



**ENTITY PROFESSIONAL LIABILITY APPLICATION**  
Non-Assessable Claims-Made Coverage

**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.
- If space is insufficient to answer any questions fully, use the Additional Comments Section at the back of this form, or attach separate documentation.

**Practice**

Full Name: \_\_\_\_\_

Web Site Address: \_\_\_\_\_

Tax ID: \_\_\_\_\_

**Office Manager**

Full Name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

**Practice Mailing Address**

Address Line 1		Address Line 2	
City	State	Zip Code	

**Practice Names**

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

\_\_\_\_\_

**Practice Locations**

Address Line 1		Address Line 2	
City	State	Zip Code	
Phone		Fax	
Address Line 1		Address Line 2	
City	State	Zip Code	
Phone		Fax	
Address Line 1		Address Line 2	
City	State	Zip Code	
Phone		Fax	

<b>Address Line 1</b>		<b>Address Line 2</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	
<b>Phone</b>		<b>Fax</b>	

### Organization

**Type of Practice (select the one most appropriate)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Single Specialty Practice | <input type="checkbox"/> University/Teaching Facility   | <input type="checkbox"/> Psychiatric/Substance Abuse Center |
| <input type="checkbox"/> Multi-Specialty Practice  | <input type="checkbox"/> Certified Trauma Center        | <input type="checkbox"/> Community Based Health Center      |
| <input type="checkbox"/> Blood Bank                | <input type="checkbox"/> Hospital Based Practice        | <input type="checkbox"/> Nursing Home                       |
| <input type="checkbox"/> Emergency Center          | <input type="checkbox"/> MRI/CT (Fixed/Mobile)          | <input type="checkbox"/> Physical Fitness Center            |
| <input type="checkbox"/> Laboratory (Pathology)    | <input type="checkbox"/> Free Clinic                    | <input type="checkbox"/> Renal Dialysis                     |
| <input type="checkbox"/> Outpatient Surgery Center | <input type="checkbox"/> Rehabilitation/Chronic Disease | <input type="checkbox"/> State/County Health Department     |
| <input type="checkbox"/> Physical Therapy Center   | <input type="checkbox"/> Urgent Care Center             | <input type="checkbox"/> Other _____                        |
| <input type="checkbox"/> Walk-in Center            |   |   |

If other, please explain:

---



---

**Type of Organization (select the one most appropriate)**

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Solo Incorporated             | <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Other - describe legal entity: _____ |
| <input type="checkbox"/> Solo Unincorporated           | <input type="checkbox"/> Government Agency        | _____   |
| <input type="checkbox"/> Multi-Shareholder Corporation | <input type="checkbox"/> Partnership              | _____   |
| <input type="checkbox"/> Non-profit Organization       | <input type="checkbox"/> Joint Venture            | _____   |

List any non-physician owners and their percentage of ownership:

---



---

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

---



---

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

---



---

### Coverage

Practice State	Practice County	Desired Effective Date ____/____/____
----------------	-----------------	--

**Desired Limits (Each Claim/Aggregate)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Same As Employer        | <input type="checkbox"/> \$3,000,000/\$3,000,000 | <input type="checkbox"/> \$5,000,000/\$7,000,000                            |
| <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$3,000,000/\$5,000,000 | <input type="checkbox"/> \$6,000,000/\$6,000,000                            |
| <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$4,000,000/\$4,000,000 | <input type="checkbox"/> \$6,000,000/\$8,000,000                            |
| <input type="checkbox"/> \$2,000,000/\$2,000,000 | <input type="checkbox"/> \$4,000,000/\$6,000,000 | <input type="checkbox"/> \$2,000,000/\$6,000,000 Available in Virginia only |
| <input type="checkbox"/> \$2,000,000/\$4,000,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000 |   |

Will the Applicant be covered by any additional professional liability insurance policy with any other insurance company?  Yes  No

Please explain and provide evidence of such coverage:

---



---

## Prior Acts Coverage

Does the Applicant desire Prior Acts coverage?  Yes  No

Retroactive Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If Prior Acts coverage is requested, please review the section below (Prior Acts Coverage Certification) and attach a copy of your most recent policy declarations page.

## Prior Acts Coverage Certification

I request Prior Acts Coverage retroactive to \_\_\_\_\_, 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 that 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, incident or circumstance should be given to your 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 \_\_\_\_\_

## General Information

- Does the Applicant's collection agency have authority to file a collection suit at its discretion without prior approval of the Applicant?  Yes  No
- Has the Applicant or any of its employees ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital, or professional association?  Yes  No
- Has the Applicant or any of its employees 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, suspend, restricted, placed on probation, or voluntarily surrendered?  Yes  No
- Has the Applicant or any of its employees ever filed for bankruptcy?  Yes  No
- 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)?  Yes  No
- Does all biomedical equipment receive scheduled preventative maintenance annually by a qualified biomedical equipment technician?  
If yes, is your biomedical equipment checked by your employees on a routine basis?  Yes  No  
If yes, are these check logs maintained in your practice?  Yes  No
- Does the Applicant provide dialysis services?  Yes  No  
If yes, does your practice have a Reuse policy?  Yes  No  
If yes, do you follow the reuse of hemodialyzers developed by the Association for the Advancement of Medical Instrumentation (AAMI)?  Yes  No
- Does the Applicant have an Ambulatory Surgery Center?  Yes  No  
If yes, is this facility accredited?  Yes  No  
ASC Accreditation:  JCAHO  AAAHC  Other \_\_\_\_\_  
What is the time in minutes to the nearest fully-equipped hospital? \_\_\_\_\_  
Do you have a peer review committee?  Yes  No  
Does your recovery room provide for a dedicated nurse?  Yes  No
- Does the Applicant provide pathology services?  Yes  No  
If yes, is the facility CLIA certified?  Yes  No  
When is your annual OSHA review? \_\_\_\_\_  
Who is responsible for employee OSHA training? \_\_\_\_\_

10. Does the Applicant provide walk-in clinic services?  Yes  No  
 Are the services available 24 hours a day?  Yes  No  
 What is the number of physician extenders supervised by a physician? \_\_\_\_\_

11. Does the Applicant dispense medications other than free samples?  Yes  No  
 If yes, is a pharmacist employed?  Yes  No  
 If yes, has applicable approval been received from the State Pharmacy Board?  Yes  No  
 If no, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Does the Applicant provide diagnostic imaging/X-ray services?  Yes  No  
 If yes, does the Applicant provide any radiation therapy?  Yes  No  
 Does the Applicant interpret results of tests performed at facilities other than those requesting insurance through this application?  Yes  No  
 Does the Applicant contract with outside/non-owned facilities to provide diagnostic interpretations?  Yes  No  
 If yes, please identify facility and describe contractual obligations:  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the Applicant provide teleradiology or utilize outside teleradiology services?  Yes  No  
 If yes, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

Does your equipment meet ACR standards?  Yes  No

**Who interprets the results of the tests performed?**

Name	Specialty	Status
1.		<input type="checkbox"/> Employed <input type="checkbox"/> Contracted
2.		<input type="checkbox"/> Employed <input type="checkbox"/> Contracted

**General Information – Annual Numbers**

Clinic Visits: \_\_\_\_\_ Revenues: (\$) \_\_\_\_\_ Surgeries: \_\_\_\_\_

**Insurance History**

	Current Carrier	1 <sup>st</sup> Prior Carrier	2 <sup>nd</sup> Prior Carrier	3 <sup>rd</sup> Prior Carrier	4 <sup>th</sup> Prior Carrier
<b>Insurance Company</b>					
<b>Policy Number</b>					
<b>Coverage form</b>	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
<b>Dates of Coverage</b>	From: ___/___/___ To: ___/___/___	From: ___/___/___ To: ___/___/___	From: ___/___/___ To: ___/___/___	From: ___/___/___ To: ___/___/___	From: ___/___/___ To: ___/___/___
<b>Liability Limit</b>					
<b>Deductible</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
<b>Retroactive Date</b>	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

**Coverage Information**

Have you ever had any professional liability insurance refused, cancelled, or non-renewed?  Yes  No  
 If yes, please explain:

---



---

Complete the following information for all of Applicant's employed and contracted physicians/dentists.

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

Last Name		First Name		MI
Degree	Role <input type="checkbox"/> Shareholder <input type="checkbox"/> Employee <input type="checkbox"/> Partner <input type="checkbox"/> Independent Contractor	% of Ownership	Specialty	

**Non-Physician/Non-Dentist Personnel**

Do you employ or contract with any non-physician or non-dentist personnel?  Yes  No  
 If yes, please complete the following:

Nurses \_\_\_\_\_ Pharmacists \_\_\_\_\_ Dental Assistants/Hygienists \_\_\_\_\_  
 CRNA's \_\_\_\_\_ Nurse Practitioners \_\_\_\_\_ Other \_\_\_\_\_  
 Nurse Midwives \_\_\_\_\_ Physician Assistants \_\_\_\_\_

If other, please specify:

---

## 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?  Yes  No

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?  Yes  No

If Yes to 1 or 2 above, please complete the following for each such circumstance. If you need more space, use comments section or attach additional sheet. For paid claims, please attach a copy of the National Practitioner Data Bank Submission.

Patient's Name			
Date of Occurrence		Insurance Carrier	
Location of Occurrence			
Date claim reported ____/____/____	Date claim closed ____/____/____	Amount reserved \$	Amount paid \$
Allegation:			

Patient's Name			
Date of Occurrence		Insurance Carrier	
Location of Occurrence			
Date claim reported ____/____/____	Date claim closed ____/____/____	Amount reserved \$	Amount paid \$
Allegation:			

