller fine of five thousand ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or, both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2). **NOTICE TO TENNESSEE AND 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. **NOTICE TO VERMONT APPLICANTS:** 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.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY PREMIUM INDICATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

Date (Mo./Day/Yr.)

Applicant Signature

Print or Type Name

Title

