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NORCAL Insurance Company

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS, SURGEONS, DENTISTS, AND PODIATRISTS

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

APPLICATION CHECKLIST

Please complete the entire application, sign, and date. Indicate not applicable (n/a) where appropriate.

- Answer all questions fully and completely. Alternatively, you may attach a credentialing application or application for another insurer that you have completed within the past 90 days and complete this application beginning with Section VI, Claims Information.
- A copy of the Declarations page and endorsements from your most recent insurance policy. If an extended reporting endorsement (tail) has been purchased, please provide a copy as well.
- Loss runs for the past 10 years, or since the date you began practicing medicine if you began in the last 10 years.
- A copy of your letterhead.
- A copy of your current Curriculum Vitae (CV).
- If you are requesting coverage for a corporation, please include a completed Entity/Organization Application and the Articles of Incorporation.
- If you employ, independently contract with, or otherwise maintain an association with other health care providers (including physicians and/or health care extenders) and desire coverage for them, a separate application is required for each provider.

SECTION I: GENERAL INFORMATION

GENERAL INFORMATION

First Name	Middle Name	Last Name	☐ MD ☐ DO ☐ DMD ☐ DDS ☐ DPM
Date of Birth (mm/dd/yyyy)	DEA License #	FEIN License #	☐ Male ☐ 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	☐ Preferred Mailing
Home Address	City	State / Zip Code	☐ Preferred Mailing
Billing Address	City	State / Zip Code	☐ Preferred Mailing
Other Address	City	State / Zip Code	☐ Preferred Mailing

MEDICAL LICENSURE

State	License #	Expiration Date	% of Practice	Status of License
				☐ Active ☐ Inactive ☐ Pending
				☐ Active ☐ Inactive ☐ Pending
				☐ Active ☐ Inactive ☐ 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 of 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 ☐ Shared ☐ Separate	Hours (per week)

Will you also carry insurance with another company? ☐ Yes ☐ No If yes, please explain in the Remarks Section.

COVERAGE HISTORY

1. List below the professional liability insurance history of this Entity/Organization for the past 10 years, beginning with the most recent. Please include periods covered by a self-insurance program, governmental program, or no coverage. Use the Remarks Section if you need more space.

Coverage Period (mm/dd/yyyy)	Insurer	Coverage Type	Limit Amount	Premium	Tail Purchased
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No

2. Does the Entity/Organization provide services covered by another professional liability policy?
   ☐ Yes ☐ No
   If yes, please provide proof of coverage and details of those services.

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			☐ Yes ☐ No	☐ Yes ☐ No
Sub specialty			☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL PROCEDURES

2. Please 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

- ☐ Abdominoplasty
- ☐ Abortion
  - Trimester: ☐ 1st ☐ 2nd ☐ 3rd
  - ☐ Elective % of Practice _____
  - ☐ Therapeutic % of Practice _____
- ☐ Acupuncture or Acupressure
- ☐ Addiction Medicine
  - ☐ Suboxone Therapy
- ☐ Anesthesia (General/Spinal/Caudal)
- ☐ Angiography/Arteriography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Pain Management
  - ☐ Implants (incl. Intrathecal Pumps)
  - ☐ Medication Only
  - ☐ Nerve Block (Spinal, Paraspinal, Paravertebral, Epidural)
  - ☐ Nerve Block (Other)
- ☐ Radiofrequency Procedures
  - ☐ Spinal Stimulators
- ☐ Prenatal Care
  - ☐ Including 1st Trimester only
  - ☐ Including 1st and 2nd Trimesters
  - ☐ Prenatal to term, no delivery
  - ☐ Prenatal to term, incl. delivery

- ☐ Bariatric Surgery
  - ☐ Gastric Bands # Per Year: _____
  - ☐ Bypass or Staples # Per Year: _____
  - ☐ Gastric Sleeve # Per Year: _____
  - ☐ Other # Per Year: _____
- ☐ Botox # Per Year: _____
- ☐ Bronchoscopy
- ☐ Cardiac Catheterization
- ☐ Chelation Therapy
- ☐ Cryosurgery
- ☐ D&C
- ☐ Dermatology Procedures
  - ☐ Chemabrasion/Dermabrasion
  - ☐ Chemical Peels
    - ☐ Deep ☐ Superficial only
  - ☐ Hair Transplants
  - ☐ Liposuction/Lipoinjection
  - ☐ Silicone Injections
  - ☐ Skin Flaps/Grafts
- ☐ Endoscopic Procedures
  - ☐ Sigmoidoscopy only
  - ☐ Other than Sigmoidoscopy
  - ☐ Laster Therapy
- ☐ Fertility/Infertility Treatment
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ General Surgery
- ☐ Hysterectomy
- ☐ Lithotripsy
- ☐ Laparoscopy
- ☐ Needle Biopsy
  - Type: _____
- ☐ Obstetrics ☐ Performing ☐ Assist only
  - ☐ C-Sections # Per Year: _____
  - ☐ Vaginal Births # Per Year: _____
  - ☐ VBACs # Per Year: _____
- ☐ Orthopedics
  - ☐ Including Spine
  - ☐ No Spine
- ☐ Permanent Pacemakers
- ☐ Prolotherapy
- ☐ Radiology
  - ☐ Interventional
  - ☐ Radiopaque Dye
- ☐ Radiation/X-Ray Therapy
- ☐ 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	☐ Yes ☐ No		
Independent Medical exams	☐ Yes ☐ No		
Weight Control Medication	☐ Yes ☐ No		

Telemedicine*	☐ Yes ☐ No		

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

PRACTICE INFORMATION

6. Do you currently practice at any additional locations other than the primary office location listed in Section I: General Information?
   ☐ Yes ☐ No
   If yes, please describe:

Practice Name	Location (City, State, Zip)	Hours (per week)	Specialty (if different than above)	Start date (mm/dd/yyyy)

7. Have you changed medical specialties, hours, or location within the last 5 years?
   ☐ Yes ☐ No
   If yes, please explain:

Location (City, State, Zip)	Hours (per week)	Specialty (if different than the current)	Period (mm/dd/yyyy)	Tail purchased?
			From: To:	☐ Yes ☐ No
			From: To:	☐ Yes ☐ No
			From: To:	☐ Yes ☐ No

8. Do you currently have Hospital Privileges?
   ☐ Yes ☐ No
   If yes, please list all locations below.

Hospital	Location (City, State, Zip)	Type of Privileges	Current Restrictions? If yes, please comment*
		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No

		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No

*Comments:

9. Do you work as an emergency room physician, other than for maintaining hospital privileges?
   ☐ Yes ☐ No
   If yes, do you have separate coverage for this exposure?
   ☐ Yes ☐ No
   If yes, how many hours per month?: _____

10. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director, or attending physician at any of the following:
    ☐ Hospital ☐ Sanitarium ☐ Nursing Home ☐ Surgery Center
    ☐ Birthing Clinic ☐ Clinic ☐ Laboratory ☐ Blood Bank
    ☐ Prepaid Health Plan ☐ HIMO ☐ Other: _____
    If yes, do you have separate coverage for this exposure?
    ☐ Yes ☐ No
    Do you practice medicine at the above institution?
    ☐ Yes ☐ No

SECTION IV: EDUCATION AND TRAINING

1. Please describe your medical professional education and training.
   ☐ Check this box if you have attached a current Curriculum Vitae (CV) and continue with Section V, Entity/Organization Information

	School/facility	Location	Specialty	Start (mm/dd/yyyy)	Complete (mm/dd/yyyy)
Medical School					
Internship					
Residency					

Fellowship					
Other Training					

Please explain any gaps in training:

2. Are you a Foreign Medical School Graduate?
   ☐ Yes ☐ No
   If yes, please provide a copy of your USMLE.
3. Are you certified in:
   ☐ ACLS ☐ ATLS ☐ PALS ☐ Other: _____
4. Are you entering private practice for the first time following your residency, training, military services, or an academic position?
   ☐ Yes ☐ No

SECTION V: ENTITY/ORGANIZATION INFORMATION

ENTITY/ORGANIZATION STRUCTURE

1. Indicate which practice organization applies to you:
   ☐ Solo Unincorporated ☐ Partner or Partnership ☐ Corporate Shareholder
   ☐ Government Employee ☐ Solo Corporation ☐ Employee
   ☐ Other: _____
2. Name of Entity/Organization: _____
3. Do you wish for coverage for this Entity/Organization?
   ☐ Yes ☐ No
   Limit Type: ☐ Shared ☐ Separate
   If yes, a separate Entity/Organization application is required. Note: Separate limits are not available in all states.
4. Is there any other name under which you practice (i.e. DBA, unincorporated name, trade name)?
   ☐ Yes ☐ No
   If yes, please provide all names:

Name	Description

5. Do you currently employ, independently contract, or otherwise maintain an association with any other health care providers?
   ☐ Yes ☐ No
   If yes, please provide the number of each below. If coverage is desired, a separate application is required for each provider.

☐ Check this box if you have included a current roster in place of completing the table below.

	# Employed	# Contracted	# Supervise Only	Coverage Desired
Physicians and Surgeons				☐ Yes ☐ No
Dentists				☐ Yes ☐ No
Podiatrist				☐ Yes ☐ No
Fellows				☐ Yes ☐ No
Residents				☐ Yes ☐ No
Interns				☐ Yes ☐ No
CRNAs				☐ Yes ☐ No
Midwife				☐ Yes ☐ No
Nurse Practitioner				☐ Yes ☐ No
Optometrist				☐ Yes ☐ No
Perfusionist				☐ Yes ☐ No
Physician Assistants				☐ Yes ☐ No
Radiology Assistants				☐ Yes ☐ No
Surgical Assistants				☐ Yes ☐ No

6. Please provide the coverage information below for all health care providers you employ, contract or otherwise associate with, for which coverage is not desired or attach a copy of their current Declarations page of Certificate of Insurance.

Name	Specialty	Insurer	License #	Association	Start date
				☐ Employed ☐ Supervise ☐ Contracted ☐ Other:	
				☐ Employed ☐ Supervise ☐ Contracted ☐ Other:	
				☐ Employed ☐ Supervise ☐ Contracted ☐ Other:	

SECTION VI: 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 within 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 VII: 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 crimes 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 membership of 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
    If yes, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.
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 individual 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 our clinical trials questionnaire.
19. Do you use any non-FDA-approved devises, 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 NORCAL may deny coverage for a claim or other event for any Insured who attempts to defraud NORCAL or who intentionally conceals or misrepresents a material fact concerning: (1) information submitted in or as part of an application or questionnaire; (2) the risk insured; or (3) an insured's rights to coverage under the policy including, but not limited to, the report of a claim. A misrepresentation, an omission, a concealment of facts, or an incorrect statement will not prevent recovery under the policy unless: (1) it is fraudulent; (2) it is material either to the acceptance of the risk, or to the hazard assumed by NORCAL; and (3) NORCAL in good faith would either not have issued the policy or provided coverage, or would not have issued the policy or provided coverage in as large an amount, or would not have provided coverage with respect to the hazard resulting in the claim or other event, if the true facts had been made known to NORCAL as required either by the application for the policy or coverage or otherwise. 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 that the foregoing statements contained in this application and any supplemental information are accurate, true, and complete. I also represent 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.

CLAIM | SUIT | INCIDENT SUPPLEMENTAL FORM

Attach a detailed narrative, which includes at least the information requested below, or complete this form, for each claim, suit, or incident within the past 10 years. Provide adequate detail to allow proper evaluation. Additional information may be requested.

Patient Name	Age	☐ Male ☐ Female
Date of Incident (mm/dd/yyyy)	Location of Incident	
Name of insurer	Date reported to Insurer (mm/dd/yyyy)	

Type: ☐ Suit ☐ Demand for Money ☐ Incident Only ☐ Notice of Intent to Sue
☐ Request for Records ☐ Other: _____

1. Summary of condition/diagnosis at time if incident:

2. Description of treatment rendered, including dates:

3. Allegations:

4. Other persons and entities involved:

5. Status/Disposition:
   ☐ Open Describe current status and defense strategy
   ☐ Closed without indemnity payment ☐ Settled ☐ Judgement/Verdict for defense
   ☐ Judgement/Verdict for defense If closed, date closed (mm/dd/yyyy): _____
   Amount reserved for you: _____ Indemnity: $_____ Defense: $_____
   Amount reserved for other defendants : _____ Indemnity: $_____ Defense: $_____
   Amount reserved on your behalf: _____ Indemnity: $_____ Defense: $_____
   Amount paid on behalf of other defendants : _____ Indemnity: $_____ Defense: $_____

6. Has there been a change in practice as a result of this claim, suit, or incident? ☐ Yes ☐ No
   If yes, please explain:

I understand this information is part of my Application.

Signature Printed Name Date (mm/dd/yyyy)