THE MEDICAL PROTECTIVE COMPANY

BEHAVIORAL HEALTH HOSPITAL APPLICATION GUIDE

Thank you for choosing The Medical Protective Company for your liability insurance needs. The purpose of this guide is to identify the applications necessary for the insurance coverage(s) that you are requesting a premium quote.

Please find below a list of liability coverages offered by The Medical Protective Company. You may select any of the additional coverage types listed based on your needs. For every coverage selected, please fill out the corresponding application requirement.

This coverage may be limited to claims first made and reported to the Company during the policy period as stated in the Declarations or any applicable Extended Reporting Period.

BASIC COVERAGE	APPLICATION REQUIREMENTS
Every submission must include the **General Application** and the **Completed Application Notices and Agreements** signature section.	
□ Corporate/Facility Professional Liability	Behavioral Health Hospital Professional Liability Application
	Claim/Suit Information Application
□ Employed or Contracted Physicians Limited Duty & Scope Professional Liability* Each physician's prior 10 years loss history is required.	Hospital Physicians (Short Form) Application & ISO Code Reference
	Physicians Claim/Suit Information Application
□ Optional Outside Activities Physicians Professional Liability* Each physician for whom coverage is being requested for services performed outside the hospital/facility.	Hospital Physician (Long Form) Application
	Hospital Physician Outside Activities Application
	Physicians Claim/Suit Information Application
□ Employed or Contracted Healthcare Providers Professional Liability	Healthcare Providers Application
□ General Liability	General Liability Application
□ Limited Polluction Short Term Event Liability	Optional Coverages Application
□ Managed Care Professional Liability	Managed Care Application
□ Employee Benefits Professional Liability	Optional Coverages Application
□ Employer's Liability	Optional Coverages Application
□ Excess Professional Liability	Excess Liability Application
□ Excess General Liability	Excess Liability Application
□ Excess Employer's Liability	Excess Liability Application
□ Self-Insured Retention/Captive/Trust/RRG	Self-Insured Retention (SIR) Application
□ Cyber-liability (only required if additional limits desired above the $100,000 provided at no additional charge)	Cyber-liability, Crisis Management and Reputational Harm Supplemental Application
□ Directors & Officers/Employment Practices Liability Insurance	Executive Liability, Entity Liability, Employment Practices Liability and Third Party Liability Insurance Supplemental Application

In addition to the applications required for each coverage selected above, a copy of the following information, if applicable, must be submitted:

1. A copy of the applicant's certificate/accreditation including any recommendations made; and JCAHO Report.
2. Financial information. Last two (2) years audited financial statements, and annual reports (if one is published) including auditor's opinion.
3. American Hospital Association annual survey.
4. Medical staff bylaws, and rules and regulations.
5. Loss information for all applicable coverages being requested. Recently valued loss runs from insurance carriers covering the last ten (10) full years, including indemnity payments or full indemnity reserves of $50,000 or more including expenses. All claims must be first dollar/ ground up, and if possible, sent electronically.
6. Copy of your current professional liability insurance policy with endorsements.
7. Declarations page of current general liability, helipad, aircraft, watercraft, auto, employer's liability and umbrella/excess liability policies.
8. Organizational chart, including the names of all entities and a brief description of operations.
9. Catalog or list of durable medical equipment that is manufactured, leased, rented or sold to others.

*Additional information may be required at the underwriters discretion for physicians with prevalent claims history.

Should you have any questions regarding coverage types or the application instructions, please contact your independent agent or a Customer Service Representative at 800-4MEDPRO.

THE MEDICAL PROTECTIVE COMPANY
GENERAL APPLICATION

INFORMATION

(If multiple facilities/locations exist, please complete a separate application for each.)

1. Please print legibly. Policy is based on readability of your brokerage firm/agency name.
2. Please answer all questions. If a question is not applicable, print, "n/a". 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 with a reference to the question or an additional form.

GENERAL INFORMATION

A. Applicant Information

_____
Applicant Name. Where ever "Applicant" or "Named Insured" is used in this application, the term means the entity listed above.

_____ _____
Mailing Address County

_____
Street Address (if different)

_____ _____
Primary Contact Person Name (Officer or Authorized Representative of Applicant) Title

_____-_____-_____ _____-_____-_____ _____
Phone Fax E-mail

_____
Website Address

Person responsible for risk management:

_____ _____
Name Title

_____-_____-_____ _____
Phone Email

Requested effective date: _____ /_____ /_____ 12:01 AM

B. Brokerage Firm/Agency Information

_____
Brokerage Firm/Agency Name

_____
City, State and Zip Code

_____ _____
Broker/Agent Name Broker/Agent License Number and Type

_____-_____-_____ _____-_____-_____ _____
Phone Fax E-mail

C. Type of facility: (Check all that apply.)

□ General Acute Care Hospital
□ Behavioral Health Hospital
□ Senior Living/Long-term Care Center
□ Other _____
_____

□ Governmental
□ Corporation
□ Individual
□ Partnership
□ Joint Venture
□ Other _____

□ For Profit
□ Not for Profit

D. If licenses or locations are held in other states, please list the states: _____

E. Are there any plans to build or expand operations during the next 12 months? □ Yes □ No

If Yes, please explain and include the timeframe and estimated cost: _____

_____

F. Has the applicant's license ever been revoked, denied, limited or surrendered? □ Yes □ No

If Yes, please explain: _____

G. Please list all of the applicant's professional association(s) memberships: _____

H. Have there been any technology systems improvements designed to monitor and/or control quality improvement initiatives (electronic medical records, incident reporting, security, etc.)**?** □ Yes □ No

1. Does the applicant have a business continuity plan in the event of a computer system failure, virus or malfunction? □ Yes □ No

If Yes, please provide a copy of the plan.

I. Is there a medical audit system that includes surgical procedures and ties into the physician credentialing process? □ Yes □ No

J. Is there an active peer review process for physicians that is part of the quality management program? □ Yes □ No

If No, please explain: _____

_____

K. Is there a full-time risk manager? □ Yes □ No

If No, what are his/her other responsibilities and how much time is devoted to risk management? _____

_____

L. Is there a formal written risk management program? □ Yes □ No

If Yes, has the program been communicated to administrative and medical staff? □ Yes □ No

M. Is the program periodically reviewed for effectiveness and necessary changes made? □ Yes □ No

N. Is there a written incident reporting procedure? □ Yes □ No

1. If Yes, does this procedure require review and appropriate corrective action be taken? □ Yes □ No
2. Is follow-up made to assure compliance? □ Yes □ No

O. Is there an on-going quality assurance (QA) committee in place? □ Yes □ No

1. If Yes, is the person responsible for risk management a member of this committee? □ Yes □ No
2. To whom is the quality assurance committee accountable:

_____ _____

Name Title

3. What quality indicators are monitored (please list): _____

_____

_____

4. Do you monitor infection rates at your facility(ies)? □ Yes □ No

P. Have there been other process enhancements or facility improvements the applicant feels has significantly improved patient safety and quality? □ Yes □ No

If Yes, please describe: _____ Date implemented (MM/DD/YYYY): ____ / ____ / _____

Q. Have all known claims, as well as incidents which may give rise to future claims, been reported to past or current insurers? □ Yes □ No

R. <u>Has there been a recent review of such incidents and other potential claims?</u> □ Yes □ No

If Yes, was this review provided to the applicant's current insurer? □ Yes □ No

If Yes, when: _____ By whom? _____

S. Please check which type of notice your <u>present professional liability insurer</u> requires before they will formally recognize a claim under their policy:

□ Summons and complaint or attorney demand letter

□ Written notice from you that a potentially compensable event has occurred

T. Has any company ever cancelled or refused to offer the applicant insurance coverage?

<u>Note:</u> Do **not** answer in the states of Missouri and California. □ Yes □ No

If Yes, please explain: _____

U. Do you have a written policy concerning staff training, competency, and performance assessments? □ Yes □ No

V. Are criminal background checks, including sexual offender, performed on all employees and physicians? □ Yes □ No

W. Are drug screens performed on all employees? □ Yes □ No

X. Are job descriptions, orientation programs and performance appraisals job specific and competency based? □ Yes □ No

If No, please explain: _____

Y. Are agency personnel used? □ Yes □ No

If Yes, is orientation provided and documented? □ Yes □ No

Z. Do you participate in any alternative work programs (i.e. work release, court mandated community service, etc.)? □ Yes □ No

AA. Please furnish the following information for all owned or leased property operated or occupied by the applicant.
A separate summary of locations/exposures is acceptable, providing the information outlined below is furnished.

Address of Property to be Insured	Use/Occupancy	Square Footage	Age	Type of Construction	Number of Stories	Fire Protection*
Patient Care Buildings:						
Other Buildings:						

*For each building, indicate if there is a: Sprinkler System—Full, Partial or No sprinkler system; Smoke Detector, Heat Detector; Fire Alarm—Central Station or Local Alarm

BB. Do all facilities comply with the National Fire Protection Association (NFPA) 101 Life Safety Code 2000 Edition or newer? □ Yes □ No

If No, please explain: _____

CC. Do any of the facilities have a Highly Protected Risk (HPR) designation? □ Yes □ No

If Yes, which ones? _____

DD. Please list the entities related to the applicant on the Schedule of Related Entities below for all entities that the applicant is requesting coverage (subsidiaries, joint ventures, LLC's, partnerships, PPO's, HMO's, etc.). If extra space needed, please attach a separate piece of paper.

SCHEDULE OF RELATED ENTITIES

Name of Entity	Description of Operations	Date Acquired, Created or Merged	Indicate your ownership percentage in this entity	Coverage Desired?	Retroactive Date
				□ Yes □ No	
				□ Yes □ No	
				□ Yes □ No	
				□ Yes □ No	

EE. Please complete the Schedule of Current Liability Policies and Coverages. For each policy below, please *provide a copy of the declarations page and the primary and excess loss runs for the last ten years.* If excess auto coverage is being requested in this application, also *provide a copy of the schedule of vehicles listed on the primary auto policy.*

SCHEDULE OF CURRENT LIABILITY POLICIES AND COVERAGES

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY (Per Claim or Medical Incident/ Aggregate)	EXPIRING PREMIUM
Professional Liability Facility				$ /$	$
General Liability				$ /$	$
Employer's Liability				$ /$	$
Employee Benefits Professional Liability				$ /$	$
Auto Liability Emergency Vehicle Liability				$ /$	$
Excess Professional Liability				$ /$	$
Excess General Liability				$ /$	$
Other, Please describe: _____				$ /$	$
Other, Please describe: _____				$ /$	$

SUPPLEMENTAL INFORMATION

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

COMPLETED APPLICATION NOTICES AND AGREEMENTS

Please read the following information carefully and return fully executed with the completed application.

IMPORTANT NOTICE

THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES MAY BE LIMITED TO LIABILITY FOR CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR MADE AND REPORTED DURING THE (60) DAY AUTOMATIC EXTENDED REPORTING PERIOD IN ACCORDANCE WITH ARK. CODE ANN §23-79-306(2), OR DURING ANY OPTIONAL EXTENDED REPORTING PERIOD ISSUED IN ACCORDANCE WITH ARK. CODE ANN. §23-79-306(3A).

FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Initial Here

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 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 form 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 a 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

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

BEHAVIORAL HEALTH HOSPITAL PROFESSIONAL LIABILITY APPLICATION

A. Please list all behavioral healthcare facilities locations:
If More than three, please attach a separate page showing the additional locations.

Location #1:

_____ _____ _____ _____
Street Address City State Zip

Distance to nearest hospital: _____

Date this location opened: _____ Estimated number of annual visits at this location: _____

Location #2:

_____ _____ _____ _____
Street Address City State Zip

Distance to nearest hospital: _____

Date this location opened: _____ Estimated number of annual visits at this location: _____

Location #3:

_____ _____ _____ _____
Street Address City State Zip

Distance to nearest hospital: _____

Date this location opened: _____ Estimated number of annual visits at this location: _____

B. Please provide the FEIN#(s) _____ **CMS (Medicare) Provider#:** _____

C. Bond and/or Debt Rating: _____ **Rating Company:** _____

D. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage Coverage is provided on a limited duty and scope basis unless otherwise requested.	**Requested Per Event Limits**	**Requested Aggregate Limits**	**Occurrence or Claims-Made**	**Shared or Separate Limits** (where allowed by state law)	**Deductible** (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	**Is ALAE included in the deductible** (if allowed by state law)**?**
☐ **Professional Liability Facility**	$	$	☐ Occcurrence ☐ Claims-Made Retro-Date: _____	☐ Shared Limits ☐ Separate Limits	☐ Deductible Amount: $_____ ☐ SIR ☐ None	☐ Yes ☐ No

* Please complete the applicable Physicians and/or Healthcare Providers supplemental application.

E. Please indicate the certifications/accreditations held by your facility:

☐ JCAHO ☐ CARF ☐ NCQA ☐ HBIP ☐ Other _____

If JCAHO, is the accreditation: ☐ Conditional/Provisional* ☐ Full

**If Conditional/Provisional, attach a copy of the Type 1 Recommendations from the last visit.*

F. Medical School Affiliations:

1. Does the applicant have any formal relationships with a medical school for the purpose of training or educating residents, medical or nursing students, CRNAs or other allied health professionals? ☐ Yes ☐ No

   If Yes, please provide the name and location of the school and a description of each program: _____

   _____

   _____

2. Indicate by program type, how many students are involved:

   Type: _____ Number of Students: _____ Type: _____ Number of Students: _____

   Type: _____ Number of Students: _____ Type: _____ Number of Students: _____

3. Who supervises the students? _____

4. Is the applicant required to provide professional liability coverage for the residents or students as part of their residency or training program? ☐ Yes ☐ No

G. Is there a full time patient advocate? □ Yes □ No

H. What is the applicant's total annual payroll? $_____ **Total annual receipts?** $_____

I. Is there an on-going continuing education program for:
Nursing Staff? □ Yes □ No
Medical Staff? □ Yes □ No
Allied Health Professionals? □ Yes □ No

J. Does the applicant require all foreign medical school graduates to be certified by the Education Council for Foreign Medical School Graduates? □ Yes □ No

K. Does the applicant provide service to any prison/detention centers on or off premises? □ Yes □ No

If Yes, please explain: _____

L. Does the applicant provide ancillary services to non-patients and non-owned entities? (i.e. DME, pharmacy, wellness center, blood bank, etc.) □ Yes □ No

If Yes, please describe: _____

M. Indicate if the applicant does, or will, conduct or provide any of the following services:

1. Research activities for pharmaceuticals, surgery, biomedical equipment or psychotherapy □ Yes □ No
   If Yes, complete a separate research supplemental questionnaire.
2. Full body scans to non-patients. □ Yes □ No
   If Yes, indicate the number of procedures anticipated for the next 12 months: _____
3. Alternative/complementary medicine. □ Yes □ No
   If Yes, indicate the type of alternative medicine provided: _____

N. Are any changes planned to the services offered by the applicant in the next 12 months? □ Yes □ No
If Yes, please describe. Please include additional services as well as services to be discontinued. _____

O. Have any services been discontinued during the last 24 months? □ Yes □ No

If Yes, please describe. _____

P. Does the applicant engage in telemedicine (i.e. radiology, cardiology, ophthalmology, remote monitoring for home patients, dermatology, etc.)**?** □ Yes □ No

If Yes, please describe. _____

Q. Medical Staff—Physicians:

1. Indicate the total number of medical staff: _____
2. Indicate the total number of staff physicians: _____
3. a. Are credentials for all new staff physicians checked and approved prior to granting privileges? □ Yes □ No
   b. Are privileges probationary for at least 6 months for all new staff physicians? □ Yes □ No
4. Are all staff physicians licensed and privileged without restrictions? □ Yes □ No
   If No, please provide details: _____
5. Is a new staff physician's work evaluated by the department chief? □ Yes □ No
   If Yes, is it done in writing? □ Yes □ No
6. How often are privileges reviewed? _____
7. Is an ongoing quality assurance review maintained on all staff physicians' clinical work? □ Yes □ No
8. Is clinical staff reappointed at least every two years, with reappointment based on evaluation of clinical practice by the department chief? □ Yes □ No
   If Yes, is it done in writing? □ Yes □ No
9. Does the applicant perform drug and alcohol testing for all physicians for credentialing and privileging purposes? □ Yes □ No
10. Are each of the physicians practicing at the applicant's facility board-certified? □ Yes □ No
    If No, how many are not board-certified? _____
11. Are all privileges granted to staff physicians in writing? □ Yes □ No
12. a. 1) Are staff physicans required to carry professional liability insurance? □ Yes □ No
    If Yes, what are the liability limits? $_____ Per Event / $_____ Annual Aggregate
    b. Are they insured with a carrier rated less than A– by AM Best? □ Yes □ No
13. Does the applicant collect certificates of insurance from all staff physicians as evidence of compliance? □ Yes □ No
14. Has the license of any staff physician been restricted, revoked or suspended during the last five years? □ Yes □ No
    If Yes, please explain: _____

15. Have you made reports to the National Practiioner Data Bank regarding any peer review action, suspension or professional liability payment involving any member of the medical/dental staff during the last five years? □ Yes □ No

16. Does the applicant supervise anyone other than its own employees? □ Yes □ No
If Yes, please describe the responsibility of each individual, relationship to each individual and also indicate by type of medical professional, the number of individuals the applicant supervises:

_____

R. Pharmaceutical Services:

1. Does a full-time registered pharmacist direct the pharmacy? □ Yes □ No

   If No, please explain: _____

2. Is the pharmacy staffed in whole or in part by a contract group? □ Yes □ No
   If Employees, skip to next question.

   If contract group, what is the name of the group? _____

   Name of group's insurance carrier: _____

3. Does the group provide a hold harmless agreement in favor of the hospital? □ Yes □ No
4. Does the group annually provide the applicant with a certificate of insurance for professional liability? □ Yes □ No
5. What are the minimum professional liability limits that is required for the group to carry?

   $_____ Per Medical Incident / $_____ Annual Aggregate

6. Do the limits apply on an individual or shared limits basis? □ Individual Limits □ Shared Limits

S. Anesthesia Services:

1. Number of employed and contracted: Anesthesiologists: _____ CRNA's: _____
2. Are the anesthesiologists required to be board certified/eligible in anesthesiology? □ Yes □ No
3. Does the applicant require certificates of insurance by those performing anesthesia? □ Yes □ No
4. What is the ratio of CRNAs to anesthesiologists? _____
5. Are CRNAs supervised by a physician? □ Yes □ No
6. Is anesthesia administered without the direct supervision of an anesthesiologist? □ Yes □ No

   _____

7. Is an anesthesiologist or CRNA on site 24/7? □ Yes □ No
   If No, is an anesthesiologist or CRNA on-call when one is not on site? □ Yes □ No
   If Yes, what is the maximum amount of time for arrival for the on-call physician? _____
8. Does an informed consent discussion take place between the patient and the anesthesiologist or CRNA that includes anesthesia contemplated, possible risks and alternatives? □ Yes □ No
9. Does the anesthesia equipment have oxygen analyzers? □ Yes □ No

   If No, please explain: _____

10. Does the anesthesia equipment have disconnect alarms? □ Yes □ No

    If No, please explain: _____

11. Who owns and maintains the anesthesia equipment? _____

T. Please indicate the % of the following services that are being provided by your facility. (Total % should equal 100%)

_____ **Alcohol and other drugs/addictions**

_____ **Mental Health, Psychosocial Rehabilitation**

_____ **Family Services** (programs designed to help maintain or improve the quality of life for children, adolescents, or other family members individually or in their relationships with their families, their environments, or other individuals; services can include family counseling, educational programs, etc.)

_____ **Integrated AOD/Mental Health** (programs designed to provide alcohol, drug, addictions and other mental health services)

_____ **Integrated DD/Mental Health** (programs designed to provide services to persons whose primary diagnosis is intellectual or other developmental disabilities, and who are at risk for or exhibiting behavioral disorders, or have identified mental health needs.)

U.

	# of outpatient visits (if applicable)	# of licensed beds (if applicable)	# of occupied beds (if applicable)	Average length of stay
Substance Abuse Counseling				
Substance Abuse Skilled Medical*				
Mental Health Counseling				
*"Skilled" - medical treatment for chemical dependency				

V. Please check any of the following services that will be provided at the applicant's facility:
If additional space is needed, please attach a separate sheet.

- □ Acupuncture
- □ Addiction/Dependency Treatment/Substance Abuse Disorder
- □ Art/Dance/Drama/Music Therapy
- □ Aversion Therapy
- □ Biofeedback/Neurofeedback
- □ Bootcamps/Wilderness/Survival training
- □ Case Management/Social Services
- □ Community Housing
- □ Community Integration
- □ Counseling
- □ Criminal Justice/Domestic Violence
- □ Crisis Intervention
- □ Day Treatment
- □ Day/Evening Care Programs
- □ Detoxification — Rapid
- □ Drug Court Treatment
- □ Electroconvulsive Therapy (ECT)
- □ Employee Assistance Programs
- □ Equine Therapy
- □ Experimental Protocols; Please describe:

  _____
  _____
  _____
- □ Genetic Counseling
- □ Hypnotherapy
- □ Integrated Behavioral Health/Primary Care Programs
- □ Learning & Developmental Disabilities
- □ Life Coaching
- □ Marriage/Family Counseling
- □ Massage Therapy
- □ Nutrition/Eating Disorders
- □ Out of Home Treatment
- □ Partial Hospitalization
- □ Pet Therapy
- □ Psychodrama Therapy
- □ Psychotherapy/Psychoanalysis
- □ Recreation Therapy
- □ Residential Therapy
- □ Sexual Therapy
- □ Spiritual/Religious/Grief Counseling
- □ Supported Living
- □ Therapeutic Communities/Group Homes
- □ Trauma
- □ Vocational/Training Programs
- □ Other _____

W.

Patients	# of outpatient visits (if applicable)	# of licensed beds (if applicable)	# of occupied beds (if applicable)	Average length of stay
9 yrs old or younger				
10—17 yrs old				
18-64 yrs old				
65 yrs old or older				

X. Please identify where services are provided:

- □ Acute Care Hospitals
- □ Addiction Treatment
- □ Community Health Centers
- □ Correctional Institutions
- □ Governmental Mental Health Centers
- □ Inpatient Mental Health Treatment Facilities
- □ Long Term Care Facilities
- □ Outpatient Clinics
- □ Physician Offices
- □ Psychiatric Hospitals
- □ Rehabilitation Facilities
- □ Schools
- □ Transitional Living Facilities

Y. Please check any and all that the applicant's facility uses:

□ Restraints — Hours of restraint use: _____
Are there specific policies & procedures addressing use? □ Yes □ No

□ Seclusion — Hours of seclusion use: _____
Are there specific policies & procedures addressing use? □ Yes □ No

Z. Are the following assessments performed on all patients?

1. Violence Risk	□ No	□ When Admitted	□ When Discharged	□ Both
2. Substance Abuse	□ No	□ When Admitted	□ When Discharged	□ Both
3. Trauma	□ No	□ When Admitted	□ When Discharged	□ Both
4. Patient Strengths (cognitive-behavioral coping skills, family support, motivation)	□ No	□ When Admitted	□ When Discharged	□ Both
5. Suicide Risk	□ No	□ When Admitted	□ When Discharged	□ Both

AA. When assessments are completed:

1. Is the assessment completed by a physician or the nursing staff? □ Physician □ Nursing Staff
2. Is there a follow-up with the patient after discharge? □ Yes □ No
3. Is the patient referred to a physician/psychiatrist for on-going support? □ Yes □ No
4. Are discharge assessments and aftercare recommendations sent to the next level of providers? □ Yes □ No

BB. Are patients allowed to self medicate while at the facility? □ Yes □ No

CC. Is informed consent secured for all treatments? □ Yes □ No

DD. Are guidelines in place to determine whether a patient is capable of giving consent for treatment? □ Yes □ No

EE. Identify any outstanding deficiencies, problems, failures or user errors in safety management, life safety management, equipment management or utilities management as cited in any recent inspections.

_____

_____

FF. Are all patient areas visible from a nursing station? □ Yes □ No

GG. Are all patient areas compliant with the standards for psychiatric wards and suicide prevention (physical environment)? □ Yes □ No

HH. Are all patients segregated by:

1. Gender? □ Yes □ No
2. Age? □ Yes □ No

II. Are patients constantly monitored in:

1. common areas? □ Yes □ No
2. when mixed? □ Yes □ No

JJ. Are patients discharged with antipsychotic medicines? □ Yes □ No
If Yes, please provide the percentage _____%

KK. Are patients discharged on multiple antipsychotic medicines? □ Yes □ No
If Yes, please provide the percentage _____%

LL. Are patients searched upon return to an inpatient area/facility? □ Yes □ No

MM. Are contraband controls in place? □ Yes □ No

NN. Are all inpatients facilities locked and secured? □ Yes □ No

OO. Do all exit doors require a magnetic key? □ Yes □ No

PP. Please identify any other measures used to address: escapes, leaving without authorization, unauthorized visitors, etc.

_____

_____

QQ. Are any precautions taken to warn identified third parties of threats made against them by patients? □ Yes □ No

RR. Are credentials of each physician reviewed by a medical staff committee and approved by the governing body prior to granting privileges? □ Yes □ No

SS. Does the applicant have any physicians on staff that do not maintain staff privileges at a hospital? □ Yes □ No

If yes, please explain: _____

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

CLAIM/SUIT INFORMATION APPLICATION

Please complete the questions below for all of the applicant's **(1) Open and; (2) Closed Claims with an indemnity payment or indemnity reserve of $50,000 or more including expenses**. 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 Medical Protective Company.

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

1. **Claim Number:** _____

2. **Patient/Claimant Name:** _____ **Age:** _____
   Last Name, First Name

3. **Date of treatment and/or surgery which led to the allegations against you.** ____ ____
   MM YYYY

4. **Date claim/incident notice received:** ____ ____
   MM YYYY

5. **Has this claim/incident been reported to your current or former insurer?** □ Yes □ No
   If Yes, provide the date the claim was reported to your current or former insurer: ____ ____
   Please provide a copy of the report(s). MM YYYY

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

7. **Defending insurance carrier name:**

8. **Was a claim made or a suit filed?** □ Yes □ No

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

10. **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 your consent? □ Yes □ No
    If Open, has settlement been offered? □ Yes □ No
    If Open, has trial date been set? □ Yes □ No

    Trial date: ____ ____
    MM YYYY

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 be 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.

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

HOSPITAL PHYSICIANS (SHORT) APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage Coverage is provided on a limited duty and scope basis unless otherwise requested.	**Requested Per Event Limits**	**Requested Aggregate Limits**	**Occurrence or Claims-Made**	**Shared or Separate Limits** (where allowed by state law)	**Deductible** (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	**Is ALAE included in the deductible** (if allowed by state law)**?**
□ **Professional Liability Employed or Contracted Physicians** (Physician, Surgeons, Residents, Interns, Fellows, Dentists and Oral Surgeons)	$	$	□ Occcurrence □ Claims-Made Retro-Date: _____	□ Shared Limits □ Separate Limits	□ Deductible Amount: $_____ □ SIR □ None	□ Yes □ No

B. Schedule of Medical Professionals—Physicians, Surgeons, Dentists and Oral Surgeons

Please provide the information below for each physician, surgeon, resident, intern, fellow, dentist and oral surgeon for whom coverage is to be provided under this policy. If additional space is needed, please use an additional piece of paper and include all information requested in the Schedule of Medical Professionals, below.

PLEASE COMPLETE THE PHYSICIANS CLAIM/SUIT INFORMATION APPLICATION TO PROVIDE THE PREVIOUS 10 YEARS LOSS HISTORY FOR EACH PHYSICIAN .

Coverage is provided on a limited duty and scope basis unless otherwise requested. If coverage for Outside Activities is being requested, please complete the Hospital Physicians Application, the Hospital Physicians Outside Activities Application and Physicians Claim/Suit Information Application for each. Coverage is designed to provide retroactive dates equal to the start date with the applicant unless otherwise requested. If an individual application is requested and received by the Company that conflicts with the information below, the provider will be subject to re-classification and re-rating based on the information contained in the application.

Employee Status: (C)ontract; (E)mployed; (F)aculty; (R)esident
Limits: (SH) Shared limits with the facility, restricted to the named insured's operations.
(SE) Separate limits, restricted to the named insured's operations.

SCHEDULE OF MEDICAL PROFESSIONALS—PHYSICIANS, SURGEONS, DENTISTS AND ORAL SURGEONS

Name of Medical Professional Last Name, First Name, Middle Name	Status (C) (E) (F) (R)	State	County	Indicate: Physician, Surgeon, Dentist or Oral Surgeon	Specialty ISO Code-List all that apply. (Please see ISO Code Reference)	Surgery Type: No surgery, Minor, or Major	Retro Date *	Hire Date	Number of hours per week if less than 40	License #	Limits (SH) (SE)

*If prior acts coverage is desired for services provided prior to the hire date with the applicant, please submit an individual application for each medical professional for whom prior acts coverage is being requested.

SCHEDULE OF TERMINATED-INACTIVE PHYSICIANS

C. Schedule of Terminated-Inactive Physicians

If coverage is sought for inactive physicians who are sharing limits or who have been previously provided ongoing incurred but not reported coverage, please complete the Schedule of Terminated-Inactive Physicians below. If coverage for inactive physicians is not being requested, skip to the next question. Coverage is provided on a shared limit basis unless otherwise requested. If additional space is needed, use an additional piece of paper.

Name of Medical Professional Last Name, First Name, Middle Name	MD or DO	State	County	Specialty ISO Code List all that apply. (Please see ISO Code Reference)	License Number	Retro Date	Hire Date	Termination Date

ISO CODE REFERENCE		
SPECIALTY	ISO CODE	
	M.D.	D.O.
Allergy—No Surgery	80254	84254
Anesthesiology	80151	84151
Colon & Rectal Surgery	80115	84115
Cardiology (including Swan-Ganz) - No Surgery	80255	84255
Cardiology (including left heart catheterization, angioplasty, electrophysiological studies [left heart])	80422	84422
Cardiovascular Surgery	80150	84150
Cosmetic Surgery	80136	84136
Dermatology—No Surgery	80256	84256
Dermatology—Performing any of the following procedures: liposuction: tumescent technique only, deep chemical peels	80282	84282
Dermatology—Skin flaps/grafts, cosmetic, assisting in major surgery—own patients	80294	84294
Emergency Medicine (including major surgery)	80157	84157
Endocrinology—No Surgery	80238	84238
Family/General Practice—No Surgery/No obstetrics	80420	84420
Family/General Practice—Performing any of the following procedures: Vasectomies—own patients only; Lumbar Epidural Steroid Nerve Blocks	80421	84421
Family/General Practice—Performing any of the following procedures: Prenatal practice with delivery or to term; no delivery, Tubal Ligations, Colonoscopy	80273	84273
Family/General Practice—including deliveries	80273	84273
General Surgery—No bariatric	80143	84143
General Surgery—Bariatric	80148	84148
Forensic Medicine—No Surgery	80240	84240
Gastroenterology—No Surgery	80241	84241
Gastroenterology—Performing any of the following procedures: Colonoscopy, Endoscopic Biopsy, Upper GI Endoscopy - ERCP, Gastrostomy (PEG tube replacement), Upper GI Endoscopy - Duodenoscopy	80274	84274
Geriatrics—No Surgery	80243	84243
Gynecology—No Surgery	80244	84244
Gynecology—Major Surgery	80167	84167
Hand Surgery	80169	84169
Head & Neck Surgery	80170	84170
Hematology/Oncology—No Surgery	80245	84245
Infectious Disease-No Surgery	80246	84246
Internal Medicine—No Surgery	80257	84257
Internal Medicine—Performing any of the following procedures: Gastrointestinal Endoscopy, Biopsy: Endoscopic	80284	84284
Internal Medicine—Performing any of the following procedures: Colonoscopy	80284	84284
Neonatology—No Surgery	80471	84471
Nephrology—No Surgery	80260	84260
Neurology—No Surgery	80261	84261
Neurology—Performing any of the following procedures: Lumbar Epidural Steroid-Nerve Blocks, Myelography, Angiography, Arteriography	80288	84288
Neurosurgery– Neurosurgeons (Craniotomy, Laminectomy, Spinal Fusions)	80152	84152
Nuclear Medicine—No Surgery	80262	84262
Nutrition—No Surgery	80248	84248
Obstetrics/Gynecology	80153	84153

ISO CODE REFERENCE		
SPECIALTY	ISO CODE	
	M.D.	D.O.
Occupational Medicine—No Surgery	80233	84233
Ophthalmology—No Surgery	80263	84263
Ophthalmology—Performing any of the following procedures: Ectropion/Entropian repair, Excision of growths in area of eyes and lids	80289	84289
Ophthalmology—Performing any of the following procedures: Cataract surgery, Blepharoplasty, Lasik/Refractive surgery	80114	84114
Orthopedic Surgery—Exclude back	80176	84176
Orthopedic Surgery—Include back	80154	84154
Otorhinolaryngology—No Surgery	80265	84265
Otorhinolaryngology—Performing any of the following procedures: Endoscopic biopsy, lymph node excision, hair transplants (follicular unit transplantation)	80291	84291
Otorhinolaryngology—Assisting in surgery on other than own patients	80117	84117
Otorhinolaryngology—Performing any of the following procedures: Rhinoplasty, Reconstructive Blepharoplasty, Tonsillectomy & Adenoidectomy, Reconstructive Cleft Plate surgery, Mastoidectomy	80159	84159
Pain Management	80295	84295
Pathology—No Surgery	80266	84266
Pediatrics—No Surgery	80267	84267
Pediatrics—Performing any of the following procedures: Colonoscopy, Upper GI Endoscopy - ERCP, Upper GI Endoscopy - Esophagoscopy, Pulmonary Artery Catheterization	80293	84293
Physiatry-No Surgery	80235	84235
Plastic Surgery	80156	84156
Psychiatry—No Surgery (including child)	80249	84249
Radiology—Diagnostic	80280	84280
Radiology—Therapy	80425	84425
Rheumatology—No Surgery	80252	84252
Thoracic Surgery	80144	84144
Traumatic Surgery	80171	84171
Urgent Care—No Surgery/No ER	80102	84102
Urology	80145	84145
Vascular Surgery	80146	84146

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

PHYSICIANS CLAIM/SUIT INFORMATION APPLICATION

For **each physician** complete this form for **each claim**.

Please complete the questions below for all **(1) Open and; (2) Closed Claims covering the past ten (10) years**. 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 Medical Protective Company.

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

1. **Claim Number:** _____

2. **Patient/Claimant Name:** _____ **Age:** _____
   Last Name, First Name

3. **Date of treatment and/or surgery which led to the allegations against you.** ____ ____
   MM YYYY

4. **Date claim/incident notice received:** ____ ____
   MM YYYY

5. **Has this claim/incident been reported to your current or former insurer?** □ Yes □ No
   If Yes, provide the date the claim was reported to your current or former insurer: ____ ____
   Please provide a copy of the report(s). MM YYYY

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

7. **Defending insurance carrier name:**

8. **Was a claim made or a suit filed?** □ Yes □ No

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

10. **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 your consent? □ Yes □ No

    If Open, has settlement been offered? □ Yes □ No

    If Open, has trial date been set? □ Yes □ No

    Trial date: ____ ____
    MM YYYY

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 be limited to the type of treatment and/or surgery, including applicant's involvement).

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

HOSPITAL PHYSICIAN (LONG FORM) APPLICATION

A. If additional space is needed, please complete in the Supplemental Information section with a reference to the question.
B. Additional documentation may be requested by the Company as necessary. For example: A copy of your most recent professional liability policy, including all endorsements, declarations page, etc.
C. Please print legibly. Please answer all questions; if a question is not applicable, print, "N/A."

GENERAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name: _____ Suffix: _____

B. Employment Status:

□ Employee □ Contractor □ Other: _____ Date joined: ____ / ____ / _____
MM DD YYYY

C. Residence Address:

Number and Street: _____ Apartment # _____

City: _____ State: _____ Zip Code: _____

County: _____

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, are you certified by the Educational Commission for Foreign Medical Graduates or have you 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. Have you 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):: ____ / _____

E. Are you entering practice for the first time? □ Yes □ No

F. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 credit hours: _____

G. Have you completed a risk management education course within the last twelve (12) months? □ Yes □ No

PRACTICE INFORMATION

A. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your 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 you hold a license to practice medicine: (Exclude state abbreviation from license number)

Please check the appropriate box to indicate the status of your license.

		Active	Inactive	Temporary	Pending
1.	State: _____ License #: _____	□	□	□	□
2.	State: _____ License #: _____	□	□	□	□
3.	State: _____ License #: _____	□	□	□	□
4.	State: _____ License #: _____	□	□	□	□

C. Do you have previous practice location(s)? □ Yes □ No

If Yes, list all location(s) within the past ten (10) years. If your 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 Hospital/Facility/Program: _____

   City: _____ State: _____ Country: _____

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

D. Please explain the following gaps if they occurred in the last ten (10) years:

1. Gaps greater than 1 year between your 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 do you belong? _____

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.
Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.

F. What is your present specialty? _____ ____ % of total practice

What is your sub-specialty? _____ ____ % of total practice

G. Are you 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, are you board eligible? □ Yes □ No If Yes, when do you take your boards? ____ / ____ (MM/YYYY)

If not American Board Certified, have you 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 you practice, and average weekly hours at that location:

State/County: _____ Hours: _____ State/County: _____ Hours: _____

J. Indicate the estimated average weekly numbers, under each of the following categories, for which you require The Medical Protective Company Company Coverage:

Hours per week: ____ Patients seen per week: ____ □ None Unscheduled walk-in patients per week: ____ □ None

K. Please indicate the percentage of your total practice performing the following surgical activities:

____ % Cardiac	____ % Obstetrics	____ % Otolaryngology	____ % Traumatic
____ % Gynecology	____ % Ophthalmology	____ % Plastic (cosmetic enhancement only)	____ % Urology
____ % Hand	____ % Orthopedic (including back)	____ % Plastic (reconstruction only)	____ % Vascular
____ % Neurosurgery	____ % Orthopedic (not including back)	____ % Thoracic	

____ % Other (describe) _____

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

□ Abdominoplasty—Tummy Tuck
□ Abortions—elective _____% of total practice
□ Abortions—Therapeutic _____% of total practice
□ Acupuncture—Therapeutic/Local Anesthetic
□ Anesthesia General/Spinal/Caudal
□ Angiography
□ Angioplasty
□ Arteriography
□ Arthroscopy
□ Assisting in major surgery-own patients only
□ Assisting in major surgery-own & other than own patients
□ Bariatric Surgery—Laparoscopic
□ Bariatric Surgery—Non-Laproscopic
□ Biopsy—Endoscopic
□ Blepharopigmentation _____% of total practice
□ Blepharoplasty—cosmetic _____% of total practice
□ Blepharoplasty-reconstruction _____% of total practice
□ Botox _____% of total practice
□ Brachioplasty
□ Breast Implants-Cosmetic _____% of total practice
□ Breast Implants-Reconstruction _____% of total practice
□ Breast Reduction—Cosmetic
□ Bronchoscopy
□ Bronco-esophagology
□ Buttock Implants
□ Calf Implants
□ Cataract Surgery
□ Catheterization—Left Heart
□ Catheterization-Right Heart (other than CVP lines)/ Swanz Ganz
□ Cheek/Chin/Lip Implants
□ Chelation Therapy
□ Chemical Peels—Superficial/Medium
□ Chemical Peels—Deep _____% of total practice
□ Cleft Lip Surgery—Reconstructive
□ Cleft Palate Surgery—Reconstructive
□ Colonoscopy
□ Cryosurgery (Cervical)
□ Cryosurgery (non-external lesions)
□ D & C
Disectomy
□ Open
□ Other Than Open
□ Electromagnetic Therapy
□ Electroconvulsive/Shock Therapy
□ Embolization
□ ERCP
□ Face Lifts
□ Face Lifts Mini (done with laser) _% of total practice
□ Gastrointestinal Endoscopy
□ Gynecology—Major Surgery
□ Hair Transplants—Follicular Unit Transplantations
□ Hair Transplants—Other
□ HVLA on the cervical spin on patients younger than 18 years of age
□ Intrathecal Pumps
□ Kyphoplasty
□ Laporoscopic Cholecystectomy
□ Laparoscopy
□ Laser Surgery
□ Laser Therapy (Endoscopic)
□ Laser Therapy (Non-Endoscopic)
□ Lipoinjection _____% of total practice
Liposuction
□ Other Than Tumescent Technique
□ Tumescent Technique Only____% of total practice
□ Lithotripsy
□ Lymphangiography
□ Mammograms
□ Myelography
Nerve Blocks
□ Facet
□ Lumbar Epidural Steroid
□ Myofascial
□ Occipital
□ Paraspinal/Paravertebral
□ Peripheral
□ Sciatic
□ Triggerpoint Injection
□ Oxidation Therapy
□ Pacemakers—Epicardial
□ Pacemakers—Endocardial
□ Pacemakers—Temporary
□ Peritoneoscopy
□ Phlebography
□ Pneumoencephalography
□ Polypectomy
Prenatal / Gynecological Practice
□ Prenatal Practice—1st & 2nd Trimester
□ Prenatal Practice—1st & 2nd Trimester
□ Prenatal Practice—to term, no delivery
□ Normal Deliveries—total per year ___
□ Cesarean Deliveries—total per year__
□ Prolotherapy
□ Radial/Laser Keratotomy
□ Radiation/X-Ray Therapy
□ Rectal Ozone Therapy
□ Rhinoplasty _____% of total practice
□ Sigmoidoscopy—60 cm or less
□ Sigmoidoscopy—greater than 60 cm
□ Silicone Injections ____% of total practice
Skin Flaps/Grafts
□ Cosmetic _____% of total practice
□ Reconstruction _____% of total practice
□ Spinal Cord Stimulators
□ Thigh Lift
□ Tubal Ligations
□ Upper GI Endoscopy
□ Vasectomies—own patients
□ Vasectomies-own & other than own patients
□ Weight Control Medication
_____% of total practice
□ Other Medical Techniques, List Procedures (do not restate your specialty):
_____
_____
_____
_____
_____
_____

M. In the last 10 years,

1. Have you 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. Have you performed weight control surgery or prescribed weight control medication? □ Yes □ No
   a. If Yes, what percentage of your 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 your practice (% of patient care) was devoted to performing weight control surgery?
      □ <1% □ 1% - 10% □ 11% - 50% □ >50% □ Never prescribed weight control surgery

N. Do you work in an emergency room on a scheduled basis? (If Yes, answer 1 and 2 below.)

1. Indicate average number of of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.) _____hrs
2. On average how many of the above hours are you working in order to fulfill staff privilege requirements? _____hrs

(If you have 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 you feel will help The Medical Protective Company better understand any special circumstances concerning your practice:

_____

_____

_____

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 you are covered by other insurance for these activities.)

A. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes. ____ % □ None

B. Indicate the percentage of your practice devoted to working in a nursing home facility. ____ % □ None

C. 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.

D. Do you practice as a medical director? □ Yes □ No

Type and name of facility: _____

If Yes, what percentage of your practice is devoted to this activity? _____ %

Briefly describe your responsibilities: _____

E. Do you devise or review plant/employer safety standards? □ Yes □ No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

F. Will you be performing activities which will be covered by another professional liability policy? □ Yes □ No

If Yes, are you a(n): □ Employee □ Independent Contractor □ Resident/Fellow □ Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

G. 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 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

Note: Missouri and California residents, do NOT answer Question H below.

H. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy? □ Yes □ No

If Yes, please indicate the date(s) and explain: ____ / _____ _____
MM YYYY

I. Have you ever been accused of sexual misconduct of any kind? □ Yes □ No

If Yes, please indicate the date(s) and explain: ____ / _____ _____
MM YYYY

J. Have you ever incurred or become aware of having a condition that impairs your ability to practice your 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 your treating physician(s) in the space 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.**

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): _____

_____

LOSS INFORMATION (Important! Please fully complete.)

Please complete the **Physicians Claim/Suit Information Application** for each written request, incident, claim or suit (A, B or C) below that has **NOT** been covered by a The Medical Protective Company policy.

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 you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?

If Yes, how many? _____ □ None

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? 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, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?

If Yes, how many? _____ □ None

COVERAGE INFORMATION

Notes: THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES MAY BE LIMITED TO LIABILITY FOR CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR MADE AND REPORTED DURING THE (60) DAY AUTOMATIC EXTENDED REPORTING PERIOD IN ACCORDANCE WITH ARK. CODE ANN §23-79-306(2), OR DURING ANY OPTIONAL EXTENDED REPORTING PERIOD ISSUED IN ACCORDANCE WITH ARK. CODE ANN. §23-79-306(3A).

1. **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 "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 your 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. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your 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

E. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your rquested retroactive date.

_____

_____

_____

F. 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 Medical Protective Company, will not provide Prior Acts coverage.

Initial Here

SUPPLEMENTAL INFORMATION

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

HOSPITAL PHYSICIAN OUTSIDE ACTIVITIES APPLICATION

A. Complete this supplemental application for all activities outside the primary applicant's hospital/facility.
B. Additional documentation may be requested by the Company as necessary. For example: A copy of your most recent professional liability policy, including all endorsements, declarations page, etc.
C. Please print legibly. Please answer all questions; if a question is not applicable, print, "N/A."

GENERAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name: _____ Suffix: _____

B. Practice Locations: (Please list primary location first. Combined percentage for all locations must total 100% and cannot be of equal values).

1. Type of Facility:

□ Office □ Hospital □ Nursing Home □ Prison/Correctional Facility □ Weight Loss Clinic □ Other: _____

_____ **# Hours** _____ _____
Practice/Hospital Name County

_____ _____ _____ _____ _____
Street Address Suite City State Zip Code

Start Date (MM/YYYY): _____ / _____

2. Type of Facility:

□ Office □ Hospital □ Nursing Home □ Prison/Correctional Facility □ Weight Loss Clinic □ Other: _____

_____ **# Hours** _____ _____
Practice/Hospital Name County

_____ _____ _____ _____ _____
Street Address Suite City State Zip Code

Start Date (MM/YYYY): _____ / _____

3. Type of Facility:

□ Office □ Hospital □ Nursing Home □ Prison/Correctional Facility □ Weight Loss Clinic □ Other: _____

_____ **# Hours** _____ _____
Practice/Hospital Name County

_____ _____ _____ _____ _____
Street Address Suite City State Zip Code

Start Date (MM/YYYY): _____ / _____

C. Please list all activities for which you are requesting coverage: _____

_____

_____

ADDITIONAL PROFESSIONAL INFORMATION

Please fully explain any, "Yes," answer in Section X, Supplemental Information with a reference to the question. (For questions A through G, please complete Question H, if you are covered by other insurance for these activities.)

A. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates. ____ Hrs. □ None

B. Indicate the average hours per week devoted to treating non-federal prison inmates. ____ Hrs. □ None

C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes. ____ % □ None

D. Indicate the percentage of your practice devoted to working in a nursing home facility. ____ % □ None

E. 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.

F. Do you practice as a medical director? □ Yes □ No
Type and name of facility: _____
If Yes, what percentage of your practice is devoted to this activity? _____ %
Briefly describe your responsibilities: _____

G. Do you devise or review plant/employer safety standards? □ Yes □ No
What products are manufactured by the company? _____

Company Name: _____

Location: _____

H. Will you be performing activities which will be covered by another professional liability policy? □ Yes □ No

If Yes, are you a(n): □ Employee □ Independent Contractor □ Resident/Fellow □ Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

I. 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 reimbursement privileges refused, denied, revoked suspended, restricted, subject o a reprimand, placed on probation or voluntarily surrendered? □ Yes □ No

If Yes, please indicate the date(s) and explain: ____ / _____ _____
MM YYYY

COVERAGE INFORMATION

Notes: THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES MAY BE LIMITED TO LIABILITY FOR CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR MADE AND REPORTED DURING THE (60) DAY AUTOMATIC EXTENDED REPORTING PERIOD IN ACCORDANCE WITH ARK. CODE ANN §23-79-306(2), OR DURING ANY OPTIONAL EXTENDED REPORTING PERIOD ISSUED IN ACCORDANCE WITH ARK. CODE ANN. §23-79-306(3A).

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 your 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. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your 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

E. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your rquested retroactive date.

_____

_____

_____

F. 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 Medical Protective Company, will not provide Prior Acts coverage.

Initial Here

SUPPLEMENTAL INFORMATION

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

HEALTHCARE PROVIDERS APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits (where allowed by state law)	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
□ **Professional Liability Employed or Contracted Healthcare Providers** (CRNAs, Nurse Midwives, CRNPs, Podiatrists, Physician Assistants and Surgical Assistants)	$	$	□ Occcurrence □ Claims-Made Retro-Date: _____	□ Shared Limits □ Separate Limits	□ Deductible Amount: $_____ □ SIR □ None	□ Yes □ No

B. When hiring allied professionals, are credentials checked and verified? □ Yes □ No

If No, please explain: _____

C. Provide the number of allied professionals working at your facility in the chart below.

ALLIED PROFESSIONALS	NUMBER EMPLOYED	NUMBER CONTRACTED
AIDES		
CHIROPRACTORS		
DENTAL HYGIENISTS/TECHNICIANS		
DIETICIANS		
EMT'S/PARAMEDICS		
LABORATORY TECHNICIANS		
LPN'S		
MEDICAL TECHNICIANS		
PERFUSIONISTS		
PHARMACISTS		
PSYCHOLOGISTS		
RADIOLOGY/X-RAY TECHNICIANS/THERAPISTS		
RESPIRATORY THERAPISTS		
RN'S		

D. Medical Staff Mid-Level Providers

1. a. Are credentials for all new staff providers verified and approved prior to granting privileges? □ Yes □ No
   b. Are privileges probationary for at least 6 months for all new staff providers? □ Yes □ No
   c. Does an identical credentialing and privileging process apply to:
      1) mid-level providers (i.e. CRNA's, Certified Nurse Midwives, Physician Assistants, etc.)? □ Yes □ No
      2) physicans' employees on premises (private scrubs, first assistants, nurse practitioners, etc.)? □ Yes □ No
   d. Are physicans' employees working on the premises required to meet the identical standards of employed staff (i.e. education, training, licensure, certification, etc.)? □ Yes □ No
2. Are all staff members licensed and privileged without restrictions? □ Yes □ No

   If No, please provide details: _____
3. How often are privileges reviewed? _____
4. Are all privileges granted to mid-level providers in writing? □ Yes □ No
5. Are mid-level providers required to carry professional liability insurance? □ Yes □ No
   a. If Yes, what are the liability limits? $_____ Per Event / $_____ Annual Aggregate
   b. Are they insured with a carrier rated less than A– by AM Best? □ Yes □ No
      If Yes, please explain: _____

E. Schedule of Medical Professionals—CRNA's, CRNPs, Nurse Midwives, Physician Assistants, Podiatrists and Surgical Assistants
If shared or separate limits coverage is desired for the below classifications of other health care professionals, please complete the Schedule of Medical Professionals—CRNA's, CRNPs, Nurse Midwives, Physician Assistants, Podiatrists and Surgical Assistants. Coverage is designed to provide retroactive dates equal to the date of employment with the named insured entity, unless otherwise requested.

Coverage is provided on a limited duty and scope basis.

Employee Status: (C)ontract; (E)mployed
Full Time Equivalency (FTE): Calculate (FTE) by dividing the total number of hours of professional service per week by 40 hours.
Limits: (SH) Shared limits with the facility, restricted to the named insured's operations.
(SE) Separate limits, restricted to the named insured's operations.

SCHEDULE OF MEDICAL PROFESSIONALS—CRNAs, CRNPs, NURSE MIDWIVES, PHYSICIAN ASSISTANTS, PODIATRISTS & SURGICAL ASSISTANTS

Name of Medical Professional	Status: (C) (E)	State	County	Indicate: CRNA, CRNP, Nurse Midwife, Physician Assistant, Podiatrist, Surgical Assistant	If a CRNP or a Physician Assistant, does the individual prescribe medication?	Retro date*	Hire Date	FTE's	License Number	Limits (SH) (SE)
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					
					☐ Yes ☐ No					

*If prior acts coverage is desired for services provided prior to the hire date with the applicant, please submit an individual application for each medical professional for whom prior acts coverage is being requested.

SCHEDULE OF TERMINATED-INACTIVE HEALTHCARE PROVIDERS

F. If coverage is sought for inactive healthcare providers who are sharing limits or who have been previously provided ongoing incurred but not reported coverage, please complete the Schedule of Terminated-Inactive Healthcare Providers below. If coverage for inactive healthcare providers is not being requested, skip to the next question. Coverage is provided on a shared limit basis unless otherwise requested. If additional space is needed, use an additional piece of paper.

Name of Medical Professional Last Name, First Name, Middle Name	State	County	License Number	Retro Date	Hire Date	Termination Date

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

GENERAL LIABILITY APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event / Medical Incident or Per Occurrence Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
□ **General Liability****	$	$	□ Occcurrence □ Claims-Made Retro-Date: _____	□ Shared Limits □ Separate Limits	□ Deductible Amount: $_____ □ SIR □ None	□ Yes □ No

** Fire and water damage liability is automatically provided at a $50,000 limit. If higher limits are desired, please contact your agent.

B. Please indicate below which of the following apply and specify the corresponding projected number or amount of receipts for the next 12 months.

1. □ Child Daycare Center □ Adult Daycare Center □ None

a) Number of Children/Adults per week: _____ Children _____ Adults

b) Are references checked prior to hiring on all employees and on all volunteers? □ Yes □ No

c) Are these services offered to: □ Employees Only □ Open to the Public

d) What is the staff to participant ratio? _____ Staff _____ Children/Adults Participants

2. Habitational Risk: □ Apartment □ Dwelling □ Hotel □ None □ Other, please describe: _____

a) Number of Units: _____ Units Year Built: _____

b) Are there at least two exits located remotely from each other? □ Yes □ No

c) For apartment buildings and hotels, are there lighted emergency exit signs? □ Yes □ No

3. Paid Parking: □ Yes □ No Receipts/Year: $_____

4. Restaurant: □ Yes □ No Receipts/Year: $_____

a) Is the restaurant staff contracted or employed? □ Contracted □ Employed

b) If contracted, do you require them to carry a general liability (GL) insurance policy with a limit of $1,000,000 per occurrence? □ Yes □ No

c) Are certificates of insurance obtained annually to verify coverage is in place? □ Yes □ No

d) Is the hospital added as an additional insured on their GL policy? □ Yes □ No

e) Does the restaurant comply with all state and local codes and regulations? □ Yes □ No

If No, please explain: _____

f) Did any inspector who visited the restaurant during the last 12 months indicate any violations or make any recommendations for change? □ Yes □ No

If Yes, please provide a copy of the violation/recommendation and indicate the corrective action(s) taken.

5. Special Athletic or Fund Raising Events: Receipts/Year: $_____

Describe planned events for the upcoming year and indicate if alcohol will be served: _____

_____

6. Swimming Pool: □ Yes □ No How deep is the pool? _____

a) Is it open to the public? □ Yes □ No If Yes, Receipts/Year: $_____

b) Is there a diving board? □ Yes □ No If Yes, is there a lifeguard on duty at all times? □ Yes □ No

C. Is there a heliport/helipad on the premises? □ Yes □ No

1. If Yes, is it FAA approved? □ Yes □ No
2. What is the estimated number of landings per year? □ 0-365 □ 366-1000 □ 1001—Up
3. Is there a separate insurance policy in place covering this heliport/helipad exposure? □ Yes □ No
4. If yes, what are the limits? $_____ Per Event / $_____ Annual Aggregate
   Please provide a copy of the Declarations and Loss Runs.

D. Provide the number and type of owned, non-owned, leased or chartered watercraft: _____

1. Give a brief explanation of watercraft use: _____
2. Are any of the watercraft over 26 feet? □ Yes □ No

   If Yes, provide a description of the craft and its length: _____

   _____
3. Is there a separate insurance policy in place covering this watercraft exposure? □ Yes □ No
4. If yes, what are the limits? $_____ Per Event / $_____ Annual Aggregate
   Please provide a copy of the Certificate of Insurance.

E. Do you lease space to others? □ Yes □ No

1. If Yes, indicate the address, square footage and the occupancy/use of the space. _____

   _____
2. Does the lease require the tenant to carry a general liability (GL) insurance policy with a limit of $1,000,000 per occurrence? □ Yes □ No
3. Are certificates of insurance obtained annually to verify coverage is in place? □ Yes □ No
4. Is the hospital added as an additional insured on their GL policy? □ Yes □ No

F. Is there an employee or contract security service? □ Yes □ No

If Yes, do they carry guns? □ Yes □ No

G. Are the management services of your facility provided by a management company? □ Yes □ No

1. If Yes, please provide the name and address of the hospital management company and indicate the operational positions provided:

   _____

   _____
2. If contracted, do you require them to carry a general liability (GL) insurance policy with a limit of $1,000,000 per occurrence? □ Yes □ No
3. Are certificates of insurance obtained annually to verify coverage is in place? □ Yes □ No

H. Do you rent or lease equipment from others? □ Yes □ No

If Yes, who is responsible for the maintenance of the equipment? _____

I. Is there a preventative maintenance and corrective maintenance program in place for medical equipment at the facility? □ Yes □ No

If Yes, do you adhere to each manufacturer's established guidelines and standards for all medical equipment? □ Yes □ No

J. Do you manufacture, produce, modify, customize, service or assemble any durable medical equipment or any other products? □ Yes □ No

1. If Yes, please describe and *provide a copy of your brochures*: _____

   _____
2. Do you sell, rent or lease any medical equipment to others? □ Yes □ No
   Please provide a copy of your equipment list or catalog of products available.
3. Is there a preventative maintenance plan in place on this equipment? □ Yes □ No
4. If Yes, is it performed by a qualified biomedical technician? □ Yes □ No

K. Environmental Exposures:

1. Is there a hazardous waste management/environmental safety program? □ Yes □ No
2. Is there a program in place for monitoring the facility's environmental exposures on an ongoing basis? □ Yes □ No
   Submit the following items:
   A) Copies of any governmental sanctions or citations.
   B) Documentation of any voluntary cleanup from releases or spills (over $50,000) whether or not reported to your insurance carrier.
3. Do you have written spill prevention and spill control programs in place? □ Yes □ No

L. Do you use an advertising agency? □ Yes □ No

1. If Yes, what professional liability limits do you require them to carry? $_____ Per Event / $_____ Annual Aggregate
2. Are certificates of insurance obtained annually to verify coverage is in place? □ Yes □ No
3. Is the hospital added as an additional insured on the Agency's policy? □ Yes □ No
4. Is there a hold harmless agreement in the contract in favor of the hospital? □ Yes □ No

M. Do you have any other contracts in place not previously discussed in this application? □ Yes □ No

If Yes, what services are provided? _____

_____

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

OPTIONAL COVERAGES SUPPLEMENTAL APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
☐ **Limited Pollution Short Term Event Liability**	☐ $100,000/$100,000 ☐ $200,000/$200,000 ☐ $300,000/$300,000		☐ Occcurrence ☐ Claims-Made Retro-Date: _____	☐ Shared Limits	☐ Deductible Amount: $_____ ☐ SIR ☐ None	☐ Yes ☐ No
☐ **Employer's Liability**	$	$	☐ Occcurrence ONLY	☐ Shared Limits ☐ Separate Limits	☐ Deductible Amount: $_____ ☐ SIR ☐ None	☐ Yes ☐ No
☐ **Employee Benefits Liability**	$	$	☐ Claims-Made ONLY Retro-Date: _____	☐ Shared Limits ☐ Separate Limits	☐ Deductible Amount: $_____ ☐ SIR ☐ None	☐ Yes ☐ No

EMPLOYEE BENEFITS LIABILITY ☐ Coverage Requested ☐ Coverage Not Requested

A. Is liability for the applicant's employee benefits program self-insured? ☐ Yes ☐ No

If Yes, please describe: _____

B. Is the applicant's employee benefits program self-administered? ☐ Yes ☐ No

If Yes, please describe: _____

C. Total number of employees:
☐ 0-499 ☐ 500-699 ☐ 701-999 ☐ 1,000-1,499 ☐ 1,500-2,999 ☐ 3,000+

EMPLOYER'S LIABILITY ☐ Coverage Requested ☐ Coverage Not Requested

A. Are any of the applicant's facilities in a monopolistic state and require primary employer's liability coverage? ☐ Yes ☐ No

B. Is excess employer's liability coverage requested? ☐ Yes ☐ No

C. Is the applicant subject to: ☐ Jones Act ☐ FELA ☐ Stop Gap ☐ Other: _____

DAMAGE TO PREMISES RENTED TO AN INSURED BUSINESS ☐ Coverage Requested ☐ Coverage Not Requested

A $50,000 limit is automatically provided. If higher limits are desired, please indicate below.

If requested, please identify the Per Occurrence Limit:
☐ $100,000 Per Occurrence Limit
☐ $250,000 Per Occurrence Limit

MEDICAL PAYMENTS ☐ Coverage Requested ☐ Coverage Not Requested

If requested, please identify the Per Person Limit:
☐ $1,000 Per Person Limit
☐ $2,500 Per Person Limit
☐ $5,000 Per Person Limit
☐ $10,000 Per Person Limit

PATIENTS' PROPERTY LIABILITY ☐ Coverage Requested ☐ Coverage Not Requested

If requested, please identify the Per Patient Limit and Deductible:

☐ $1,000 Per Patient Limit	☐ $250 Deductible ☐ $500 Deductible
☐ $2,000 Per Patient Limit	☐ $250 Deductible ☐ $500 Deductible
☐ $5,000 Per Patient Limit	☐ $250 Deductible ☐ $500 Deductible

HIRED AND NON-OWNED AUTO LIABILITY COVERAGE □ Coverage Requested □ Coverage Not Requested

If provided, the limits and deductible will the same as, and this coverage will share the limits and deductible of, the Commercial General Liability, Coverage A.

A. Does the applicant maintain a commercial auto policy for owned autos? □ Yes □ No

If Yes, is hired and non-owned auto liability coverage available under that policy? □ Yes □ No

B. What evidence of auto insurance does the facility require from employees and volunteers who are using their own, personal autos?

□ None □ Certificate of Insurance □ Copy of Auto ID Card □ Copy of Auto Policy □ Other, please explain: _____

C. What minimum personal auto liability limits does the applicant require of employees and volunteers using their personal autos for the applicant's business?

□ Not Required □ Statutory □ Other, please explain: _____

D. Does the applicant check Motor Vehicle Records on the employees and volunteers? □ Yes □ No

E. How many active employees and volunteers work for the applicant's business?

□ 0-150 □ 151-1,000 □ 1,001-2,500 □ 2,501+

F. Does the facility use hired and non-owned autos to transport patients? □ Yes □ No

G. Does the applicant's home health employees and volunteers, rent or use their own autos? □ N/A □ Yes □ No

If Yes, how many employees and volunteers rent or use their own autos? _____

H. Has the applicant had any hired or non-owned auto claims? □ Yes □ No

If Yes, please provide complete loss runs.

LIMITED POLLUTION SHORT TERM EVENT LIABILITY □ Coverage Requested □ Coverage Not Requested

Pollution Liability: Coverage is excluded from our standard coverage with exception for a very limited grant for bodily injury and property damage. A limited endorsement of coverage is available, including an option for underground storage tanks.

A. Environmental Exposures

1. Is the limited pollution short-term event coverage option desired? □ Yes □ No
   If No, skip to the next section.
2. If Yes, do you want the limited pollution short-term event coverage option with underground storage tanks? □ Yes □ No
   If Yes, complete the all of the questions in Question B.
3. Is preventative maintenance on all above ground and underground tanks performed by outside contractors? □ Yes □ No
   If No, please explain: _____
4. How often are tanks tested? _____

B. Underground Tanks: If the limited pollution short-term event option with underground tanks is desired, please provide the information requested below for each underground tank. If you have more than two tanks, attach a separate page indicating the information for each question below.

UNDERGROUND TANKS		
	Tank 1	**Tank 2**
Registration Number or Identifier		
Age		
Contents		
Capacity in Gallons		
Construction Type	□ Fiberglass Steel Coats □ Fiberglass Lined Steel Tank □ Cathodically Protected Steel □ Unprotected □ Fiberglass □ Other: (describe) _____	□ Fiberglass Steel Coats □ Fiberglass Lined Steel Tank □ Cathodically Protected Steel □ Unprotected □ Fiberglass □ Other: (describe) _____
Single or Double Wall Construction	□ Single □ Double	□ Single □ Double
Is the tank in a vault?	□ Yes □ No	□ Yes □ No
Is there a leak detection system in place?	□ Yes □ No If Yes, indicate type: □ Automatic Tank Gauging □ Intersistal Monitoring (liquid/vapor monitoring within the wall of the tank) □ Vapor Monitoring Systems (alarms) □ Ground Water Monitoring □ Other: (describe) _____	□ Yes □ No If Yes, indicate type: □ Automatic Tank Gauging □ Intersistal Monitoring (liquid/vapor monitoring within the wall of the tank) □ Vapor Monitoring Systems (alarms) □ Ground Water Monitoring □ Other: (describe) _____
When was the last tightness test performed? **Did the tank pass or fail?** **If it failed, provide details in the comments section below.**	Date: _____ □ Pass □ Fail	Date: _____ □ Pass □ Fail

UNDERGROUND TANKS UNDERGROUND TANKS UNDERGROUND TANKS (CONTINUED)		
	Tank 1	**Tank 2**
Is the tank equipped with spill protection? **Over-fill protection?**	□ Yes □ No □ Yes □ No	□ Yes □ No □ Yes □ No
Are the tanks in compliance with all governmental regulations for leak detection, overflow protection and corrosion protection? **If No, provide details in the comments section below.**	□ Yes □ No	□ Yes □ No

Underground Tanks Comments: _____

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

CYBER-LIABILITY, CRISIS MANAGEMENT AND REPUTATIONAL HARM SUPPLEMENTAL APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Cyber Suite Coverages	Requested Limits of Liability	Retroactive Date	Retention
□ **Coverages A through G** (A) Multimedia Liability, (B) Security and Privacy, (C) Privacy Regulatory Defense and Penalties, (D) Privacy Breach Response Costs, Customer Notification Expenses, Customer Support and Credit Monitoring Expenses, (E) Network Asset Protection, (F) Cyber Extortion, (G) Cyber Terrorism	□ $500,000 □ $3,000,000 □ $1,000,000 □ $4,000,000 □ $2,000,000 □ $5,000,000	□ Retroactive Date for Coverages A, B, C and H: _____	
□ **Coverage H** Regulatory Proceeding	□ $500,000 □ $3,000,000 □ $1,000,000 □ $4,000,000 □ $2,000,000 □ $5,000,000		□ Retention Amount: $_____
Coverages I through K Crisis Management Coverages (I) Evacuation Expense Reimbursement, (J) Disinfection Expense Reimbursement, and (K) Public Relations Expense Reimbursements	$100,000		□ Other: _____
Coverage L Crisis Management Coverage E-Discovery Claim Expenses/E-Discovery Regulatory Investigation Expense	$100,000	Subject to same retroactive date requested above.	
Coverage M Data Protection Reputational Harm	$100,000		

GENERAL INFORMATION

A. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:

_____ _____
Name Title

_____-_____-_____ _____
Phone Email

B. Does the applicant own any physician groups? □ Yes □ No

If yes, please provide the date(s) acquired or incepted: _____

C. What is the applicant's total annual operating revenues? Please provide the following:

Anticipated revenue? $_____ **Current year?** $_____ **One year ago?** $_____

1. Total Billings: $_____
2. Annual Medicare revenue: $_____
3. Annual Medicaid revenue: $_____
4. Commercial insurance revenue: $_____

D. In-Patient Exposure vs. Outpatient Exposure:

In-Patient

1. Number of In-Patient Beds: _____
2. Estimated percentage of Medicare Admissions as a percentage of total admissions: _____%
3. Billings as a percentage of Medicare Bills:
   a. Hospital: _____%
   b. Skilled Nursing: _____%
   c. Other: _____%

Outpatient

4. Estimated percentage of bills to Medicare Outpatient Services as a percentage of total outpatient services: _____%

E. Has the applicant acquired any entities in the past five years? □ Yes □ No

If yes, please provide specific details, including size, dates, what specialty/specialties were involved and what the Medicare/Medicaid billings were as a percentage of the total practice for each of the past five years. Please attach a separate sheet of paper, if necessary.

_____

_____

F. Please complete the Schedule of Current Liability Policies and Coverages. For each policy below, please *provide a copy of the policy, including the declarations page, and the loss runs for the last ten years.*

SCHEDULE OF CURRENT LIABILITY POLICIES AND COVERAGES

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY	RETROACTIVE DATE	EXPIRING PREMIUM
Cyber-Liability				$		$
Regulatory Proceeding				$		$
Crisis Management				$		$
Reputational Harm				$		$

BILLING COMPLIANCE INFORMATION

A. Does the applicant handle all billings in-house? □ Yes □ No
If no, please list the amount done centrally and amount done by third party billing service(s) and any ownership percentage in the third party billers used:

_____

_____

B. Does the applicant have a compliance program in place for both HIPAA and billing errors? □ Yes □ No
If yes, when was it implemented and provide detail on any compliance software being utilized:

_____

_____

Does it include the oversight of Medicaid Billing? □ Yes □ No

C. Does the applicant have a Medical Billings Compliance Officer? □ Yes □ No
If yes, please provide the following information:

_____ _____
Name Title

Experience and qualifications: _____

_____

D. Does the applicant's organization currently use non-credentialed staff to perform medical billing procedures? □ Yes □ No
If yes, please provide the following:
1. Number of non-credentialed staff: _____
2. Name of the positions the non-credentialed staff hold: _____
3. Are coders regularly educated? □ Yes □ No
4. Does the applicant have written policies and procedures for coders? □ Yes □ No
   If yes, are they updated yearly? □ Yes □ No
5. The approximate split between the billings processed by credentialed and non-credentialed staff: _____%

E. Please identify whether all of the activities listed are included in the compliance program:
1. Specifically drafted policies and procedures □ Yes □ No
2. Education and training □ Yes □ No
3. Internally conducted audits □ Yes □ No
4. Third party audits □ Yes □ No
5. Review of Medicare/Medicaid billing □ Yes □ No
6. Outside coding consultant □ Yes □ No
7. Outside legal counsel □ Yes □ No
8. Other (please describe): _____ □ Yes □ No

F. Does the organization have a written repayment policy for billing errors that are found? □ Yes □ No

G. If the applicant has any other CMS (Medicare) Provider number than that listed on the Hospital Professional Liability Supplemental Application, please provide: _____

If other Medicare Provider number is applicable, please provide the corresponding entity name: _____

NETWORK SECURITY AND PRIVACY INFORMATION

A. Does the applicant enforce a security policy that must be followed by all employees, contractors, or any other person with access to the applicant's networks? □ Yes □ No

B. Does the applicant's virus or malicious code control program address the following:
1. anti-virus on all systems? □ Yes □ No
2. filtering of all content for malicious code? □ Yes □ No
3. controls on shared drives and folders? □ Yes □ No
4. CERT or similar vendor neutral threat notification services? □ Yes □ No
5. removal of spyware and similar parasitic code? □ Yes □ No

C. Does the applicant test its security at least yearly to ensure effectiveness of the technical controls as well as its procedures for responding to security incidents (e.g. hacking, viruses, and denial of service attacks)? □ Yes □ No

Does this include a network penetration test? □ Yes □ No

D. Is all remote access to the applicant's network authenticated, encrypted, and from systems that are at least as secure as the applicant's? □ Yes □ No

E. Does the applicant require all third parties entrusted with sensitive or non-public personal information to contractually agree to protect such information using safeguards at least equivalent to the applicant's own? □ Yes □ No

If yes, does the applicant audit the third party's compliance with the foregoing safeguards? □ Yes □ No

F. Does the applicant retain non-public personal information and others' sensitive information only for as long as needed and when no longer needed, irreversibly erase or destroy them using a technique that leaves no residual information? □ Yes □ No

G. Does the applicant employ physical security controls to prevent unauthorized access to computer, networks, and data? □ Yes □ No

H. Does the applicant control and track all changes to its network to ensure that it remains safe? □ Yes □ No

I. How long does it take to restore the applicant's operations after a computer attack or other loss/corruption of data?

□ 12 hrs or less □ 12-24 hrs □ More than 24 hrs

J. Is all sensitive and confidential information that is transmitted within and from the organization encrypted using industry-grade mechanisms? □ Yes □ No

K. Is all sensitive and confidential information stored on the applicant's databases, servers and data files encrypted? □ Yes □ No

LOSS INFORMATION

After the applicant's inquiry, has the applicant or any member of its staff or any person or entity for whom the applicant performs billing services, ever:

A. Been investigated or sanctioned by any local, state or federal government agency or private payer regarding the delivery of health care services or reimbursement thereof? □ Yes □ No

If yes, please provide specific details: _____

_____

B. Had to refund amounts to public and/or private payers? □ Yes □ No

If yes, please provide specific details: _____

_____

C. Been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? □ Yes □ No

If yes, please provide specific details: _____

_____

D. Been accused of errors by any government agency or commercial payer? □ Yes □ No

If yes, please provide specific details: _____

_____

E. Has the applicant received any complaints, claims or been subject to litigation involving matters of privacy, injury, identity theft, denial or service attacks, computer virus infections, theft of information, damage to third party networks, or the applicant's customer's ability to rely on the applicant's network? □ Yes □ No

If yes, please provide specific details: _____

_____

F. Has insurance of the type for which the applicant is now applying ever been declined, cancelled or had the renewal thereof refused to the proposed insured? Note: Do **not** answer in the states of Missouri and California. □ Yes □ No

If yes, please provide specific details: _____

_____

G. Does the applicant have knowledge of any claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the requested policy? □ Yes □ No

If yes, please provide specific details: _____

_____

H. Has the applicant ever received a letter or subpoena from any government entity outlining the intent to audit the applicant? □ Yes □ No

If yes, please provide specific details: _____

_____

I. In the last five (5) years, has the applicant experienced any claims, or is the applicant aware of any circumstances that may give rise to a claim that would have been covered by this policy? □ Yes □ No

If yes, please provide specific details: _____

_____

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

EXECUTIVE LIABILITY, ENTITY LIABILITY, EMPLOYMENT PRACTICES LIABILITY AND THIRD PARTY LIABILITY INSURANCE SUPPLEMENTAL APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Limits of Liability	Pending or Prior Date	Retention
□ **Coverages A through C** Executive Liability, Executive Indemnification and Entity Liability	□ $1,000,000 □ $4,000,000 □ $2,000,000 □ $5,000,000 □ $3,000,000	□ Pending or Prior Date: _____	□ Retention Amount: $_____ □ Other: _____
Antitrust Violation Claims This coverage will be provided as a sublimit of Coverages A, B & C, if selected above.	$1,000,000		
□ **Coverage D** Employment Practices Liability	□ $1,000,000 □ $4,000,000 □ $2,000,000 □ $5,000,000 □ $3,000,000	□ Pending or Prior Date: _____	□ Retention Amount: $_____ □ Other: _____
□ **Coverage E** Third Party Liability	□ $1,000,000 □ $4,000,000 □ $2,000,000 □ $5,000,000 □ $3,000,000	□ Pending or Prior Date: _____	□ Retention Amount: $_____ □ Other: _____
Internal Revenue Code of 1986 Sublimit This coverage will be provided as a sublimit of the Maximum Aggregate for all coverages.	$50,000		
Excess Benefit Transaction Sublimit This coverage will be provided as a sublimit of the Maximum Aggregate for all coverages.	$10,000		

NOTICE: THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES MAY BE LIMITED TO LIABILITY FOR CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR MADE AND REPORTED DURING THE (60) DAY AUTOMATIC EXTENDED REPORTING PERIOD IN ACCORDANCE WITH ARK. CODE ANN §23-79-306(2), OR DURING ANY OPTIONAL EXTENDED REPORTING PERIOD ISSUED IN ACCORDANCE WITH ARK. CODE ANN. §23-79-306(3A).

The limit of liability available to pay damages or settlements shall be reduced and may be exhausted by amounts paid for defense costs. Payment of defense costs shall be applied to the retention. Submission of this application does not guarantee coverage. In no event will the Company be liable for defense costs or other loss in excess of the applicable limits of liability. Read the entire application carefully before signing.

GENERAL INFORMATION

A. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:

_____ _____
Name Title

_____-_____-_____ _____
Phone Email

B. Individual responsible for Human Resources or employment law matters:

_____ _____
Name Title

_____-_____-_____ _____
Phone Email

C. Does the applicant have any subsidiaries, affiliates or control over any other entity or organization to be covered? □ Yes □ No
If yes, please provide a description of the operations, ownership/relationship to the above named applicant, and the tax status of each such entity (if an additional space is needed, please attach a separate sheet with all of the requested information):

_____

_____

D. Is the applicant publicly-held or a public reporting company under the Securities Exchange Act of 1934? □ Yes □ No
If yes, coverage is not available.

E. In the last 18 months, has the applicant transacted or attempted a private debt or equity offering of securities? □ Yes □ No

F. Within the next 18 months, does the applicant anticipate any:

1. private debt equity offering of securities? □ Yes □ No
2. public offering of securities? □ Yes □ No

G. Has the applicant contemplated within the last eighteen (18) months, been involved with any actual, negotiated, or attempted merger, acquisition, divestment or reorganization, or arrangement with creditors under any federal or state law? □ Yes □ No

H. Does the applicant contemplate transacting any mergers or acquisitions in the next 12 months? □ Yes □ No

I. Please complete the Schedule of Current Liability Policies and Coverages. For each policy below, please *provide a copy of the policy, including the declarations page and the loss runs for the last ten years.*

SCHEDULE OF CURRENT LIABILITY POLICIES AND COVERAGES

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY	RETROACTIVE/PENDING OR PRIOR DATE	EXPIRING PREMIUM
Directors & Officers				$		$
Employment Practices Liability				$		$

J. Is any of the applicant's medical malpractice/health care professional liability exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk sharing arrangement or pool? □ Yes □ No

If yes, please describe that insurance program by separate attachment, state how the program is administered and attach a copy of the most recent actuarial study. If a funded trust, captive or subsidiary is used:

1. Does the funded trust, captive or subsidiary provide insurance other than to the applicant? □ Yes □ No
2. Is the program funded in accordance with annually determined actuarial requirements? □ Yes □ No

If any of the questions, K through M, below are answered, yes, please complete the Claim/Wrongful Act/ Incident Supplemental Application.

K. Has any insurer made payments to or on behalf of any person or entity proposed for this insurance at any time in the last 5 years? □ Yes □ No

L. Has the applicant given written notice under the provisions of any current or prior policy providing similar insurance of any specific facts or circumstances which might give rise to a claim under such insurance? □ Yes □ No

California and Missouri applicants, do NOT answer question M. below.

M. Has any insurer ever cancelled or non-renewed any similar insurance? □ Yes □ No

FINANCIAL INFORMATION

A. Describe the following financial information of the applicant for the most recent fiscal year-end:

1. Fiscal year ending: _____
2. Total Assets: $_____
3. Income/Loss: $_____ Check one: □ Net Income; or □ Net Loss
4. Equity: $_____

B. Do the current liabilities exceed current assets? □ Yes □ No

If yes, please explain: _____

C. Do long-term liabilities exceed 45% of total assets? □ Yes □ No

If yes, please explain: _____

D. Will more than 50% of the total long-term liabilities mature within the next 18 months? □ Yes □ No

If yes, please explain: _____

E. Has any auditor in the last 2 fiscal years rendered a "going concern" opinion for the financial statements of the applicant? □ Yes □ No

If yes, please explain: _____

EXPERIENCE AND COMPLIANCE

A. Has the applicant been investigated or sanctioned by any local, state or federal government agency or private payer regarding the delivery of health care services or reimbursement thereof? □ Yes □ No

B. Does the applicant have a compliance program in effect, including but not limited to compliance for billing, HIPAA and EMTALA regulations? □ Yes □ No

C. Does the applicant have a compliance officer/manager? □ Yes □ No

1. If yes, please provide his or her name, qualifications and to whom he/she reports: _____
2. If no, who ensures compliance? _____

D. Does the applicant use an outside compliance consultant? □ Yes □ No

If yes, who? _____

E. Does the applicant have legal counsel for compliance issues? □ Yes □ No

If yes, who? _____

DIRECTORS & OFFICERS AND INSURED ORGANIZATION COVERAGE INFORMATION

A. Do the directors and officers, as a whole, directly or indirectly own or control the voting rights of more than 5% of the outstanding securities of the applicant? □ Yes □ No

B. Does the applicant act as a general partner in any partnership? □ Yes □ No

If yes, please explain: _____

C. Does the applicant have any direct or indirect insurance operations? □ Yes □ No

If yes, please explain: _____

D. Please provide the applicant's accreditation(s): □ JCAHO □ NCQA □ Other: _____

E. Is the coverage requested for outside service positions on any for-profit or public corporate boards or other joint venture? □ Yes □ No

If yes, please explain: _____

If yes, please submit the following for the outside company:

1. Name;
2. Audited Financial Statement;
3. Schedule of primary Directors & Officers; and,
4. Schedule of proposed insured persons and their capacity.

F. Does the applicant control more than twenty percent (20%) of the market share in any given geographical area of providers in any given field of practice or health care services? □ Yes □ No

If yes, please provide market share percentages by separate attachment.

G. Prior Activities:

1. Within the last five years, has any person or entity proposed for this insurance been the subject of or involved in any litigation, administrative proceeding, demand letter or formal or informal governmental investigation or inquiry, including and not limited to violations of any federal or state securities laws, or anti-trust copyright or patent litigation? □ Yes □ No
   If yes, please complete the Claim/Wrongful Act/Incident Supplemental Application.
2. Is any person or entity proposed for this insurance aware of any wrongful act, facts, incidents, or any circumstance which may result in claims being made against the applicant(s)? □ Yes □ No

   If yes, please explain: _____

EMPLOYMENT PRACTICES COVERAGE SECTION INFORMATION

A. What is the total number of employees, including providers/doctors?

Full time: _____ **Part time:** _____ **Temporary:** _____

B. What is the total number of providers/doctors?

Employed: _____ **Contracted:** _____

C. Have any officers or senior management voluntarily or involuntarily left the employment of the applicant within the last 18 months? □ Yes □ No

If yes, please provide details: _____

_____

D. Does the applicant anticipate in the next twelve (12) months, or transacted in the last twelve (12) months, any plant, facility, branch or office closing, consolidations or layoffs affecting 20% or more of the total employees or affecting an entire division, location or business unit? □ Yes □ No

If yes, please provide details: _____

_____

E. Describe the internal controls maintained for Employment Practices:

1. Have all supervisors and officers attended training on sexual harassment and discrimination within the last eighteen (18) months? □ Yes □ No
2. Does labor relations counsel review the employment policies/procedures at least annually? □ Yes □ No
3. Is there a separate Human Resources Department? □ Yes □ No
4. Does the applicant publish and distribute an employee handbook? □ Yes □ No
   If yes, does it include policies for:
   a. anti-harrassment? □ Yes □ No
   b. equal employment opportunity? □ Yes □ No
   c. at-will employment provision? □ Yes □ No
   d. Americans with Disabilities Act? □ Yes □ No
   e. Family and Medical Leave Act? □ Yes □ No
   f. all employees to receive a copy and sign for receipt? □ Yes □ No
5. Are all mandatory federal and state posting requirements met? □ Yes □ No
6. Are there written procedures for handling employee grievances or complaints? □ Yes □ No
7. Does the applicant use an application for employment? □ Yes □ No
   If yes, does it include:
   a. an "at will" statement? □ Yes □ No
   b. an equal employment opportunity statement? □ Yes □ No

8. Are terminations reviewed by either Human Resources, Senior Management or outside labor relations counsel? □ Yes □ No

F. What is the applicant's annual percentage turnover rate for employees?
(voluntary=retired or resigned; and involuntary=terminated)

	Previous Year	Current Year
Voluntary:	_____	_____
Involuntary:	_____	_____

G. Are stock options offered to employees, officers or directors as part of their compensation? □ Yes □ No

If yes, please explain: _____

H. Third Party Claims Exposure

1. Does the applicant have direct contact with customers, clients or other third parties? □ Yes □ No
2. Does the applicant have written procedures for the handling of customer/client/third party relations? □ Yes □ No
   a. Are these procedures included in the employee handbook? □ Yes □ No
   b. Do they include anti-discrimination and anti-sexual harassment policies? □ Yes □ No
   c. Do they include procedures for handling complaints of discrimination and sexual harassment by a customer/client/ other third party? □ Yes □ No

I. Prior Activities Information

1. Within the last five (5) years, has any person or entity proposed for this insurance been the subject of or involved in any litigation, administrative proceeding, demand letter or formal or informal governmental investigation or inquiry, including any investigation by the Department of Labor or the Equal Employment Opportunity Commission? □ Yes □ No
   If yes, please complete the Claim/Wrongful Act/Incident Supplemental Application for each such matter.
2. Is any person or entity proposed for this insurance aware of any wrongful act, facts, incidents, or any circumstance which may result in claims being made against you? □ Yes □ No

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

Supplemental Claim/Wrongful Act/Incident Form

Please complete a separate form for each claim or incident and answer all questions fully. Prior to attaching to the application, a principal, partner or officer of the applicant must sign and date this form and attach it to the signed application along with any explanations. No full indication can be provided without this complete information.

1. Name of individual(s) employed by the applicant charged in the claim/incident:

{Defendant(s)}: _____ Title: _____

{Defendant(s)}: _____ Title: _____

{Defendant(s)}: _____ Title: _____

2. Name of person(s) or entities making complaint/allegations in incident (Plaintiff)**:** _____

_____

3. Date of alleged Wrongful Act. ____ ____ (MM YYYY)

4. Date the applicant became aware of alleged Wrongful Act: ____ ____ (MM YYYY)

5. How did the applicant become aware of the Wrongful Act? (Please check all that apply)

- **a.** _____ **Personally observed incident**
- **b.** _____ **Verbal complain from employee**
- **c.** _____ **Written notice from employee or employee's attorney**
- **d.** _____ **Verbal/written notice from someone else other than complaining employee**
- **e.** _____ **Filing with state agency**
- **f.** _____ **Filing with EEOC**
- **g.** _____ **Receipt of lawsuit**
- **h.** _____ **Filing with HUD**
- **i.** _____ **Other** (please describe)**:** _____

6. Name of insurer that the claim was report to (if any)**:** _____

7. Is the applicant represented by an attorney? □ Yes □ No

8. Present status of claim/incident: □ Pending □ Closed □ In Suit

9. If closed, total damages paid: $_____

total expenses paid: $_____

10. If EEOC or state agency filing:

a. Has a right to sue letter been issued? □ Yes □ No

If yes, date: ____ ____ ____ (MM DD YYYY)

Date right to sue expires (or did expire)? ____ ____ ____ (MM DD YYYY)

b. Has determination of fault been decided? □ Yes □ No

If yes, what was the determination? _____

If claimant/plaintiff has a right to sue, what date does (did) this expire? ____ ____ ____ (MM DD YYYY)

11. If pending, is plaintiff demanding a settlement amount? □ Yes □ No

If yes, how much? $_____

Has plaintiff offered a settlement amount? □ Yes □ No

Is yes, how much? $_____

Legal expenses to date: $_____

12. Please provide a detailed description of the complaint and the applicant's response (please attach a separate piece of paper if additional space is needed)**:**

_____

_____

13. Explain what actions have been taken to prevent an incident like this from happening again:

_____

_____

14. If a complaint was for sexual harassment, has the alleged perpetrator been disciplined or terminated? Please explain:

_____

_____

I understand that the information submitted herein becomes a part of my application and in the event that coverage is bound, is subject to the same warranty and conditions.

Applicant's Signature: _____ Date: _____

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

MANAGED CARE APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Claim / Medical Incident or Per Occurrence Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
□ **Managed Care Liability**	$	$	□ Claims-Made ONLY Retro-Date: _____	□ Shared Limits □ Separate Limits	□ Deductible Amount: $_____ □ SIR □ None	□ Yes □ No

B. Is Managed Care Coverage desired? □ Yes □ No

C. Applicant is organized as: (Check all that apply.)

□ HMO □ PPO □ IPA □ TPA □ Utilization Review Contractor □ Other: _____

Please describe operations: _____

D. Does the applicant own, operate or manage another entity (hospital, clinic, pharmacy, dispensary or other medical facility)? □ Yes □ No

If Yes, please provide details: _____

E. Do you offer peer review or post care review services for others? □ Yes □ No

If Yes, please provide details: _____

F. Is the applicant administering or providing managed care services on behalf of a health care plan that includes:

1. the creation, sale and marketing of a health care plan? □ Yes □ No

2. the selection, credentialing and contracting of health care providers? □ Yes □ No

3. the evaluation of the cost, quality and proper utilization of treatment options available or being provided to participants? □ Yes □ No

4. the adjustment, investigation and processing of claims for benefits? □ Yes □ No

5. case management? □ Yes □ No

If Yes for any of the above, please provide details:

With/for whom: _____

Type of services being provided: _____

Annual revenue for services: _____

If other services (not listed above) are being provided, please provide details: _____

G. Does the applicant employ physicians, surgeons, dentists or other healthcare professionals to perform any medical duties other than administrative functions or as member of peer review or utilization review boards or committees? □ Yes □ No

If Yes, please describe their duties and attach a schedule showing the number in each specialty and/or the number of each type of allied professional: _____

H. Are medical services provided under a written contract between the applicant and a health care provider? □ Yes □ No

If Yes, please attach a copy of the contract. If No, please explain: _____

I. Credentialing:

1. Who is responsible for the applicant's credentialing activities relating to managed care for healthcare professionals:

□ Applicant

□ Other, please explain: _____

a. If the applicant contracts with an outside source for credentialing, does the applicant review the process and results? □ Yes □ No

If No, please explain: _____

b. Does the applicant require the outside credentialing source to carry professional liability insurance? □ Yes □ No

c. How frequently does the applicant credential contract healthcare providers? _____ # Times/ □ Wk. □ Mo. □ Yr.

J. Operational Volume:

1. Please provide the number of enrollees in the table below:

	THIS POLICY YEAR (ESTIMATED)	PRIOR POLICY YEAR
Insured enrollees (if operations cover more than one state, provide listing by state)		
Enrollees in self-insured plans administered by the applicant (listing by state)		
Percentage of enrollees NOT covered by ERISA		
Number of admissions per 1000 enrollees per year		
Number of inpatient days per 1000 enrollees per year		
Quality, Cost or Utilization Review Service Contracts: Case Numbers		
Quality, Cost or Utilization Review Service Contracts: Revenue		

2. Does the applicant provide EAP or other counseling services? □ Yes □ No

3. How many counselors are employed by the applicant? _____

Are the counselors required to be licensed? □ Yes □ No

4. Do these employees provide assessment and referral? □ Yes □ No

Short-term counseling? □ Yes □ No

If Yes, what is the maximum number of visits allowed? _____

5. Do any employees of the insured provide longer term counseling? □ Yes □ No

6. Does the applicant have any physicians or psychiatrists providing clinical services or furnishing drug prescriptions? □ Yes □ No

7. How many client contact hours were provided last year? _____

8. How many client contact hours does the applicant estimate for this year? _____

9. Healthcare providers under contract:

a. Number of hospitals: _____

b. Number of physicians: _____

c. Other (please specify): _____

d. Does the applicant anticipate any changes in these numbers over the next year? □ Yes □ No

If Yes, please estimate the amount of the changes: _____

10. Does the applicant own all health plans being managed? □ Yes □ No

11. Does the applicant manage health plans for others under contract? □ Yes □ No

If Yes, how many? _____

12. Does the applicant have any investment or minority ownership in plans managed for others? □ Yes □ No

If Yes, please describe: _____

13. Does the applicant have any investment or minority ownership in plans managed by others? □ Yes □ No

If Yes, please describe: _____

14. Who is the stop-loss insurance carrier? _____

Per Claim attachment point and limit: _____ Aggregate attachment point and limit: _____

15. Are any claims handled by outside adjusters? □ Yes □ No

If Yes, what percentage and types of claims are handled outside? _____% Types of claims: _____

_____

Please attach a copy of any contract or agreement with outside adjuster services.

16. If the applicant is compensated through capitation, how is the price set? _____

_____

Who is the consulting actuary? _____

K. Related Services:

1. Please complete the table below. If not applicable, print "N/A."

	THIS POLICY YEAR (ESTIMATED)	PRIOR POLICY YEAR
Claims Administration: Years of experience: _____		
Revenue		
Number of Claims		
Number of Claims Handlers		
Management Services: Years of experience: _____		
Revenue		
Number of Contracts		

1. (Continued) Please complete the table below. If not applicable, print "N/A."

	THIS POLICY YEAR (ESTIMATED)	PRIOR POLICY YEAR
Computer Services: Years of experience: _____		
Revenue		
Number of Contracts		
Actuarial Services: Years of experience: _____		
Revenue		
Number of Contracts		
Insurance Services: Years of experience: _____		
Sales Revenue (including insurance, annuities and mutual funds)		
Consulting Revenue		
Number of Contracts		
Other Service Revenue (please describe): _____		

2. Does the applicant carry any other insurance which may apply to the above operations? □ Yes □ No

3. Does the applicant, or any partner, director, officer or employee of the applicant, act as a trustee for any client? □ Yes □ No

L. Sales and Marketing:

1. Describe how the applicant's products and services are marketed: _____

2. Are products and services sold exclusively by employees? □ Yes □ No
If No, please specify: _____

3. How many sales personnel are employed? _____
What are their duties? Please describe: _____

4. Are all sales representatives licensed (whether employed or not)? □ Yes □ No

5. Do all contracts, advertising, sales and marketing materials:

a. clearly specify what is and is not covered? □ Yes □ No

b. clearly define any restrictions on experimental or investigational care or treatment? □ Yes □ No

c. clearly define organ transplants and the extent of the plan's coverage for such procedures? □ Yes □ No

d. clearly state that the applicant has the discretion to interpret the provisions of the plan? □ Yes □ No

e. always refer to healthcare providers under contract as independent contractors? □ Yes □ No

6. Do any contracts, advertising, sales and marketing materials make any broad or generalized warranties or statements regarding the comprehensiveness or breadth of coverage, or the quality of quantity of care? □ Yes □ No
If Yes, please describe: _____

7. Are all contracts reviewed by the applicant's legal counsel before being used or distributed? □ Yes □ No

M. General Information:

1. Are appeal procedures for claims clearly explained to plan participants? □ Yes □ No

2. Is the person making the appeal decision identified to plan participants? □ Yes □ No

3. Is an expedited appeal process in place for claim situations where denial or delay of the requested health care may seriously affect the plan participant's quality of life (e.g. organ transplants)? □ Yes □ No

4. Does the applicant provide profit sharing arrangements or other financial inducements to the contracted healthcare providers, professionals or claims handling companies? □ Yes □ No
If Yes, will current procedures allow them to appeal any negative input regarding their individual cost, utilization or quality performance? □ Yes □ No

5. Does the applicant make sure its plans and its client's plans comply with ERISA? □ Yes □ No

6. Does the applicant suggest or require providers to follow pre-determined practice parameters or critical pathways? □ Yes □ No
If Yes, how were these parameters formulated? _____

7. To what extent does the applicant retain outside counsel to review contracts? _____

8. Is the applicant aware of any claims that have been made or incidents which may give rise to any claims that may be covered by this insurance? □ Yes □ No
If Yes, please provide details: _____

9. Who is the applicant's current managed care professional liability carrier? _____

Per Claim Limit: $_____ Aggregate Limit: $_____

Deductible or Retention: $_____ Expiring Policy Premium: $_____

ATTACHMENTS

A copy of the following information must be submitted with this Managed Care Supplemental Application:

A. Financial information. Last three (3) years of audited financial statements and annual reports including auditor's opinion.

B. Loss information. Current loss runs with updated values from insurance carriers covering the last ten (10) full years including indemnity payments or indemnity reserves of $50,000 or more including expenses. All claims must be first dollar/ground up, and if possible, sent electronically.

C. Copy of your current managed care liability insurance policy, with endorsements.

D. Organizational chart, including the names of all entities and a brief description of operations.

E. Agreements or contracts with healthcare providers or professions (a sample is sufficient if they are all the same).

F. Agreements or contracts with members enrolled in the applicant's health plan, or health plans being administered.

G. Contracts for management services, computer services, evaluation and payment of health care claims, actuarial services or insurance services to others.

APPLICANT NAME: _____

THE MEDICAL PROTECTIVE COMPANY

SELF-INSURED RETENTION (SIR) APPLICATION

A. Please indicate any applicable retention by checking the box(es) below:

□ Self-Insured Retention □ Captive

□ Trust □ Risk Retention Group (RRG)

B. What are the limits of liability for the SIR? $_____ Per Medical Incident / $_____ Annual Aggregate

C. Please indicate ALAE treatment within the SIR/Captive/RRG limit:

□ ALAE erodes the SIR limit

□ ALAE is paid by the retention but does not erode the retention limit

□ Other, please explain: _____

D. Please indicate the ALAE treatment in excess of the SIR/Captive/RRG limit:

□ ALAE is included inside the excess limit

□ ALAE is paid entirely by the SIR/Captive/RRG and the excess limit excludes ALAE payments

□ Other, please explain: _____

E. What coverages are contemplated? Specify the claims basis for each line of business: _____

_____

_____

F. Is there a dedicated trust? □ Yes □ No

G. Has an independent actuarial funding study been completed? □ Yes □ No

H. Who handles the claims within the SIR/Captive/RRG? _____

I. Is the applicant interested in utilizing The Medical Protective Company for handling claims within the retention? □ Yes □ No

J. What law firm is utilized for claims? _____

K. If a TPA is being utilized, please provide the contact information below:

_____
Third Party Administrator

_____
Mailing Address

_____ _____
Primary Contact Person Name Title

_____-_____-_____ _____-_____-_____ _____
Phone Fax E-mail

ATTACHMENTS

Please provide a copy of the following documents (if applicable):

1. Most recent **actuarial funding study**.
2. **Trust agreement** for the Self-insured Retention or policy form(s) for Captive or RRG.
3. **Claims handling policy and procedure manual**.
4. **Trust fund or Captive/RRG financials**.