**Issuing Company:**

**The Medical Protective Company**

**Fort Wayne, Indiana**

**PHYSICIAN APPLICATION**

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| **INSTRUCTIONS** |

1. Please answer all questions. If a question is not applicable, print, “n/a”.
2. This application must be completed and signed by an authorized officer of the applicant.
3. If additional space is needed, please use the Supplemental Information section at the end of the application and refer to the question or an additional form.

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| **I. GENERAL INFORMATION** |

**A.** Last Name:

 First Name:

 Middle Name:       Suffix:

**B. Joining As:**

  **[ ]** Employee  **[ ]** Contractor  **[ ]**  Other:       Date joined:    /    /

 MM DD YYYY

 Social Security #:

**C. Residence Address:**

 Number and Street:       Apartment #:

 City:       State:     Zip Code:

 County:

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| **II. EDUCATIONAL BACKGROUND** |

**A. Medical School:**

 Name of School Degree

           Completed From:    /      To:    /

 City State MM YYYY MM YYYY

 Country:

**B. If a foreign medical school graduate, is the applicant certified by the Educational Commission for Foreign Medical Graduates or has**

 **the applicant completed the Fifth Pathway Program?** [ ] Yes [ ] No

If No, please explain:

**C. Residency: List all residency training programs.** Please enter each specific specialty.

1. Name of Hospital/Facility/Program:

 City:       State:     Country:

 Specialty type:

 Completed: [ ] Yes [ ] No [ ] Still in training From (MM/YYYY):    /      To (MM/YYYY):    /

 2. Name of Hospital/Facility/Program:

 City:       State:     Country:

 Specialty type:

 Completed: [ ] Yes [ ] No [ ] Still in training From (MM/YYYY):    /      To (MM/YYYY):    /

**D. Has the applicant participated in any additional training?** (i.e. Fellowship, etc.) [ ] Yes [ ] No

 If Yes, please provide the following information:

 1. Name of Hospital/Facility/Program:

 City:       State:     Country:

 Specialty type:

 Completed: [ ] Yes [ ] No [ ] Still in training From (MM/YYYY):    /      To (MM/YYYY):    /

 2. Name of Hospital/Facility/Program:

 City:       State:     Country:

 Specialty type:

 Completed: [ ] Yes [ ] No [ ] Still in training From (MM/YYYY):    /      To (MM/YYYY):    /

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| **II. EDUCATIONAL BACKGROUND (continued)** |

**E. Will Medical Protective be covering the applicant’s moonlighting while the applicant is in the applicant’s**

 **Residency or Fellowship?** [ ] Yes [ ] No

**F. Is the applicant entering practice for the first time?** [ ] Yes [ ] No

**G. If the applicant has participated in continuing medical education within the last 3 years, indicate the number of**

 **Category 1 credit hours:**

**H. Has the applicant completed a risk management education course within the last 12 months?** [ ] Yes [ ] No

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| **III. PRACTICE INFORMATION** |

**A. Does the applicant perform consultations, render medical services, medical opinions, or give medical advice outside**

 **the state of the applicant’s primary location, including but not limited to, Telemedicine or Internet Medicine?** [ ] Yes [ ] No

 If this is covered by another professional liability insurance policy, complete Question F of the Additional Professional Information section.

 If Yes, which state(s):

**B. States in which the applicant holds a license to practice medicine:**

Please check the appropriate box to indicate the status of the applicant’s license.

 (Exclude state abbreviation from license number) Active Inactive Temporary Pending

 **1**. State:     License #:       [ ]  [ ]  [ ]  [ ]

 **2**. State:     License #:       [ ]  [ ]  [ ]  [ ]

 **3**. State:     License #:       [ ]  [ ]  [ ]  [ ]

 **4**. State:     License #:       [ ]  [ ]  [ ]  [ ]

**C. Does the applicant have previous practice location(s)?** [ ] Yes [ ] No

If Yes, list all location(s) within the past 10 years. If the applicant’s requested retroactive date is greater than 10 years, provide locations back to the

 retroactive date. Please list the most recent location first.

 1. Name of Practice:

 City:       State:     Country:

 Specialty type:       From (MM/YYYY):    /      To (MM/YYYY):    /

 2. Name of Practice:

 City:       State:     Country:

 Specialty type:       From (MM/YYYY):    /      To (MM/YYYY):    /

**D. Please explain the following gaps if they occurred in the last 10 years:**

1. Gaps greater than 1 year between the applicant’s medical school, residency, other training or first time in practice:

 2. Gaps greater than 6 months between practice locations:

**E. To which medical societies or associations does the applicant belong?**

Note: All percentages requested below for specialties, procedures and surgical activities are of the applicant’s total practice.

**Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.**

**F. What is the applicant’s present specialty?**    % of total practice

 **What is the applicant’s sub-specialty?**    % of total practice

**G. Is the applicant permanently retired from the practice of clinical medicine?** [ ] Yes [ ] No

**H. American Board Certified?** [ ] Yes [ ] No          /      (MM/YYYY)

 Specialty Board Date most recently certified.

          /      (MM/YYYY)

 Specialty Board Date most recently certified.

 If not American Board Certified, is the applicant board eligible? [ ] Yes [ ] No

 If Yes, when does the applicant take the applicant’s boards?    /      (MM/YYYY)

 If not American Board Certified, has the applicant ever taken a specialty board examination and failed to pass? [ ] Yes [ ] No

 If Yes, how many times?

 If Yes, please explain:

**I. Indicate the state and county where the applicant practices, and average weekly hours at that location:**

 State(s)/County(ies):       Hours:     State(s)/County(ies):       Hours:

**J. Indicate the estimated average weekly numbers, under each of the following categories, for which the applicant requires the**

 **Company’s coverage:**

 Hours per week:     Patients seen per week:      [ ]  None Unscheduled walk-in patients per week:      [ ]  None

**K. Please indicate the percentage of the applicant’s total practice performing the following surgical activities:**

    % Cardiac     % Nephrology     % Orthopedic (not including back)     % Thoracic

     % Endocrinology     % Neurosurgery     % Otolaryngology     % Traumatic

     % Gynecology     % Obstetrics     % Plastic (cosmetic enhancement only     % Urology

     % Hand     % Ophthalmology     % Plastic (reconstruction only)     % Vascular

     % Neoplastic Surgery     % Orthopedic (not including back)     % Other: (describe)

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| **III. PRACTICE INFORMATION (continued)** |

**L. Please check any of the following procedures the applicant will perform:**

[ ]  Abdominoplasty – Tummy Tuck [ ]  D & C [ ]  Pacemakers – Epicardial

[ ]  Abortions – Elective     % of total practice Disectomy [ ]  Pacemakers – Endocardial

[ ]  Abortions – Therapeutic     % of total practice [ ]  Open [ ]  Pacemakers – Temporary

[ ]  Acupuncture – Therapeutic/Local Anesthetic [ ]  Other Than Open [ ]  Peritoneoscopy

[ ]  Anesthesia General/Spinal/Caudal [ ]  Electromagnetic Therapy [ ]  Phlebography

[ ]  Angiography [ ]  Electroconvulsive/Shock Therapy [ ]  Pneumoencephalography

[ ]  Angioplasty [ ]  Embolization [ ]  Polypectomy

[ ]  Arteriography [ ]  ERCP Prenatal/Gynecological Practice

[ ]  Arthroscopy [ ]  Face Lifts [ ]  Prenatal Practice – 1st & 2nd Trimester

[ ]  Assisting in major surgery – own patients only [ ]  Face Lifts Mini (done with laser)     % of total practice [ ]  Prenatal Practice – to term, no delivery

[ ]  Assisting in major surgery – own & other than own patients [ ]  Gastrointestinal Endoscopy [ ]  Prenatal Practice – to term and delivery

[ ]  Bariatric Surgery – Laparoscopic [ ]  Gynecology – Major Surgery [ ]  Normal Deliveries-total per year

[ ]  Bariatric Surgery – Non-Laparoscopic [ ]  Hair Transplants – Follicular Unit Transplantations [ ]  Cesarean Deliveries-total per year

[ ]  Biopsy – Endoscopic [ ]  Hair Transplants – Other [ ]  Prolotherapy

[ ]  Blepharopigmentation     % of total practice [ ]  HVLA on the cervical spine on patients younger [ ]  Radial/Laser Therapy

[ ]  Blepharoplasty – Cosmetic     % of total practice than 18 years of age [ ]  Radiation/X-Ray Therapy

[ ]  Blepharoplasty – Reconstruction     % of total practice [ ]  Intrathecal Pumps [ ]  Rectal Ozone Therapy

[ ]  Botox     % of total practice [ ]  Kyphoplasty [ ]  Resident – Non-Moonlighting

[ ]  Brachioplasty [ ]  Laparoscopic Cholecystectomy [ ]  Resident – Moonlighting

[ ]  Breast Implants – Cosmetic     % of total practice [ ]  Laparoscopy [ ]  Rhinoplasty     % of total practice

[ ]  Breast Implants – Reconstruction     % of total practice [ ]  Laser Surgery [ ]  Sigmoidoscopy – 60 cm or less

[ ]  Breast Reduction – Cosmetic [ ]  Laser Therapy (Endoscopic) [ ]  Sigmoidoscopy – greater than 60 cm

[ ]  Bronchoscopy [ ]  Laser Therapy (Non-Endoscopic) [ ]  Silicone Injections    % of total practice

[ ]  Bronco-esophagology [ ]  Lipoinjection    % of total practice Skin Flaps/Grafts

[ ]  Buttock Implants Liposuction [ ]  Cosmetic    % of total practice

[ ]  Calf Implants [ ]  Other Than Tumescent Technique [ ]  Reconstruction    % of total practice

[ ]  Cataract Surgery [ ]  Tumescent Technique Only    % of total practice [ ]  Spinal Cord Stimulators

[ ]  Catheterization – Left Heart [ ]  Lithotripsy [ ]  Thigh Lift

[ ]  Catheterization – Right Heart (other than CVP lines)/ [ ]  Lymphangiography [ ]  Tubal Ligations

 Swanz Ganz [ ]  Mammograms [ ]  Upper GI Endoscopy

[ ]  Cheek/Chin/Lip Implants [ ]  Myelography [ ]  Vasectomies – own patients

[ ]  Chelation Therapy [ ]  Needle Biopsy [ ]  Vasectomies – own & other than own

[ ]  Chemical Peels – Superficial/Medium Nerve Blocks patients

[ ]  Chemical Peels – Deep     % of total practice [ ]  Facet [ ]  Weight Control Medication

[ ]  Cleft Lip Surgery – Reconstructive [ ]  Lumbar Epidural Steroid     % of total practice

[ ]  Cleft Palate Surgery – Reconstructive [ ]  Myofascial [ ]  Other Medical Techniques, List

[ ]  Colonoscopy [ ]  Occipital Procedures (do not restate the applicant’s

[ ]  Cryosurgery (Cervical) [ ]  Paraspinal/Paravertebral specialty):

[ ]  Cryosurgery (non-external lesions) [ ]  Peripheral

 [ ]  Sciatic

 [ ]  Triggerpoint Injection

 [ ]  Oxidation Therapy

**M. In the last 10 years,**

 1. Has the applicant discontinued major surgical procedures, performance of obstetrics, or any other medical activity? [ ] Yes [ ] No

 If Yes, list procedures/activities, reason for discontinuing, and date discontinued:    /

 MM YYYY

 2. Has the applicant performed weight control surgery or prescribed weight control medication? [ ] Yes [ ] No

 a. If Yes, what percentage of the applicant’s practice (% of patient care) was devoted to prescribing anorectic drugs?

 [ ]  <1% [ ]  1% - 10% [ ]  11% - 50% [ ]  >50% [ ]  Never prescribed weight control medication

 b. If Yes, what percentage of the applicant’s practice (% of patient care) was devoted to performing weight control surgery?

 [ ]  <1% [ ]  1% - 10% [ ]  11% - 50% [ ]  >50% [ ]  Never prescribed weight control surgery

**N. Does the applicant work in an emergency room on a scheduled basis?** (If Yes, answer 1 and 2 below.) [ ] Yes [ ] No

 1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.)     hrs

      % Major Surgery      % Minor Surgery

 2. On average how many of the above hours is the applicant working in order to fulfill staff privilege requirements?     hrs

 (If the applicant has emergency room activities which are covered by another professional liability insurance policy, please

 complete Question F of the Additional Professional Information section.)

**O. Please use the space below for any comments the applicant feels will help the Company better understand any special circumstances**

 **concerning the applicant’s practice:**

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| **IV. ADDITIONAL PROFESSIONAL INFORMATION** |

**Please fully explain any, “Yes,” answer in the Supplemental Information section with a reference to the question.** (For questions A through E. please complete Question F, if the applicant is covered by other insurance for these activities.)

**A. Indicate the percentage of the applicant’s practice devoted to being a team physician for any professional**

 **or collegiate athletes.**    %[ ]  None

**B. Indicate the average hours per week devoted to treating non-federal prison inmates.**    hrs [ ]  None

**C. Indicate the percentage of the applicant’s practice devoted to working in a nursing home facility.**    %[ ]  None

**D. Does the applicant 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.

**E. Does the applicant practice as a medical director?** [ ] Yes [ ] No

 Type and name of facility:

 If Yes, what percentage of the applicant’s practice is devoted to this activity?     %

 Briefly describe the applicant’s responsibilities:

**F. Does the applicant devise or review plant/employer safety standards?** [ ] Yes [ ] No

 What products are manufactured by the company?

 Company Name:

 Location:

**G. Will the applicant be performing activities which will be covered by another professional liability policy?** [ ] Yes [ ] No

 If Yes, is the applicant a(n): [ ]  Employee [ ]  Independent Contractor [ ]  Resident/Fellow [ ]  Faculty

 Practice Name:

 Location:

 Name of Insurer:

**H. Has the applicant 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 the applicant’s hospital privileges, DEA license, medical license or reimbursement**

 **privileges refused, denied, revoked suspended, restricted, subject or a reprimand, placed on probation or voluntarily**

 **surrendered?** [ ] Yes [ ] No

 If Yes, please indicate the date(s) and explain:    /

 MM YYYY

**I. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed the applicant’s coverage**

 **or has the applicant ever had an involuntary deductible or surcharge assessed against the applicant’s policy?** [ ] Yes [ ] No

 If Yes, please indicate the date(s) and explain:    /

MM YYYY

**J. Has the applicant ever been accused of sexual misconduct of any kind?** [ ] Yes [ ] No

 If Yes, please indicate the date(s) and explain:    /

 MM YYYY

**K. Has the applicant ever incurred or become aware of having a condition that impairs the applicant’s ability to practice the**

 **applicant’s medical specialty?** (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled

 substances, etc.) [ ] Yes [ ] No

 If Yes, state condition(s) and date(s) and identify the applicant’s treating physician(s) in the space below. In the event of any such impairment, **a**

 **statement from the applicant’s physician attesting to the applicant’s fitness to practice the applicant’s specialty must**

 **accompany this application.**

 Type(s) of illness:

 Date(s) of treatment(s): From:    /    /      To:    /    /      [ ]  Currently in treatment

 MM DD YYYY MM DD YYYY

 Name of treating physician(s):

 Address(es):

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| **V. LOSS INFORMATION (Important! Please fully complete.)** |

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against the applicant even if the applicant

believes the claim or suit would be without merit.

**A. Is the applicant now, or has the applicant ever been involved, in a claim or suit arising out of the rendering or failure to render**

 **professional services?**

If Yes, how many?     [ ]  None

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| **V. LOSS INFORMATION (Important! Please fully complete.) (continued)** |

**B. Is the applicant aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably**

 **result in a claim or suit against the applicant? This includes but is not limited to, the following:**

Amputation, Death, Loss of major organ function, Loss of vision, Permanent neurological injury.

 If Yes, how many?     [ ]  None

**C. In the last 12 months, has the applicant or anyone from the applicant’s practice received a written request from an attorney for**

 **treatment records concerning any of the applicant’s current or former patients that might reasonably result in a claim or suit**

 **against the applicant?**

If Yes, how many?     [ ]  None

Please complete the questions below for all of the applicant’s **(1) Open and; (2) Closed Claims.** All claims must be first dollar/ground up, and if

possible, sent electronically. Only provide the claims information on those claims that are not being handled directly by the Company.

Note: Additional documentation (office/hospital records) may be requested at the underwriting department’s discretion. All fields must be completed.

**D. Claim Number:**

**E. Patient/Claimant Name:**       **Age:**

 Last Name, First Name

**F. Date of treatment and/or surgery which led to the allegations against the applicant:**

 MM YYYY

**G. Date claim/incident notice received:**

 MM YYYY

**H. Has this claim/incident been reported to the applicant’s current or former insurer?** [ ] Yes [ ] No

 If Yes, provide the date the claim was reported to the applicant’s current or former insurer:

 *Please provide a copy of the report(s).* MM YYYY

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

**J. Defending insurance carrier name:**

**K. Was a claim made or suit filed?** [ ] Yes [ ] No

**L. Indicate case value established by carrier, if known:** $

**M. Disposition or current status of claim or suit:** [ ]  Open [ ]  Closed

 **If closed,** date of closing/settlement or award:

 MM YYYY

 **If closed,** was payment made? [ ] Yes [ ] No

 If No, was claim or suit withdrawn? [ ] Yes [ ] No

 If Yes, indicate total amount of settlement or award: $

 Was the matter closed with the applicant’s consent? [ ] Yes [ ] No

 **If Open,** has settlement been offered? [ ] Yes [ ] No

 **If Open,** has trial date been set? [ ] Yes [ ] No

 Trial date:

 MM YYYY

**N. Nature of allegations in the claim or suit:**

 Condition treated:

 Treatment provided:

 Alleged negligence:

 Alleged injury:

**O. Please provide a narrative description of the medical facts:** (must include, but not limited to, the type of treatment and/or surgery,

 including applicant’s involvement). If additional space is needed, please attach a separate piece of paper.

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| **VI. COVERAGE INFORMATION** |

**Notes:**

**1. Claims-Made and reported coverage is generally limited to liability for injuries for which claims are first made and reported during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact the applicant’s agent should the applicant have any questions pertaining to the differences between Claims-Made and Occurrence coverage, or the additional expense associated with “extension contract” or “tail coverage.”**

**2. Requested limits and/or policy types may not be available in all states.**

**A. Requested coverage period (12:01 am):** From:    /    /      To:    /    /

 MM DD YYYY MM DD YYYY

**B. The retroactive date shown on the applicant’s current Claims-Made policy is:**

(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.)    /    /

 MM DD YYYY

**C. Desired limits:** Per Occurrence/Per Claim Filed:       Annual Aggregate:

**D. The Indiana Patient Compensation Fund (“Fund”) retroactive date if different than the retroactive date identified above.**    /    /

 MM DD YYYY

**E. Is the applicant aware of any gaps in Fund coverage?** [ ] Yes [ ] No

If yes, please provide exact dates and explain:

**F. If the applicant is practicing outside the state of Indiana, please indicate the state(s) and the desired limits:**

State: Per Occurrence/Per Claim Filed:       Annual Aggregate:

 State: Per Occurrence/Per Claim Filed:       Annual Aggregate:

**G. List all previous professional liability insurers within the past 10 years. If the applicant’s requested retroactive date is greater**

 **than 10 years, provide previous insurers back to the applicant’s requested retroactive date.**

  **1.** Current Insurer:

 [ ]  Occurrence [ ]  Claims-Made From:    /    /      To:    /    /

 MM DD YYYY MM DD YYYY

 **2.** Previous Insurer:

 [ ]  Occurrence [ ]  Claims-Made From:    /    /      To:    /    /

 MM DD YYYY MM DD YYYY

 **3.** Previous Insurer:

 [ ]  Occurrence [ ]  Claims-Made From:    /    /      To:    /    /

 MM DD YYYY MM DD YYYY

**H. Please explain any gaps in coverage within the past 10 years. If the applicant’s requested retroactive is greater than 10**

 **years, please explain any gaps back to the applicant’s requested retroactive date.**

**I. If “Occurrence” or “Claims-Made coverage without Prior Acts” coverage was selected as the desired coverage, and the most**

 **recent prior coverage was issued on a Claims-Made basis, please complete one of the following:**

 [ ]  An extension contract endorsement (tail coverage) has been or will be purchased.

 [ ]  An extension contract endorsement (tail coverage) 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 a result of professional services rendered while insured by my current carrier’s policy. I understand

 that the policy, which I am applying from the Company, will not provide Prior Acts coverage. Initial Here

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| **VII. IMPORTANT NOTICE** |

This insurance may contain claims-made and reported coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date and reported to the Company during the policy period or during any applicable extended reporting period. Please read and review the policy carefully.

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| **VIII. FRAUD NOTICE** |

**MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:**

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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, WHICH MAY INCLUDE Initial Here

VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

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| **IX. PLEASE READ AND SIGN** |

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity’s behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter “**Attachments**”) are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

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

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company’s receipt of the applicant’s acceptance of the Company’s quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered 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.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

**This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.**

Signature of Officer or Authorized Representative Title Date

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| **X. SUPPLEMENTAL INFORMATION** |