EASTERN SPECIAL RISK
INSURANCE AGENCY
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CA License #0619313
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Broker _____ Date _____
Address _____ Surplus lines licensee? ☐Yes ☐No If yes,
_____ indicate State, License No. and Expiration
Phone _____ _____
Fax _____

Application for a Premium Quotation (without obligation)

PHYSICIAN'S SUPPLEMENTAL MALPRACTICE APPLICATION

*This is an application for **claims-made** coverage*

Use this Application for each Physician who needs to become an Insured under the Clinic Professional Liability Coverage Part The coverage being applied for is by endorsement to a Clinic entity only. No notification of coverage, limitations, restrictions or cancellation will be provided to the applicant physician. Contact the Insured Clinic entity for coverage status. Duplicate this form as needed.

1. Facility (Clinic/Lab) _____
2. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
3. Physician Applicant _____

   Physician's Mailing Address: _____ City: _____ State: _____ Zip Code: _____

   Date of Birth _____ / _____ / _____ SSN _____
4. Proposed date for coverage to be effective _____ / _____ / _____
5. Relationship of Physician to "Facility" ☐ Employee ☐ Independent Contractor ☐ Other (describe) _____

   _____

   Is there a written contract between the Physician and the "Facility"? ☐ Yes ☐ No If yes, attach a copy of the contract to this application.
6. Medical School attended _____ Degree _____ Year _____
7. If you are a graduate of a foreign Medical School, are you certified by the Educational Council for Foreign Medical Graduates? ☐ Yes ☐ No If yes, what year were you certified? _____
8. Please indicate your medical specialty:

_____ Administrative	_____ Gastroenterology	_____ Neoplastic Diseases	_____ Pediatrics
_____ Allergy	_____ General Practice	_____ Nephrology	_____ Pharmacology-clinical
_____ Anesthesiology	_____ General Preventive	_____ Neurology	_____ Physical Med. & Rehabilitation
_____ Broncho-esopha	_____ Geriatrics	_____ Nuclear Medicine	_____ Psychiatry
_____ Cardiovascular	_____ Gynecology	_____ Nutrition	_____ Psychoanalysis
_____ Dermatology	_____ Hematology (office practice only)	_____ Obstetrics	_____ Psychosomatic Medicine
_____ Diabetes	_____ Infectious Diseases	_____ OB-GYN	_____ Public Health
_____ Emergency	_____ Intensive Care (your patients only)	_____ Occupational Medicine	_____ Pulmonary Diseases
_____ Endocrinology	_____ Intensive Care (incl. patients of others)	_____ Ophthalmology	_____ Radiology
_____ Family Practice (excl. all OB)	_____ Internal Medicine	_____ Orthopedics	_____ Rheumatology
_____ Family Practice (Incl. prenatal care only)	_____ Laryngology	_____ Otology	_____ Rhinology
_____ Forensic	_____ Legal Medicine	_____ Pathology	_____ Urology (office practice only)

_____ Other (describe) _____
_____

Breakdown of surgical activities:

_____ Abdominal	_____ Plastic Otorhinolaryngology	_____ OB-GYN	_____ Hand
_____ General	_____ Vascular	_____ Otorhinolaryngology	_____ Orthopedic (incl. spinal surgery)
_____ Laparoscopic Surgery	_____ Cardiac	_____ Traumatic	_____ Plastic
_____ Orthopedic (no spinal surgery)	_____ Gynecology	_____ Colon Rectal	_____ Urological

9. What services will you perform on behalf of the "Facility"? _____

Will you provide deliveries on behalf of the "Facility"? ☐ Yes ☐ No If yes, provide details _____

Will you perform surgery on behalf of the "Facility"? ☐ Yes ☐ No If yes, provide details _____

10. Will the work be performed by you as an individual, or in any other capacity, such as a partner or member of another entity? (Explain) _____

11.. Will any other persons which you are legally liable for perform or assist in the work to be performed? ☐ Yes ☐ No If yes, provide a list of each person, their relationship to you and their medical qualifications.

12. How many hours per week will you be providing services for the "Facility"? _____

13. Do you currently have an in force Professional Liability contract? ☐ Yes ☐ No If yes, with what Insurer? _____

Limits_____/_____ Expiration Date _____/ _____ / _____ Will this coverage be maintained while you are providing services for the "Facility"? ☐ Yes ☐ No If not, are you aware that the coverage being applied for will be shared with the "Facility" under the same aggregate and that your addition onto this policy will not increase the liability limit in any instance? ☐ Yes ☐ No (Note: The "Facility" will retain all control of the policy as respects changes or termination.)

14. Has any Insurance Carrier ever cancelled or refused to renew your Professional Liability Insurance? ☐ Yes ☐ No If yes, attach a letter of explanation.

15. Has any hospital or similar institution ever revoked or suspended your medical privileges? ☐ Yes ☐ No If yes, attach a letter of explanation.

15. Has your narcotics license ever been suspended, revoked, or voluntarily surrendered? ☐ Yes ☐ No If yes, attach a letter of explanation.

16. Have you ever been denied a medical license or denied certification by a specialty board? ☐ Yes ☐ No If yes, attach a letter of explanation.

17. Have you had any Malpractice claims made against you in the last 5 years? ☐ Yes ☐ No If yes, were you self-insured with respect to any loss? ☐ Yes ☐ No If the answer to claims is yes, please provide a letter of explanation of all losses, including the plaintiff's name, state and court docket number, amount paid, if any, in judgment or settlement, amounts paid in defense cost and sufficient facts to inform the underwriter of the nature of the claim.

18. Does the Applicant have knowledge of, or reason to foresee, any circumstance which occurred prior to this date of this application which might result in a claim or suit being brought? ☐ Yes ☐ No If yes, provide full details_____

Applicant agrees to report any claim or incident of which he/she receives knowledge **after** the signing of this application as a condition precedent to effecting coverage.

Warranty: The undersigned applicant declares that to the best of his or her knowledge the information contained in this application is true and correct and that this application shall be deemed a part of the policy as if annexed thereto.

_____

Signed Title Date

Must be signed by the applicant. Completion of this form does not bind coverage or obligate the applicant; however, should the quotation be acceptable, the information given above will be the basis of the contract. Application must be currently signed (within 45 days) and dated to consider for quotation. The policy being applied for is limited to only those claims that are first made against the insured while the policy is in force and which occur after the inception of the contract, unless Prior Acts coverage is included.

In Arkansas, Colorado, Florida, Hawaii, Kentucky, Maine, Minnesota, New Jersey, New Mexico, New York, Ohio Oklahoma, Pennsylvania and Virginia, notice concerning false or fraudulent statements must be attached.

NOTICE REQUIRED BY CERTAIN STATES

NOTICE TO ARKANSAS APPLICATIONS: "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 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 POLICYHOLDER 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 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 IN THE THIRD DEGREE."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

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 MAINE AND VIRGINIA 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 MINNESOTA APPLICANTS: "A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

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 NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES."

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, 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."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCLOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION SHALL UPON CONVICTION BE SUBJECTG TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE OF UP TO $15,000."

Signature: _____