

NORCAL Insurance Company

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

MEMBERS OF LARGE GROUPS

Important Notice: This application is for claims-made and reported coverage. Please read the entire policy carefully.
 The application is subject to review and acceptance by The Company and does not bind coverage. Additional information may be requested by the Company.

Agency Name:
Agency Location:
Producer Name:

REQUESTING ADDITION TO A CURRENT NORCAL POLICY

If accepted, coverage will be extended only while you are acting within the course and scope of your duties for the group and will be subject to the terms, conditions, and limitations of the policy. A copy of the policy will be made available to you upon request.

Name of Entity/Organization or Physician	Policy Number
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APPLICATION CHECKLIST

Please complete the entire application, sign, and date. Indicate not applicable (n/a) where appropriate. <ul style="list-style-type: none"> A copy of your current Curriculum Vitae (CV).
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SECTION I: ENTITY/ORGANIZATION INFORMATION

GENERAL INFORMATION

First Name	Middle Name	Last Name	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DDS <input type="checkbox"/> DPM
Date of Birth (mm/dd/yyyy)	DEA License #	FEIN License #	<input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identification (NPI) Number			

Authorized Office Representative	Title	Email	Website	
Primary Office Phone	Home Phone	Cell Phone	Fax	
Primary Office Address	City	State	Zip Code	<input type="checkbox"/> Preferred Mailing
Home Address	City	State	Zip Code	<input type="checkbox"/> Preferred Mailing
Billing Address	City	State	Zip Code	<input type="checkbox"/> Preferred Mailing
Other Address	City	State	Zip Code	<input type="checkbox"/> Preferred Mailing

MEDICAL LICENSURE

State	License #	Expiration Date	% of Practice	Status of License
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending

SECTION II: COVERAGE INFORMATION

COVERAGE DESIRED

Please provide a copy of your current Declarations page from your most recent Insurance Carrier, as well as copies of any extended reported endorsements (tails) that you may have purchased.

Claims-made WITHOUT prior acts coverage. Under this option, the retroactive date will be the same as the effective date of coverage. Coverage for claims arising from an act or omission that occurred prior to the effective date of this policy will not be provided.

Claims-made WITH prior acts coverage. Under this option, the retroactive date will be the same as the retroactive date on your current policy.

Requested Effective Date (mm/dd/yyyy)	Retroactive Date (mm/dd/yyyy)	Limit Amount	Limit Type <input type="checkbox"/> Shared <input type="checkbox"/> Separate	HOURS (per week)
Will you also carry insurance with another company?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain in the Remarks Section.	

SECTION III: SPECIALTY AND PRACTICE INFORMATION

SPECIALTY INFORMATION

1. Please describe your current medical specialty.

	Medical Specialty	% of Practice (must total 100%)	Board Certified?	Board Eligible?
Primary Specialty			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sub Specialty			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL PROCEDURES

2. Please choose the appropriate box, indicating the extent of surgery you perform:

- No surgery except incisions of boils, cysts, circumcisions (newborns), or other superficial abscesses or suturing minor lacerations
- Minor surgery includes most procedures performed under local anesthesia; assisting in major surgery on your own patients
- Major surgery includes major surgical procedures done under general, spinal, or caudal anesthesia; or assisting in major surgery on other than your own patients.

3. If you assist in surgery, please provide the number of procedures performed annually:

Assisting in major surgery on own patients: _____ # Per Year
 Assisting in major surgery on patients other than your own: _____ # Per Year

4. Please check the procedures, which you perform, for which you are requesting coverage. Please check any procedure that you have performed in the last 5 years:

- | | |
|---|--|
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Angioplasty |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Appendectomy |
| Trimester: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd | <input type="checkbox"/> Arthroscopy |
| <input type="checkbox"/> Elective % of Practice _____ | <input type="checkbox"/> Bariatric Surgery |
| <input type="checkbox"/> Therapeutic % of Practice _____ | <input type="checkbox"/> Gastric Bands # Per Year: _____ |
| <input type="checkbox"/> Acupuncture or Acupressure | <input type="checkbox"/> Bypass or Staples # Per Year: _____ |
| <input type="checkbox"/> Addiction Medicine | <input type="checkbox"/> Gastric Sleeve # Per Year: _____ |
| <input type="checkbox"/> Suboxone Therapy | <input type="checkbox"/> Other # Per Year: _____ |
| <input type="checkbox"/> Anesthesia (General/Spinal/Caudal) | <input type="checkbox"/> Botox # Per Year: _____ |
| <input type="checkbox"/> Angiography/Arteriography | <input type="checkbox"/> Bronchoscopy |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Prenatal Care |
| <input type="checkbox"/> Chelation Therapy | <input type="checkbox"/> Including 1 st Trimester Only |
| <input type="checkbox"/> Cryosurgery (non-external lesions) | <input type="checkbox"/> Including 1 st and 2 nd Trimesters |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Prenatal to term, no delivery |
| <input type="checkbox"/> Dermatology Procedures | <input type="checkbox"/> Prenatal to term, incl. delivery |
| <input type="checkbox"/> Chemabrasion/Dermabrasion | <input type="checkbox"/> Obstetrics <input type="checkbox"/> Performing <input type="checkbox"/> Assist Only |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> C-Sections # Per Year: _____ |
| <input type="checkbox"/> Deep <input type="checkbox"/> Superficial Only | <input type="checkbox"/> Vaginal Births # Per Year: _____ |
| <input type="checkbox"/> Hair Transplant | <input type="checkbox"/> VBACs # Per Year: _____ |
| <input type="checkbox"/> Liposuction/Lipoinjection | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Silicone Injections | <input type="checkbox"/> Including Spine |
| <input type="checkbox"/> Skin Flaps/Grafts | <input type="checkbox"/> No Spine |

- Endoscopic Procedures
 - Sigmoidoscopy Only
 - Other than Sigmoidoscopy
 - Laser Therapy
- Fertility/Infertility Treatment
- Fracture Reductions
 - Open
 - Closed
- General Surgery
- Hysterectomy
- Lithotripsy
- Laparoscopy
- Needle Biopsy
 - Type: _____
- Pain Management
 - Implants
 - Medication Only
 - Nerve Block (Spinal, Paraspinal)
Paravertebral, Epidural)
- Radiofrequency Procedures
 - Spinal Stimulators
- Permanent Pacemakers
- Plastics
 - Reconstructive % of Practice: _____
 - Cosmetic % of Practice: _____
- Prolotherapy
- Radiology
 - Interventional
 - Radiopaque Dye
- Renal Dialysis
- Sclerotherapy
- Spinal Surgery
- Thoracic Surgery % of Practice: _____
- Tonsillectomy/Adenoidectomy
- Transgender Surgery
- Trauma Surgery % of Practice: _____
- Tubal Ligations
- Vascular Surgery % of Practice: _____
- Vasectomies
- Wound Care
 - Hyperbaric Medicine
 - Surgical Debridement

Other Medical/Procedural techniques not listed above (please describe):

5. Do you perform or provide any of the following services as a part of your practice?
If so, please describe.

Type	Offered	% of Practice	Description
Experimental Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Independent Medical Exams	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Weight Control Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Telemedicine*	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*If you are practicing telemedicine, please complete and return the Telemedicine Supplemental Questionnaire.

SECTION IV: CLAIMS INFORMATION

1. Within the past 10 years, has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit?
 Yes No

If yes, complete the following and a claim/suit/incident supplemental form for each claim, suit, or incident and provide loss runs for the past 10 years, or since the date you began practicing medicine if you began with the past 10 years

Total Number of Claims and Suits:	# Open/Reserved:	# Closed:
Total Number of Incidents:	# Open/Reserved:	# Closed:

2. Have you made any changes to your practice as a result of any claims, suits, or incidents?

Yes No

If yes, please explain:

SECTION V: ADDITIONAL INFORMATION

For each question below that you answer "yes", please provide a complete explanation in the Remarks section.

1. Has your medical professional liability insurance ever been declined, non-renewed or cancelled including cancellation for nonpayment of premium? (Not applicable to Missouri applicants)
 Yes No
2. Has your medical professional liability insurance ever been surcharged, reduced, or issued with a deductible or other special terms?
 Yes No
3. Have you ever been charged or convicted of any crime other than minor traffic violations?
 Yes No
4. Have you ever had your medical license or DEA license revoked, limited, refused, suspended, or denied?
 Yes No
5. Have you ever failed to pass a Board Examination?
 Yes No
6. Have your hospital privileges ever been surrendered, limited, or revoked, whether voluntarily or involuntarily?
 Yes No
7. Have your hospital privileges been expanded or reduced in the last 12 months?
 Yes No
8. Has your membership in any Professional Association or Society ever been refused, revoked, or limited in any way?
 Yes No
9. Have you ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society?
 Yes No
10. During the past year, have you incurred or become aware of having an illness or physical disability that impairs, or could impair, your ability to practice your medical specialty?
 Yes No
11. Have you ever been treated for alcoholism, narcotic addiction, or mental impairment?
 Yes No

If yes, please provide the details of the rehabilitation program including dates of treatment.

12. Have you ever been accused of sexual misconduct?
 Yes No
13. Have you ever had any contact of a sexual nature with a patient or former patient?
 Yes No
14. Do you know of any individuals who works on your behalf that has a prior history or propensity for sexual misconduct?
 Yes No
15. Have you treated or will you treat celebrities or professional athletes?
 Yes No
16. Have you practiced or will you practice at a prison, correctional facility, or other similar facility, or have you provided or will you provide health care services to prisoners or inmates?
 Yes No
17. Do you enter into arbitration or similar agreements with your patients?
 Yes No
If yes, please attach a copy of the agreement(s).
18. Do you participate in clinical trials?
 Yes No
If yes, please complete of clinical trials questionnaire.
19. Do you use any non-FDA approved devices, drugs, or procedures?
 Yes No

REMARKS SECTION

Please provide any additional information/explanations for your application below.

AGREEMENTS AND NOTICES

I understand that, as a condition precedent to approval for coverage, NORCAL Insurance Company, any of its subsidiaries or affiliates, or anyone acting on its or their behalf (collectively, "NORCAL") may perform a detailed inquiry and/or investigation of any applicant's background, training, experience, and qualifications by any legal means and I consent to any such inquiry and/or investigation. In addition, I understand that third party information, records, or data regarding the applicant's practices, medical procedures, and/or prescribing practices may be used for informational or underwriting purposes. I authorize any individual or entity to which such inquiry and/or investigation is made to provide NORCAL or anyone acting on its behalf with all information within its possession or under its control that pertains to the applicant's background, training, experience, practices, procedures, and qualifications. I release and discharge any such individual or entity, including any such individual or entity's agents and representatives, from any and all liability that might arise out of any such inquiry and/or investigation.

I understand that all information provided by me or on my behalf as part of the application process is considered material and important and will be deemed attached to and made a part of the policy. I also understand that the policy could be void in its entirety or with respect to any Insured if any Insured: (1) attempts to defraud NORCAL or (2) intentionally conceals or misrepresents a material fact concerning such information or the risk insured. In addition, I understand that coverage for any claim; suit; or administrative, disciplinary, regulatory, or other type of proceeding may be unavailable if the circumstances for such claim; suit, or administrative, disciplinary, regulatory, or other type of proceeding were known before the effective date of coverage under any policy of insurance that may be issued by NORCAL. I understand that I must notify NORCAL immediately, in writing, of any changes in the information previously provided by me or on my behalf and that NORCAL may withdraw or modify any outstanding quotation(s) or authorization(s) or agreement(s) to bind insurance.

I understand that this application is subject to review and acceptance by NORCAL and does not bind coverage.

I represent and warrant that the foregoing statements contained in this application and any supplemental information are accurate, true, and complete. I also represent and warrant that I have not withheld any requested information.

I have read the fraud statement, and the state-specific notice(s), if any, applicable to the applicant on the attached State-Specific Notices Supplemental.

Applicant Signature	Date (mm/dd/yyyy)
Printed Name	Title

This application is not valid without your complete signature.