Medical Mutual℠
PROTECTING OUR PROFESSION

PHYSICIAN EXTENDER PROFESSIONAL LIABILITY APPLICATION

Non-Assessable Claims-Made Coverage

APPLICANT'S INSTRUCTIONS

- **Please answer all questions completely and as they relate to the coverage being applied for.**
- **If space is insufficient to answer any questions fully, use the Additional Comments Section at the back of this form, or attach separate documentation.**
- **Are you applying for coverage relating to vicarious liability for your employer? ❑ Yes ❑ No**

Applicant

Full Name _____

Suffix ❑ Sr. ❑ Jr. ❑ I ❑ II ❑ III ❑ IV ❑ V

Professional Designation ❑ CNM ❑ CRNA ❑ DPM ❑ LPN ❑ NP ❑ OD ❑ OT ❑ PA ❑ Pharm ❑ PhD ❑ PT ❑ RN

Date of Birth _____/_____/_____ **Social Security Number** _____

E-mail Address _____ **Office Telephone** (_____)_____

Coverage

Practice State	Practice County	Desired Effective Date / /

Desired Limits (Each Claim/Aggregate) Choose One Option

❑ Same As Employer
❑ $1,000,000/$1,000,000
❑ $1,000,000/$3,000,000
❑ $2,000,000/$2,000,000
❑ $2,000,000/$4,000,000
❑ $3,000,000/$3,000,000
❑ $3,000,000/$5,000,000
❑ $4,000,000/$4,000,000
❑ $4,000,000/$6,000,000
❑ $5,000,000/$5,000,000
❑ $5,000,000/$7,000,000
❑ $6,000,000/$6,000,000
❑ $6,000,000/$8,000,000
❑ $2,000,000/$6,000,000 Available in Virginia only

Practice Locations

I practice at this location: ❑ Primary Practice Location

Practice Name		
Address Line 1	Address Line 2	
City	State	Zip Code

List Other Locations at which you Practice

Practice Name		
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Practice Name		
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**

Continue locations on next page. . .

Practice Name		
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**

Home Address

Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Home Phone ( )		

Prior Acts Coverage

Do you desire Prior Acts coverage? ❑ Yes ❑ No If Yes, Retroactive Date _____/_____/_____

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 further more 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. <u>This policy will not provide coverage for any such claim, occurrence, incident, or circumstance.</u>

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.

Applying for coverage as:

Designation: ❑ Nurse Midwife ❑ Nurse Anesthetist (CRNA) ❑ Nurse Practitioner
❑ Physician Assistant ❑ Other: _____

License Number: _____

Professional/Clinical Education

Institution		State
From ____/____/_____	To ____/____/_____	Date of Graduation ____/____/_____
Diploma/Certification received:		

Institution		State
From ____/____/_____	To ____/____/_____	Date of Graduation ____/____/_____
Diploma/Certification received:		

Do you belong to any national organizations? ❑ Yes ❑ No

If yes, please specify:

_____

_____

Professional/Clinical Experience

Employer (Most recent)	State	From ___/___/_____	To ___/___/_____
Employer (Prior Experience)	State	From ___/___/_____	To ___/___/_____
Employer (Prior Experience)	State	From ___/___/_____	To ___/___/_____

Explain any gaps in time in your Medical Education/Training and Practice History:

_____

_____

_____

Coverage Information

How many hours will you work per week, on average with this employer? _____

Do you work outside the employment of this employing physician or group? ❑ Yes ❑ No

If yes, please explain, including name of employer, type of work, and hours:

_____

_____

_____

_____

Are you presently covered as an individual insured on another professional liability insurance policy? ❑ Yes ❑ No

If yes, will that policy continue in force? ❑ Yes ❑ No

Please explain:

**Please submit a Certificate of Insurance to verify coverage.*

Insurance History

	Current Carrier	1st Prior Carrier	2nd Prior Carrier	3rd Prior Carrier	4th Prior Carrier
Insurance Company					
Policy Number					
Coverage form	❑ Claims-Made ❑ Occurrence	❑ Claims-Made ❑ Occurrence	❑ Claims-Made ❑ Occurrence	❑ Claims-Made ❑ Occurrence	❑ Claims-Made ❑ Occurrence
Dates of Coverage	From:___/___/_____ To:___/___/_____	From:___/___/_____ To:___/___/_____	From:___/___/_____ To:___/___/_____	From:___/___/_____ To:___/___/_____	From:___/___/_____ To:___/___/_____
Liability Limit					
Deductible	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____
Retroactive Date	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____

Please answer the following:

1. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked, or restricted in any location? If yes, please explain: ❑ Yes ❑ No

2. Has your professional liability carrier ever canceled or non-renewed your coverage or surcharged your premium? If yes, please explain: ❑ Yes ❑ No

3. Have you ever been or are you currently under a "consent order"? ❑ Yes ❑ No
   If yes, please attach a copy.

4. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, or mental or physical impairment? ❑ Yes ❑ No
   If yes, please explain and provide dates and location of all treatment or evaluations as well as names of your supervising and/or monitoring physicians.

5. Have you ever been charged with any criminal activity? If yes, please explain: ❑ Yes ❑ No

6. Has any claim or suit for alleged sexual misconduct ever been brought against you? If yes, please explain: ❑ Yes ❑ No

7. Have your hospital privileges ever been denied, restricted, suspended, revoked, or voluntarily surrendered within the past 3 years?
   If yes, please explain: ❑ Yes ❑ No

8. Have you ever been questioned, investigated, or requested to appear before any of the following:
   A state licensing board or equivalent? ❑ Yes ❑ No
   A specialty or medical association? ❑ Yes ❑ No
   A Medicare/Medicaid agency? ❑ Yes ❑ No
   Other_____ ❑ Yes ❑ No
   If yes to any of the above, please explain:

If you practice any of the specialties below, please answer the applicable questions:

❑ Physician Assistant (PA) or Nurse Practitioner (NP)

a) Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the Board? ❑ Yes ❑ No
(COVERAGE CANNOT BE ISSUED WITHOUT SITE AND SUPERVISOR APPROVAL FROM THE BOARD)

If not approved, what is the status of your approval? Please explain, including name and address of intended supervising physician:

_____

_____

_____

If approved, give name and address of supervising physician:

_____

_____

b) Check the sites where you will perform your duties:

❑ Office w/ supervising physician always present ❑ Office w/ supervising physician occasionally present
❑ Hospital ❑ Emergency Room

c) Are the required written documents in place and accessible outlining your supervising physician's availability for consultation, collaboration, and evaluation of your medical acts? ❑ Yes ❑ No

❑ Nurse Midwife

a) Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the Board? ❑ Yes ❑ No
If not approved, what is the status of your approval? Please explain, including name and address of intended supervising physician:

_____

_____

_____

If approved, give name and address of supervising physician:

_____

_____

b) Are you familiar with the Approved Formulary for the writing of prescriptions by persons licensed and approved to practice Midwifery? ❑ Yes ❑ No

c) Do you perform or assist with deliveries in non-hospital settings? ❑ Yes ❑ No

d) Do you practice at a site away from the direct supervision of your approved supervising Physician? If yes, please explain: ❑ Yes ❑ No

_____

_____

❑ Nurse Anesthetist

a) Please provide the name and address of your supervising physician(s).

_____

_____

_____

b) Do you administer anesthesia when an anesthesiologist is <u>not</u> physically present? If yes, please explain: ❑ Yes ❑ No

_____

_____

c) Do you ever administer anesthesia under the supervision of a physician other than an anesthesiologist? ❑ Yes ❑ No
If yes, please explain including name and address of supervising physician:

_____

_____

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 you answered **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 on back.
For Paid Claims, please attach a copy of the National Practitioner Data Back Submission, if available.

Patient's Name			
Date of Occurrence	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/_____	Date claim closed ____/____/_____	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Patient's Name			
Date of Occurrence	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/_____	Date claim closed ____/____/_____	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Authorization and Release

(This authorization and release must be signed by the Applicant.)

I, the undersigned applicant, understand that this is an application 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 my protection if coverage is written as a result of this application.

I, the undersigned applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and the company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, ant 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.

Signature of applicant 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

Additional Comments

Question #	Comments