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Glastonbury, CT 06033
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Group Medical Liability Professional Application

This application will be incorporated into the policy if coverage is bound. All questions must be answered accurately and completely. Please call your insurance representative if you have any questions.

Instructions:

1. PLEASE PRINT OR TYPE TEXT DIRECTLY INTO THE APPLICATION (PDF Format).
2. ANSWER ALL QUESTIONS LEAVING NO BLANKS.
3. IF ANY QUESTIONS, OR PART THEREOF, DO NOT APPLY, STATE N/A IN THE SPACE.
4. THIS APPLICATION MUST BE COMPLETED, DATED AND SIGNED BY AN OFFICER OR PRINCIPAL OF THE MEDICAL GROUP.
5. IF NECESSARY, CHECK ALL BOXES THAT APPLY.

Please attach the following:

Copy of loss runs for the last 10 years (or back to retro date whichever is longer), dated within ninety days, loss experience including paid and reserved losses. Provide complete details (occurrence date, claims made date, description of occurrence and all codefendants) for any loss paid or reserved. Do not indicate patient identifiers or any personal, identifiable health information.

If available, prior two years of audited financial statements, including balance sheets and income statements; copy of interim report if audited statement is over six months. *This is required for groups with 15 or more physicians*.

Completed Physician Addendum (see page 8) and Allied/Ancillary Healthcare Provider Addendum (see page 10) or in the event that there is insufficient space attach a roster.

Copies of certificates of insurance for all employed Physicians and Allied/Ancillary Healthcare Providers for whom coverage is not being requested.

☐Copy of the incorporation papers and all business letterhead(s) for the practice.

☐Copies of curriculum vitaes for each physician to be covered under this policy.

I. GENERAL INFORMATION

Name of Medical Group: _____

Address: _____ Date of Group Establishment: _____

_____ Website: _____

City: _____ State: _____ Zip Code: _____

Practice Administrator

Name/Title: _____ Telephone #: _____

Email: _____ Fax #: _____

II. COVERAGE INFORMATION

1. Policy Effective Date: _____ Policy Expiration Date: _____

2. Claims Made with Prior Acts? ☐ Yes or ☐ No If **Yes**, Requested Retroactive Date: _____

Date first continuously insured under a claims made policy. Please attach verification of current retroactive date(s); (i.e., **copy of current policy** or **declarations page**).

3. **Select Requested Limits of Liability:** Each medical incident or event/annual aggregate for all medical incidents and events.

☐ **Connecticut Limits**

☐ $1,000,000 / $4,000,000 ☐ $2,000,000 / $5,000,000 ☐ Other*: _____

☐ **Massachusetts Limits**

☐ $1,000,000 / $2,000,000 ☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $6,000,000

☐ Other Limits*: _____

**Other limits subject to Underwriting review and approval*

4. **Coverage Form**: ☐ Claims Made ☐ Occurrence

5. **Loss Prevention/Risk Management:**

a. Who, within the organization, is responsible for claims related activities?

Name: _____ Title: _____ Phone #: _____

Do you have written loss prevention/risk management procedures? ☐ Yes or ☐ No If yes, please attach.

6. Current Insurance:	Current Year	First Prior Year	Second Prior Year	Third Prior Year
Insurance Company				
Policy Number				
Limits of Liability				
Deductible or SIR Amount				
Coverage Form (Occurrence/Claims Made)				
Retroactive Date				
Policy Period				
Premium				

III. UNDERWRITING INFORMATION

1. **Group Practice Information**

a. Please select type of ownership:

☐ Business Corporation ☐ Partnership ☐ Professional Corporation/Association

☐ Limited Liability Company ☐ Sole Proprietorship ☐ Not-for-Profit Corporation/Foundation

☐ Other: _____

b. Please describe the majority ownership of your practice: _____

(i.e., physicians, physicians' practice management company, hospital, university or medical school, other)

c. Does the medical group own (wholly or in part), operate, or manage any business not engaged in rendering health care services? ☐Yes ☐No

If yes, please provide name(s) of entity/entities and description of business:

_____

_____

i. If yes, have any of these entities operated under other names? ☐ Yes ☐ No

If yes, please provide name(s) of entity/entities:

_____

_____

d. Within the next 12 month period, does the medical group plan to:
(Please explain all "Yes" answers on the attached Remarks Addendum (page 11).

i. Acquire another medical group/entity? ☐ Yes ☐ No

ii. Add to or decrease the number of physicians? ☐ Yes ☐ No

iii. Expand or reduce the number of locations? ☐ Yes ☐ No

e. Number of projected (next 12 months) full time equivalent (FTE) physicians:

FTE's_____ Contracted MD's: _____ Employed MD's: _____

Physicians Historical # of FTEs	Current Year	First Prior Year	Second Prior Year	Third Prior Year

Please complete Physician Addendum (page 9).

f. Number of projected (next 12 months) full time equivalent (FTE) allied/ancillary health and mid-level providers:

FTE's_____ Allied/Ancillary Health Employees: _____ Allied/Ancillary Health Contractors _____

Allied/Ancillary Health and Mid-level Providers Historical # of FTEs	Current Year	First Prior Year	Second Prior Year	Third Prior Year

Please complete Allied/Ancillary Healthcare Provider Addendum (page 10).

g. Please explain all "Yes" answers on the attached Remarks Addendum (page 11).

Has the medical group, any of its member practitioners, or any employees:

i. Ever been the subject of an investigation or disciplinary proceeding by a governmental, administrative, licensing agency or body, hospital or professional association? ☐Yes ☐No

ii. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No

iii. Ever been treated for alcoholism or other chemical dependency? ☐Yes ☐No

iv. Ever had any state professional license or license to prescribe or dispense narcotics refused, reduced, suspended, revoked, non-renewed or accepted only on special terms or ever voluntarily surrendered? ☐Yes ☐No

v. Ever had privileges reduced, suspended or revoked? ☐Yes ☐No

vi. Ever been denied a license or certification to practice? ☐Yes ☐No

vii. Ever had Medicare or Medicaid authorities initiate an investigation for alleged billing fraud and abuse? ☐Yes ☐No

viii. Have you ever been investigated by a state health department, state licensing board or other governmental body? ☐Yes ☐No

h. Is your organization accredited by a national organization? If yes, which accrediting body? (check all that apply) ☐Yes ☐No

☐American Association of Accredited Ambulatory Surgery Facilities (AAAASF)

☐Accrediting Association for Ambulatory Surgery Facilities (AAAHC)

☐Joint Commission (JAHCO)

☐National Committee for Quality Assurance (NCQA)

☐Other: _____

i. Does the medical group advertise? ☐ Yes ☐ No Please enclose copies of any printed advertising materials used to promote practice.

2. <u>Radiology:</u>

a. Does the medical group operate a radiology center? ☐ Yes ☐ No

If yes, please indicate number of services and annual procedures:

☐ Diagnostic services _____ Current annual reads/studies _____ Next 12 month projection

☐ Therapeutic services _____ Annual procedures _____ Next 12 month projection

3. Surgi-Center:

a. Does the medical group operate a surgi-center? ☐ Yes ☐ No

If yes, please indicate number of surgeries for:

_____ The past 12 month period _____ Next 12 month projection

b. Does the medical group maintain any beds for overnight occupancy? ☐ Yes ☐ No

c. What is the distance to the nearest hospital? _____

d. What equipment is available in the event of an emergency? _____

4. Pharmacy:

a. Does the medical group operate a pharmacy? ☐Yes ☐No

b. Is the pharmacy for patient use only? ☐Yes ☐No

c. Does the medical group contract with a pharmacy? ☐Yes ☐No

d. If a contract group, does the group furnish mutual hold harmless agreements? ☐Yes ☐No

5. Laboratory:

a. Does the medical group operate a clinical laboratory? ☐Yes ☐No

b. Does the laboratory perform tests for other than own patients? ☐Yes ☐No

c. Projected number of tests for the next 12 months: _____

6. Bariatric Surgeons:

a. Number of bariatric procedures projected in the next 12 months? _____

	First Prior Year	Second Prior Year	Third Prior Year
Number of Bariatrics Procedures			

b. Does the bariatric program provide the following?

i. Pulmonary, cardiac, nutritional and psychological consultants ☐Yes ☐No

ii. Office support for preoperative and postoperative counseling: ☐Yes ☐No

iii. Support groups: ☐Yes ☐No

iv. Monitor and manage short-term and long-term complications ☐Yes ☐No

v. Is the program certified ☐Yes ☐No

If yes, by whom: _____

7. Managed Care:

a. Please provide names of all Managed Care Organizations (MCO) the medical group contracts with:

_____

_____

b. Is the medical group responsible for services such as peer review, quality assurance, utilization review, and credentialing, and/or health care management on behalf of the MCO? ☐Yes ☐No

i. If yes, do these MCO provide errors and omissions coverage for these activities? ☐Yes ☐No

c. Does your medical group operate or own any health plans? ☐Yes ☐No

i. If yes, is coverage desired for health plan? ☐Yes ☐No

ii. If yes, please indicate number of lives: _____

8. Clinical Trials:

a. Is the medical group involved in clinical trials? ☐ Yes ☐ No

i. If yes, do these clinical trials include your own patients or patients outside practice? _____

ii. If yes, please provide a copy of the clinical trials agreement/contract with trial sponsor.

IV. CLAIMS HISTORY

1. Please provide hard copy carrier loss runs or, when available, in electronic format:

   a. Ten years of historical professional liability losses including current year.

   b. Date of loss valuation must be within past ninety days.

V. CLAIMS INFORMATION

*Please note that the use of **claim** or **suit** in this application is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation*

2.	Are you or have you been involved in a malpractice claim or suit, either directly or indirectly? If yes, please indicate total number of claims and suits: _____ Open _____ Closed A Claim Addendum may be requested for open claims or suits.	☐Yes		☐No
3.	Have all claims and suits been reported to your current or prior professional liability carrier?	☐Yes	☐No	☐N/A
4.	Are you aware of any of the following circumstances regarding medical care you provided:			
	A. A letter or request for records from a patient or a patient's attorney or representative related to an adverse outcome from care you provided to a patient?	☐Yes		☐No
	B. A statement by or letter from a patient or patient's representative expressing dissatisfaction or questioning the quality or timeliness of any care you provided to a patient?	☐Yes		☐No
	C. A statement by or letter from a patient or patient's representative claiming a failure to provide care on your part or failure to diagnose?	☐Yes		☐No
	D. Intra- or post-procedural complications or other treatment complications resulting in death, paralysis, loss of body part or bodily function, disability, re-operation or extended hospitalization or other morbidity?	☐Yes		☐No
	E. Any death (expected or otherwise), neurological, sensory, or systematic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing, loss of limb, or other morbidity from care you provided whether or not you believe that medical standards of care were met?	☐Yes		☐No
	F. Any permanent damage related to an injury during delivery of child or administration of anesthesia?	☐Yes		☐No
	G. Has a patient, patient's representative or representative filed any compliant or grievance to any healthcare institution, institution at which you practice and/or managed care organization of which you are a member, regarding care you provided to a patient?	☐Yes		☐No
	H. Has a patient, patient's representative or any healthcare institution filed any governmental report (including Department of Public Health, and other state or federal agency) or grievance regarding care you provided to a patient?	☐Yes		☐No
	I. Has your care ever been the subject of a peer review, sentinel event report or other investigation by any healthcare institution?	☐Yes		☐No
	J. Are you aware of any expression of dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you whether from a patient or a patient's family or representative?	☐Yes		☐No
5.	Have all circumstances that might reasonably lead to a medical incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐Yes	☐No ☐ None to Report	

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANTS' ACCEPTANCE OF THE INTEGRIS INSURANCE COMPANY (THE "COMPANY") QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

VI. WARRANTY: PRIOR KNOWLEDGE OF FACTS/ CIRCUMSTANCES/SITUATIONS

For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Virginia, Washington, and West Virginia residents ONLY: the title of this section and any other reference to "WARRANTY" is deleted and replaced with "Applicant Representation."

No person or entity proposed for coverage is aware of any fact, circumstance or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage: NONE, or except

_____

Without prejudice to any other rights and remedies of the Company, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed in response to this section, any claim or action based on, arising from, or in consequence of such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Company.

VII. DISCLOSURE AUTHORIZATION

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes thereto between the Company and any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance for the purpose of confirming my coverage (including their employees, officers, agents, directors and other representatives). This authorization does not create any obligation for the Company to release or exchange such information.

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made by me herein (and their employees, officers, agents, directors and other representatives) to release such information to the Company and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues.

I AUTHORIZE the Company and such representatives to use a copy of this authorization in place of the original. This authorization shall be valid for one year from the date signed. I understand that upon request, I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization.

VIII. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

Notice to Alabama and Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a and may be subject to fines and confinement in prison.

Notice to Arkansas, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana and Rhode Island Applicants: 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.

Notice to Maine, Tennessee, Virginia and Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please read the following carefully, and initial below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. I AGREE to notify the Integris Insurance Company (the "Company") promptly of any material changes in the information I have provided herein. I UNDERSTAND that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

_____
Initials

Signature of Applicant:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Note: Group Applicants must be signed by officer or principal of the medical group

Signature of Broker or Authorized Representative:

Print Name: _____ License #: _____ Date: _____

Signature: _____ Company: _____

ASSIGNMENT OF POLICY RIGHTS

Is the medical group practice authorized to cancel policies or change coverage terms for physicians and allied health care providers for whom coverage is to be provided under this policy? ☐Yes ☐No

PHYSICIANS ADDENDUM

If available, it is preferable that the information being requested on this form be provided in an electronic format.

Include only those contracted or employed providers for whom coverage is to be provided under this policy.

Name of Physician (Last, First, Title)	Gender	D.O.B.	NPI#	If Currently Board Certified, Most Recent Certified Date	Medical License #	Medical Specialty	Employed/Shareholder/ Partner/Office of Corporation	Avg. No. Hrs/Wk	Retroactive Date

DEPARTMENT PHYSICIANS ADDENDUM

List the physicians who have previously practiced with the entity and have left within the past 5 years. Also, indicate whether that individual currently has a claim or incident pending.

Name	Specialty	Practiced with Entity		Tail Coverage Secured		Claim or Incident
		From Month/Day/Year	To Month/Day/Year	Individual	Entity	
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
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				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

ALLIED/ANCILLARY HEALTHCARE AND MID-LEVEL PROVIDER ADDENDUM
If available, it is preferable that the information being requested on this form be provided in an electronic format.

*ALLIED/ANCILLARY HEALTHCARE PROVIDERS AND MID-LEVEL PROVIDERS are defined as: chiropractor; heart/lung perfusionist; nurse anesthetist; nurse midwife (no delivery); nurse midwife (with delivery); nurse practitioner; optometrist; physician assistant; physiotherapist; psychologist; radiological technician who provides radiation therapy; surgeon assistant.

Include only those contracted or employed providers for whom coverage is to be provided under this policy.

Names of Allied/Ancillary Healthcare Providers (Last, First)	Gender	D.O.B.	NPI #	Medical License #	*Classification	Contracted or Employed	Retroactive Date Desired

Remarks Addendum

Please use this addendum for any additional remarks or explanations associated with the application. Indicate the question number to which you are referring in the space provided.

Question	Remark / Explanation:
_____	
_____	
_____	
_____	
_____	