

C. HOSPITALS WHERE YOU PRACTICE (PLEASE LIST PRINCIPAL LOCATION FIRST) (continued)

(Combined Percentage of Practice for all Office and Hospital locations must total 100%)

2. [Grid for entry]

% Of Practice

HOSPITAL NAME

[Grid for entry]

NUMBER & STREET

[Grid for entry]

SUITE

ADDRESS 2

[Grid for entry]

CITY

STATE

ZIP CODE

[Grid for entry]

COUNTY

ADMITTING NON-ADMITTING If Non-Admitting, please explain: _____

3. [Grid for entry]

% Of Practice

HOSPITAL NAME

[Grid for entry]

NUMBER & STREET

[Grid for entry]

SUITE

ADDRESS 2

[Grid for entry]

CITY

STATE

ZIP CODE

[Grid for entry]

COUNTY

ADMITTING NON-ADMITTING If Non-Admitting, please explain: _____

D. HOME ADDRESS

[Grid for entry]

NUMBER & STREET

[Grid for entry]

APARTMENT#

ADDRESS 2

[Grid for entry]

CITY

STATE

ZIP CODE

[Grid for entry]

COUNTY

E. PREFERRED MAILING/BILLING ADDRESS

OFFICE # (FROM SECTION I.B.) _____ HOME
 HOSPITAL # (FROM SECTION I.C.) _____ OTHER (PLEASE ENTER BELOW)

[Grid for entry]

NUMBER & STREET

[Grid for entry]

SUITE

CITY

STATE

ZIP CODE

F. PREFERRED METHOD OF CONTACT

E-MAIL BUSINESS FAX BUSINESS PHONE RESIDENCE PHONE

[Grid for entry]

E-MAIL ADDRESS

[Grid for entry]

BUSINESS FAX

[Grid for entry]

BUSINESS PHONE

[Grid for entry]

RESIDENCE PHONE

II. EDUCATIONAL BACKGROUND

If Additional Space Is Needed, Please Use Supplemental Form

A. MEDICAL SCHOOL

[Grid for Name of School]

NAME OF SCHOOL

[Grid for City and State]

CITY

STATE

[Grid for Country]

COUNTRY

[Grid for Degree, Completed From, and To dates]

DEGREE

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM?

[YES] [NO]

If no, please explain: _____

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS. (i.e., Residency Specialty Training, Anesthesia Residency Training, etc.)

If more than one Specialty completed please enter each specific specialty.

1. [Grid for Name of Hospital/Facility]

NAME OF HOSPITAL/FACILITY

[Grid for City, State, and Country]

CITY

STATE

COUNTRY

[Grid for Specialty Type Completed]

SPECIALTY TYPE COMPLETED

[Grid for Completed From and To dates]

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

2. [Grid for Name of Hospital/Facility]

NAME OF HOSPITAL/FACILITY

[Grid for City, State, and Country]

CITY

STATE

COUNTRY

[Grid for Specialty Type Completed]

SPECIALTY TYPE COMPLETED

[Grid for Completed From and To dates]

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., Fellowship, etc.)

[YES] [NO]

1. [Grid for Name of Hospital/Facility]

NAME OF HOSPITAL/FACILITY

[Grid for City, State, and Country]

CITY

STATE

COUNTRY

[Grid for Specialty Type Completed]

SPECIALTY TYPE COMPLETED

[Grid for Completed From and To dates]

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

C. INDICATE THE AVERAGE WEEKLY HOURS OR PATIENTS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE. (If you practice in multiple states, please identify the following information for each state.)

Please provide whole numbers (no ranges i.e., > <). If "none" please enter "0" (zero) in the space provided below.

PATIENTS SEEN PER WEEK

HOURS PER WEEK

WALK-IN PATIENTS PER WEEK

D. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abortions | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Silicone Injections |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Major Gynecological Surgery | <input type="checkbox"/> Skin Flaps/Grafts |
| <input type="checkbox"/> Therapeutic/Local Anesthetic | <input type="checkbox"/> Myelography | Cosmetic <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Mammograms | Reconstruction <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Needle Biopsy | <input type="checkbox"/> Oxidation Therapy |
| <input type="checkbox"/> Angioplasty | Nerve Blocks | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Lumbar Epidural Steroid | <input type="checkbox"/> Chelation Therapy |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Paraspinal | <input type="checkbox"/> Electromagnetic Therapy |
| <input type="checkbox"/> Assisting In Major Surgery | <input type="checkbox"/> Sciatic | <input type="checkbox"/> Rectal Ozone Therapy |
| <input type="checkbox"/> Own Patients Only | <input type="checkbox"/> Facet | <input type="checkbox"/> Swan-Ganz Catheterization |
| <input type="checkbox"/> Own & Other Than Own Patients | <input type="checkbox"/> Paravertebral | <input type="checkbox"/> Right Heart Catheterization (Other Than CVP Lines) |
| <input type="checkbox"/> Blepharopigmentation | <input type="checkbox"/> Peripheral | <input type="checkbox"/> Left Heart Catheterization |
| <input type="checkbox"/> Blepharoplasty - Brow Lifts | <input type="checkbox"/> Myofascial | <input type="checkbox"/> Tubal Ligations |
| Cosmetic <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice | <input type="checkbox"/> Occipital | Vasectomies |
| Reconstruction <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice | <input type="checkbox"/> Triggerpoint Injection | <input type="checkbox"/> Own Patients Only |
| <input type="checkbox"/> Botox <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice | <input type="checkbox"/> Intrathecal Pumps | <input type="checkbox"/> Own & Other Than Own Patients |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Spinal Cord Stimulators | <input type="checkbox"/> Weight Control Therapy/Surgery <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice |
| Cosmetic <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice | <input type="checkbox"/> Phlebography | <input type="checkbox"/> Medication - Weight Control |
| Reconstruction <input type="text"/> <input type="text"/> <input type="text"/> % Of Total Practice | <input type="checkbox"/> Pnuemoencephalography | <input type="checkbox"/> Gastric Bubble |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Radial/laser keratotomy | <input type="checkbox"/> Gastric Stapling |
| <input type="checkbox"/> Bronco-Esophagology | <input type="checkbox"/> Radiation/X-Ray Therapy | <input type="checkbox"/> Other(Type): _____ |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Radiopaque Dye | Prenatal Practice |
| <input type="checkbox"/> Cryosurgery (Other Than External Lesions) | <input type="checkbox"/> Non-Ionic Only | <input type="checkbox"/> See Patients During The First & Second Trimester |
| <input type="checkbox"/> ERCP | <input type="checkbox"/> Shock Therapy | <input type="checkbox"/> See Patients To Term But Do Not Perform Delivery |
| <input type="checkbox"/> D & C | Sigmoidoscopy | <input type="checkbox"/> See Patients To Term And Perform Delivery |
| <input type="checkbox"/> Phenol Facial Peels | <input type="checkbox"/> 60 cm or less | <input type="checkbox"/> Normal Obstetrical Deliveries |
| <input type="checkbox"/> Diagnostic Embolization | <input type="checkbox"/> Greater Than 60 cm | How Many Per Year? _____ |
| <input type="checkbox"/> Anesthesia -General/Spinal/Caudal | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Cesarean Sections |
| <input type="checkbox"/> Pulse Oximetry | <input type="checkbox"/> Polypectomy | How Many Per Year? _____ |
| <input type="checkbox"/> End Tidal CO2 Analyzer | <input type="checkbox"/> Gastrointestinal Endoscopy | <input type="checkbox"/> Other Medical Techniques |
| Hair Transplants | <input type="checkbox"/> Biopsy(Endoscopic) | List Procedures (Do not restate your specialty) |
| <input type="checkbox"/> Scalp Excision/Transplantations | <input type="checkbox"/> Peritoneoscopy | _____ |
| <input type="checkbox"/> Plug Technique/Minigraph | <input type="checkbox"/> Laser Therapy (Endoscopic) | _____ |
| <input type="checkbox"/> Laproscopic Cholecystectomy | <input type="checkbox"/> Laser Therapy (Non-Endoscopic) | _____ |
| <input type="checkbox"/> Laproscopy | Pacemakers | |
| <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Permanent | |
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Temporary | |
| <input type="checkbox"/> Lymphangiography | | |
| <input type="checkbox"/> High Velocity/Low Amplitude (HVLA) on patients 18 years of age or older | | |
| <input type="checkbox"/> High Velocity/Low Amplitude (HVLA) on patients younger than 18 years of age | | |
| <input type="text"/> <input type="text"/> <input type="text"/> % Osteopathic Manipulation Therapy on patients 18 years of age or older | | |
| <input type="text"/> <input type="text"/> <input type="text"/> % Osteopathic Manipulation Therapy on patients younger than 18 years of age | | |

If you devote more than 25% of your practice to OMT, please answer both questions below:

- Do you have an informed consent discussion with all your patients regarding your choice of OMT? YES NO
- Please describe the use of x-ray or imaging technology used in your practice (i.e., is this required prior to manipulation etc.)

V. ADDITIONAL PROFESSIONAL INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

1. **Do you perform surgery on professional athletes?** YES NO
 If **yes**, what percentage of your practice is devoted to performing surgery on professional athletes? %
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
2. **Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?** YES NO
 If **yes**, include a copy of the indemnification agreement provided by the pharmaceutical company.
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
3. **Do you treat or review treatment of federal prison inmates?** YES NO
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
4. **Do you treat non-federal prison inmates?** YES NO
 If **yes**, what percentage of your practice is devoted to treating non-federal inmates? %
 Does this facility have a law library? YES NO
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
5. **Do you use a collection agency which has the authority to file collection suits without your knowledge?** YES NO
6. **Do you practice as a Medical Director at a blood bank?** YES NO
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
7. **Do you devise or review plant/employer safety standards?** YES NO
 (1) What products are manufactured by the company? _____

 (2) Company name: _____ Location: _____
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
8. **Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?** YES NO
 If **yes**, please explain and indicate the date(s): _____ Date: -
 _____ MM YYY Y
9. **Have you had any professional liability insurance declined, refused, canceled or non-renewed?** YES NO
 If **yes**, please indicate the reason and the date(s): _____ Date: -
 _____ MM YYY Y
10. **Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty?** YES NO
 (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)
 If **yes**, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.
 Type of Illness: _____
 Duration of Illness: - To -
 MM YYY Y MM YYY Y
 Treating Physician (Name & Address): _____

VI. PRACTICE ORGANIZATION INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PRACTICE ORGANIZATION:

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status

Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

Solo Unincorporated/Sole Proprietor

Entity Name:

Employment Status

Sole Proprietor Employee Shareholder/Partner Independent Contractor Other

Date Joined/Formed: -
 MM YYY Y

If Other, please explain: _____

A. PRACTICE ORGANIZATION: (continued)

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status
 Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

Solo Incorporated-No employed or contracted physicians

Entity Name: _____

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/formed: ____ - ____

If Other, please explain: _____ MM YYYY

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Individual, Corporation or Partnership policy and group number, if known:

Policy #: _____ Group #: _____ Sub-Group#: _____

If no, do you desire coverage for this entity? YES NO

If yes, do you have any employed or contracted physicians associated with your practice? YES (1) NO

If no, do you wish to share your individual policy limits with your solo corporation? YES NO

If yes, and you desire to share your individual policy limits, please initial here. _____

Note: To qualify for shared limit solo corporation coverage, you must have no physician employees or physician independent contractors.

**** If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate entity application for consideration. ****

Multi-Shareholder Corporation, Partnership, Limited Liability Company

Entity Name: _____

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/formed: ____ - ____

If Other, please explain: _____ MM YYYY

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: _____ Group #: _____ Sub-Group#: _____

If no, do you desire coverage for this entity? YES (1) NO

Hospital **Industrial** **Government-Branch:** _____

Entity Name: _____

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/formed: ____ - ____

If Other, please explain: _____ MM YYYY

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: _____ Group #: _____ Sub-Group#: _____

If no, do you desire coverage for this entity? YES (1) NO

If making additional copies, please enter applicant's name here: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION

1. Patient/Claimant Information:

LAST NAME

FIRST NAME

AGE: [][] Gender: Male Female

2. Date of treatment and/or surgery, which led to the allegations against you. [][] - [][][][]

MM YYYY

3. Date claim/incident notice received [][] - [][][][]

MM YYYY

4. Date claim reported to prior insurer [][] - [][][][]

MM YYYY

5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: _____

6. Disposition or current status of claim or suit: OPEN CLOSED

If Closed, Date of Closing/Settlement or award : [][] - [][][][]

MM YYYY

7. Indicate case value established by carrier, if known: \$ [][][] , [][][] , [][][]

8. Defending Insurance carrier name: _____

CARRIER NAME

9. Claim file number, if known: _____

CLAIM NUMBER

10. Was this matter closed with your consent? YES NO

Was a suit filed? YES NO

Was payment made? YES NO

If no, was claim or suit withdrawn? YES NO

If yes, indicate total amount of settlement or award: \$ [][][] , [][][] , [][][]

Amount paid on your behalf: \$ [][][] , [][][] , [][][]

11. Nature of allegations in the claim or suit: _____

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

12. Please provide a narrative description of the medical facts:
(must include, but not limited to the type of treatment and/or surgery; your involvement): _____

IX. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

**A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING.
LIST CURRENT INSURER FIRST**

1.	Insurer	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY	to	MM - DD - YYYY
2.	Insurer	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY	to	MM - DD - YYYY
3.	Insurer	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY	to	MM - DD - YYYY

Please explain any gaps in coverage back to your start date of practice: _____

B. COVERAGE DESIRED

1. Occurrence
2. Claims-Made Coverage without Prior Acts Coverage
3. Claims-Made Coverage with Prior Acts Coverage *(A copy of current declaration page showing current retroactive date must be attached)*

IF 1 OR 2 ARE SELECTED FROM THE ABOVE AND THE MOST RECENT PRIOR COVERAGE WAS ISSUED ON A CLAIMS MADE BASIS, PLEASE COMPLETE ONE OF THE FOLLOWING:

- An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)
 An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying for with The Medical Protective Company if offered, will not provide prior acts coverage.

Initial Here

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claims-made and occurrence coverage or the additional expense associated with an "extension contract" or "tail coverage."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.

This date cannot be earlier than the expiration date of your current policy.

From: MM - DD - YYYY 12:01 a.m.

Annual policy terms will begin and end on the same month and day.

To: MM - DD - YYYY 12:01 a.m.

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:

(Not required for occurrence policies or Claims-Made without prior acts)

MM - DD - YYYY 12:01 a.m.

E. LIMITS DESIRED: [] , [] , [] per occurrence/per claims made

[] , [] , [] annual aggregate

Note: Requested limits may not be available from this company

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my: Employer OR Named Third Party (Include Name&Address) _____

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g., termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's Home Office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

XI. STATE STATUTORY REQUIREMENT

NOTE: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

XII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS ***I WILL HAVE NO COVERAGE FOR ANY CLAIM*** UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Date Signed: - -
MM DD YYYY

Signature

Print Name

When would you like your quote delivered? - -
MM DD YYYY

