ENTITY PROFESSIONAL LIABILITY APPLICATION

NON-ASSESSABLE CLAIMS-MADE COVERAGE

o **Medical Mutual Insurance Company of North Carolina**
o **Medical Security Insurance Company**
(both hereinafter referred to as the "Company")

(Please type or print in black ink.)

APPLICANT'S INSTRUCTIONS

- **A separate application must be completed for each joint venture, partnership, or corporation.**
- **Attach copies of all Articles of Incorporation, Partnership Agreements, etc.**
- **Answer all questions; if a question is not applicable, state NOT APPLICABLE.**
- **If space is insufficient to answer any questions fully, use Comments Section or attach separate sheet.**

I. ORGANIZATION INFORMATION

1. ____
Applicant Name **Office Manager Name**

____
Mailing Address **City** **State** **Zip**
( ) ( )
____
Fax No. **Phone No.** **E-mail Address** **Website Address**

2. **If the Applicant does business under any other name, please list all additional names:**

____

3. **Desired Policy Dates**
Effective Date:____
Do you desire Prior Acts coverage? o **No** o **Yes If yes, Retroactive Date:**______________
If Prior Acts Coverage is requested, please complete 'Section V. (Prior Acts Coverage Certification) and attach a copy of your most recent policy declarations page.

4. **Desired Limits (Each Claim/Aggregate) Choose One Option**

o $1,000,000/$1,000,000	o $4,000,000/$4,000,000
o $1,000,000/$3,000,000	o $4,000,000/$6,000,000
o $2,000,000/$2,000,000	o $5,000,000/$5,000,000
o $2,000,000/$4,000,000	o $5,000,000/$7,000,000
o $3,000,000/$3,000,000	o $6,000,000/$6,000,000
o $3,000,000/$5,000,000	o $6,000,000/$8,000,000
	o $2,000,000/$6,000,000 Available in Virginia only

5. **Will the Applicant be covered by any additional professional liability insurance policy with any other insurance company?**
o **No** o **Yes –** Please explain and provide evidence of such coverage:_____________________
____
____

I. ORGANIZATION INFORMATION (continued)

6. Please list all office locations (if additional space is needed, attach a separate sheet of paper).

Location #1:

Street Address (number, suite, etc.)	City	State	Zip

County	Telephone Number	Federal Tax ID Number	Fax Number
	( )		( )

Location #2:

Street Address (number, suite, etc.)	City	State	Zip

County	Telephone Number	Federal Tax ID Number	Fax Number
	( )		( )

Location #3:

Street Address (number, suite, etc.)	City	State	Zip

County	Telephone Number	Federal Tax ID Number	Fax Number
	( )		( )

7. Type of Organization (select the one most appropriate):

- o Single-Specialty Group Practice
- o Multi-Specialty Group Practice
- o Blood Bank
- o Emergency Center
- o Laboratory (Pathology)
- o Outpatient Surgical Center
- o Physical Therapy Center
- o Walk-in Center
- o University/Teaching Facility
- o Certified Trauma Center
- o Hospital Based Practice
- o MRI/CT (Fixed/Mobile)
- o Clinic
- o Rehabilitation/Chronic Disease
- o Urgent Care Center
- o Psychiatric/Substance Abuse Center
- o Community Based Health Center
- o Home Health Care
- o Nursing Home
- o Physical Fitness Center
- o Renal Dialysis
- o State/County Health Department

o Other – explain:____

8. Type of Legal Entity (select the one most appropriate):

- o Solo Incorporated
- o Multi-Shareholder Corporation
- o Non-profit Organization
- o Professional Corporation
- o Government Agency
- o Partnership
- o Joint Venture

o Other – explain:____

Note: Non-profit Organizations must attach list of Board of Directors and Shareholders along with proof of non-profit status

I. ORGANIZATION INFORMATION (continued)

9. List any non-physician owners and their percentage of ownership.______________________________

____

____

10. If the Applicant is a joint venture, disclose the parties in the joint venture and their percentage participation:______________________________

____

____

11. If the Applicant owns a subsidiary(ies), disclose that subsidiary here and indicate its type of organization:______________________________

____

____

II. GENERAL INFORMATION

Please fully explain any "Yes" answer in Comments Section (last page) or attach separate sheet.

1. Does the Applicant's collection agency have authority to file a collection suit at its discretion without prior approval of the Applicant? o **No** o **Yes** o **N/A**

2. Has the Applicant or any of its employees:

- **A.** Ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital, or professional association? o **No** o **Yes**
- **B.** Ever been indicted for, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges or medical licenses revoked, suspended, restricted, placed on probation or voluntarily surrendered? o **No** o **Yes**
- **C.** Ever filed for bankruptcy? o **No** o **Yes**

3. Does the Applicant maintain current certificates of insurance on file for all doctors and allied healthcare providers employed, contracted or privileged at its facility(ies)? o **No** o **Yes**

4. Does all biomedical equipment receive scheduled preventive maintenance annually by a qualified biomedical equipment technician? o **No** o **Yes** o **N/A**

- **A.** Is your biomedical equipment checked by your employees on a routine basis? o **No** o **Yes**
- **B.** If yes, are these check logs maintained in your practice? o **No** o **Yes**

5. If the Applicant provides dialysis services:

- **A.** Does your practice have a Reuse policy? o **No** o **Yes** o **N/A**
- **B.** If yes, do you follow the reuse of hemodialyzers developed by the Association for the Advancement of Medical Instrumentation (AAMI) ? o **No** o **Yes** o **N/A**

6. If the Applicant has an Ambulatory Surgery Center:

- **A.** Is the facility accredited by either o **JCAHO** or o **AAAHC?** o **No** o **Yes** o **N/A**
- **B.** What is the time in minutes to the nearest fully-equipped hospital? ______________
- **C.** Do you have a peer review committee? o **No** o **Yes** o **N/A**
- **D.** Does your recovery room provide for a dedicated nurse? o **No** o **Yes** o **N/A**

II. GENERAL INFORMATION (continued)

7. If the Applicant provides pathology services:

A. Is the facility CLIA certified? o **No** o **Yes** o **N/A**
If yes, please attach a copy of the most recent CLIA certification.

B. When is your annual OSHA review?____

C. Who is responsible for employee OSHA training?_______________________________________

8. If the Applicant provides walk-in clinic services:

A. Are the services available 24 hours a day? o **No** o **Yes** o **N/A**

B. What is the number of physician extenders supervised by a physician? ____________________

C. Do you dispense any medication(s) other than free samples? o **No** o **Yes** o **N/A**

9. If Applicant is dispensing medication (other than free samples), is a pharmacist employed? o **No** o **Yes** o **N/A**

A. Has applicable approval been received from the State Pharmacy Board? o **No** o **Yes**
If no, please explain____
____
____

10. If the Applicant provides diagnostic imaging/X-ray services:

A. Does the Applicant provide any radiation therapy? o **No** o **Yes** o **N/A**

B. Who interprets the results of the tests performed?

____o **Employed** o **Contracted**
Name/Specialty

____o **Employed** o **Contracted**
Name/Specialty

C. Does the Applicant interpret results of tests performed at facilities other than those requesting insurance through this application? o **No** o **Yes** o **N/A**

11. If Applicant is a Radiology Practice:

A. Are you using teleradiology? o **No** o **Yes** o **N/A**

B. Does your staff read or interpret X-rays from outside locations? o **No** o **Yes**
Please explain____
____
____

C. Does your equipment meet ACR standards? o **No** o **Yes**

D. Are invasive diagnostic procedures performed? o **No** o **Yes**

E. Are invasive interventional therapeutic procedures performed? o **No** o **Yes**

12. Please include annual numbers for:

A. Clinic Visits ______________________________

B. Surgeries ______________________________

C. Revenues ______________________________

III. COVERAGE INFORMATION

Please list insurance information for the past ten (10) years or back to requested retroactive date, whichever is longer.

1. Carrier Information:

	Current Carrier	**First Prior Carrier**	**Second Prior Carrier**	**Third Prior Carrier**	**Fourth Prior Carrier**
Insurance Company					
Policy Number					
Coverage form	oClaims-Made oOccurrence	oClaims-Made oOccurrence	oClaims-Made oOccurrence	oClaims-Made oOccurrence	oClaims-Made oOccurrence
Dates of Coverage					
Limit of Liability Per claim/aggregate					
Deductible or S.I.R. and amount (If applicable)	oDeductible oS.I.R. $	oDeductible oS.I.R. $	oDeductible oS.I.R. $	oDeductible oS.I.R. $	oDeductible oS.I.R. $
Retroactive Date					

2. Have you ever had any professional liability insurance refused, cancelled, or non-renewed? o **No** o **Yes**

3. List all of Applicant's employed and contracted physicians/dentist, and provide the requested information for each listed individual.

Last name first, then first and middle initials (e.g. Smith, J. G.)	Degree	(S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	Percentage of ownership (if shareholder or partner)	Specialty

4. Provide the number of employed and contracted non-physician/non-dentist personnel.

Nurses		**Nurse Practitioners**	
CRNAs		**Physician Assistants**	
Nurse Midwives		**Dental Assistant/Hygienist**	
Pharmacist		**Other-Explain:**	

IV. CLAIMS HISTORY

ATTACH CURRENT LOSS RUN (No more than 90 days old) FOR PREVIOUS 10 YEARS OF PRACTICE. (A *loss run* is a document from your previous professional liability carrier(s) verifying claims, suits or reported incidents.) *YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.*

1. **Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services?** o **No** o **Yes**
2. **Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you?** o **No** o **Yes**

IF "YES" TO 1 OR 2 ABOVE, PLEASE COMPLETE THE FOLLOWING FOR EACH SUCH CIRCUMSTANCE. IF YOU NEED MORE SPACE, USE COMMENTS SECTION (LAST PAGE) OR ATTACH ADDITIONAL SHEET. FOR PAID CLAIMS, PLEASE ATTACH A COPY OF THE NATIONAL PRACTITIONER DATA BANK SUBMISSION.

CLAIM, SUIT OR INCIDENT #1

Patient's Name	**Date of Occurrence**
Insurance Carrier	**Location of Occurrence**
Date Claim reported: o **N/A**	**Amount reserved on your behalf** $
Date Claim closed: o **N/A**	**Amount paid on your behalf** $

Allegation(s):

CLAIM, SUIT OR INCIDENT #2

Patient's Name	**Date of Occurrence**
Insurance Carrier	**Location of Occurrence**
Date Claim reported: o **N/A**	**Amount reserved on your behalf** $
Date Claim closed: o **N/A**	**Amount paid on your behalf** $

Allegation(s):

IV. CLAIMS HISTORY (continued)

CLAIM, SUIT OR INCIDENT #3

Patient's Name		**Date of Occurrence**
Insurance Carrier		**Location of Occurrence**
Date Claim reported:	O **N/A**	**Amount reserved on your behalf** $
Date Claim closed:	O **N/A**	**Amount paid on your behalf** $

Allegation(s):

V. PRIOR ACTS COVERAGE CERTIFICATION

(Complete if Prior Acts Coverage is requested in Section I. Organization Information)

I request Prior Acts Coverage retroactive to: ________________________(date), which is consistent with the attached Declarations page from my current carrier.

I certify that I have no knowledge of any professional liability claims which have been asserted against this applicant, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior or applicable carrier.

I furthermore certify I have no knowledge of any occurrence, incident or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim, occurrence, incident or circumstance should be given to your current carrier if such notice has not already been provided. This policy will not provide coverage for any such claim, occurrence, incident or circumstance)

I certify that the above is true, complete and correct to the best of my knowledge, information and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

____

Authorized Representative of Applicant | **Title** | **Date**

VI. AUTHORIZATION AND RELEASE

(This authorization and release must be signed by an authorized representative of the Applicant.)

I, the undersigned authorized representative of the Applicant, understand that this is an application for insurance and is not an insurance binder and acknowledge that the foregoing statements and answers are complete and correct to the best of my knowledge and belief. I further understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of the Applicant's protection if coverage is written as a result of this application.

I, the undersigned authorized representative of the Applicant, authorize the release and exchange of information involving either underwriting or claim matters between the Applicant's present or prior insurance carrier, any hospital and other physicians and the Company. I, on behalf of the Applicant, hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

____

Authorized Representative of Applicant | **Title** | **Date**

Name and Address of Agent:

____

____

____

Signature of Agent | **Date**

NOTICE TO VIRGINIA RESIDENTS: 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.

Please return completed application to your agent or to the Company:

Attention: Underwriting Department
PO Box 98028
Raleigh, NC 27624-8028

COMMENTS SECTION

QUESTION #	COMMENTS