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Centurion

"Guarding the Art of Medicine"

MEDICAL PROFESSIONAL LIABILITY INSURANCE

NAME:

SPECIALTY:

STATE:

EFFECTIVE DATE:

RETROACTIVE DATE:

POLICY LIMIT DESIRED:

- ☐ $100,000 / $300,000
- ☐ $200,000 / $600,000
- ☐ $250,000 / $750,000 (Florida Only)
- ☐ $1,000,000 / $3,000,000 (Arizona & Georgia Only)

Copies of the following are **REQUIRED** when your application is submitted:

__ Current CV/Resume
__ Loss/Claims History for past 10 years
__ Copy of Current Declarations Page
__ Copy of Current Medical and DEA License

Applications will not be processed until all information is received. All questions must be answered, if not applicable, use NA. Coverage is not in effect until application is approved and physician is approved by Centurion Medical Liability Protective. The Risk Retention Group reserves the right to deny coverage.

Questions?
1-800-774-5087

Return Application to: Centurion Medical Liability Protective
518 Peoples Street, Corpus Christi, TX 78401
info@cmlpins.com - fax 361-726-4400

AGENT: Lisa M Rudolph

PHONE: 480-269-7741

LICENSE #:

Centurion Medical Liability Protective
PHYSICIANS AND SURGEONS APPLICATION

FOR

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

A claims-made policy covers claims or suits first made against you during the policy period arising out of the performance of professional services rendered on or after the effective or retroactive date shown on the policy.

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

1. Name of applicant (First, Middle, Last, Title):

2. Applicant's date of birth:

3. Applicant's Social Security Number:

4. Applicant's business address (Street, City, State, Zip Code and County):

5. Applicant's home address (Street, City, State, Zip Code and County):

6. Applicant's business phone, Fax, E-mail and website:

7. Applicant's home and cell phone numbers:

8. Current Carrier (attach copy of most recent policy):

9. Have you purchased or do you plan to purchase a "tail" endorsement from your current carrier?

◯ Yes or ◯ No: If yes, please attach a copy of the endorsement.

10. Type of practice (solo practitioner, group, multi-specialty clinic, intern, resident, etc.):

11. List each professional corporation, professional association and partnership and other health care related services in which you have an ownership interest (name and description of your interest and percentage of your ownership. If none, please explain):

12. If you are employed, indicate the name of your employer:

13. If you are an independent contractor, name each entity with which you have contracted healthcare services:

14. If you as an individual contractor, employ or contract with any of the following health care professionals, please indicate the number of the following employed/contracted professionals and identify their current insurer:

Physician & Surgeon Assistants

Nurse Anesthetists

Nurse Midwives

Nurse Practitioners

Perfusionists

Podiatrists

Dentists

15. If you, as an individual, employ or contract other medical professionals to provide services, indicate their professional occupations (i.e., RN, LPN, etc.) and the number for each occupation:

16. Do you practice less than 20 Hours per Week? ◯ Yes or ◯ No

17. What is your medical specialty? :

18. Are you certified by an approved specialty board(s)?:

19. If yes, list certifying board name(s), date(s) of initial certification and date(s) of recertification:

20. If no, are you board eligible? ◯ Yes or ◯ No

If yes, date eligibility expires:

21. Indicate the percentage of time devoted to any other medical/surgical activities other than as indicated in your specialty indicated above:

22. Do you perform obstetrical procedures? ◯ Yes or ◯ No

If yes, state the average number of c-sections performed by you annually:

Number of VBAC deliveries performed by you annually:

23. Please check the following medical procedures you perform:

- ☐ Autologous Fat Injection
- ☐ Angiography
- ☐ Arteriography
- ☐ Botox Injections
- ☐ Catheterization - arterial, cardiac or diagnostic
- ☐ Chelation therapy
- ☐ Closed fracture reduction - other than fingers or toes
- ☐ Colonoscopy
- ☐ Cryosurgery - other than use on benign or premalingnant dermatological lesions
- ☐ Conscious sedation
- ☐ D&C performed under local anesthesia
- ☐ Discograms
- ☐ ECT (describe on separate sheet)
- ☐ Epidurals
- ☐ ERCP (Endoscopic retrograde cholangiopancreatography
- ☐ Lasers (describe on separate page
- ☐ Laparoscopy
- ☐ Lymphangiography
- ☐ Liposuction
- ☐ Pneumoencephalography
- ☐ Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- ☐ Needle biopsy (describe on separate sheet)
- ☐ Myelography
- ☐ Radiation Therapy
- ☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae
- ☐ Vasectomies
- ☐ Other procedure by which the body of body cavity is penetrated by use of a tube, needle, device or ionizing radiation (describe on separate sheet)

24. Medical School(s) attended:

25. Date of graduation:

26. City, State:

27. Degree:

28. If you are a foreign medical school graduate, have you obtained an ECFMG certificate?

Yes or No

Indicate which certification you obtained and the year certified:

ECFMG Fifth Pathway Yes or No Year Certified:

29. Internship from (MO/YR) to (MO/YR)
Indicate the facility name and location where your internship was served:

30. Residency from (MO/YR) to (MO/YR)
Indicate the facility name and location where your residency was served:

Specialty:

31. Did you complete your residency?: Yes or No

32. Additional medical training?: Yes or No
If Yes, indicate type (i.e. Fellowship):
Indicate the facility name and location where your fellowship was served.

From (MO/YR) to (MO/YR)

33. Name all the places where you practiced your profession during the last five years and the time period you spent at each location:

34. List each state where you are licensed to practice, your corresponding license number and the percentage of patients seen in each state:

State License Numbers:

% of patients seen, examined or treated in each state

35. Has there been any change in your practice or specialty during the past five years?

◯ Yes or ◯ No: If yes, describe:

36. Do you staff an emergency room for purposes other than to maintain hospital privileges?

◯ Yes or ◯ No: If yes, include hospital name, location, number of hours per month, relationship, etc., in your explanation.

37. Do you practice in or staff an urgent-care center or similar minor emergency clinic?

◯ Yes or ◯ No: If yes, please describe:

38. Do you perform surgery or obstetrical procedures at a location other than a licensed hospital?

◯ Yes or ◯ No: If yes, include location and distance (travel time) to the nearest hospital in your explanation:

39. Are you employed full time by the Federal Government or are you in the military service?

◯ Yes or ◯ No: If yes, please describe:

40. Are you engaged in any "moonlighting" activities? ◯ Yes or ◯ No:
If yes, describe and indicate the number of hours per month spent moonlighting and location:

41. Do you own an interest in or operate a hospital, sanitarium, or clinic with regular bed and board facilities? ◯ Yes or ◯ No: If yes, please describe:

42. Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? ◯ Yes or ◯ No: If yes, please describe:

43. Do you render patients unconscious for treatment in your office, or other non-hospital facility?

◯ Yes or ◯ No

44. Do you provide professional services on behalf of any college, university, semi-professional, or professional sporting team? ◯ Yes or ◯ No:
If yes, include name of team, percentage of practice and relationship in your explanation:

45. Do you perform surgery on professional athletes?

46. Are you employed or contracted by any facility as a medical director or similar role?
◯ Yes or ◯ No: If yes, include name of facility in your explanation:

47. Do you perform utilization review services for a fee for others? ◯ Yes or ◯ No

48. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges or has probation been invoked?
◯ Yes or ◯ No: If yes, please describe:

49. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked?
◯ Yes or ◯ No: If yes, please describe:

50. Are you aware of any complaint or investigation or disciplinary action with any state licensing board (Medical Board), the Drug Enforcement Agency (DEA), the Federal Drug Administration (FDA), or any other governmental entity?
◯ Yes or ◯ No: If yes, please describe:

51. Has any hospital, medical association, medical society or medical board, HMO, licensing authority or peer review organization notified you of its intention to consider imposing any such change of status, penalties, privileges, participation, certification or membership?
◯ Yes or ◯ No: If yes, please describe:

52. Have you ever been denied a medical license or been denied certification by a specialty board?

Yes or No: If yes, please describe:

53. Have you ever been treated for alcoholism, narcotics addiction or mental illness?

Yes or No: If yes, please describe and attach a letter outlining dates of treatment, results of treatment and current status. This letter should be from your treating physician or institution.

54. Have you ever been indicted, charged or convicted of any felony crime?

Yes or No: If yes, please describe:

55. Do you provide any diagnostic, consulting or other professional services to patients (including telemedicine) in states other than those listed above? Yes or No: If yes, include states, type of service and annual number of encounters in your explanation.

56. Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? Yes or No: If yes, include proof of coverage, location, and name of entity providing coverage.

57. Has any insurer ever cancelled, declined or refused to renew your insurance coverage?

Yes or No: If yes, explain why and give name of carrier(s).

58. Have you ever practiced without professional liability insurance? Yes or No

59. State the name and location of all facilities, including non-hospital facilities where you hold staff or courtesy privileges:

Name Location

60. During the 7 years immediately preceding the date of this Application, have you received any letter, request for medical records, notice of patient claim, or any other written communication relating to possible negligence in your care or failure to care for a patient? ◯ Yes or ◯ No if yes, please (i) describe, fully and in detail, the factual circumstances relating to each such incident and the ultimate disposition thereof and (ii) attach a correct copy of each such letter, request, notice and other communication to this Application.

61. Are you aware of any claims or potential claims, including without limitation alleged injuries, incidents, or circumstances, that could possibly lead to a claim being brought against you, even if you believe the claim is without merit? ◯ Yes or ◯ No: If yes, please fully describe and attach copies of any claim notification letters received by you and/or sent by you to your current or any prior professional liability carrier with respect to each potential claim.

62. Are you aware of any claims, potential claims or lawsuits which have occurred that have not been reported to your current or any prior professional liability insurance carrier?

◯ Yes or ◯ No: If yes, please fully describe:

63. Do you have any knowledge of an incident or an indication from a patient or family member that might result in a claim? ◯ Yes or ◯ No

64. Are you aware of any request for medical records related to an incident that might result in a claim? ◯ Yes or ◯ No

65. Please list each insurance company with which you've been insured during the past 10 years.

INSURER	POLICY NUMBER	POLICY PERIOD

The undersigned Applicant hereby certifies that the foregoing information is true, correct and complete. Applicant hereby authorizes access by, and release to, CENTURION MEDICAL LIABILITY PROTECTIVE RISK RETENTION GROUP, INC. of all information relating to any of the foregoing, and any and all other information relevant to evaluating the undersigned Applicant for issuance of medical liability coverage, including without limitation all medical claims and any other matter in the possession, custody or control of including without limitation all medical claims and any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice, other medical associations or medical organizations, any country medical society or similar organization, any insurance carrier which has previously insured or been requested to insure the undersigned applicant with respect to medical professional liability and/or premises liability coverage, and any peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or any private or public third party reimburser. Centurion Medical Liability Protective Risk Retention Group, Inc. agrees to hold such information in confidence, to be used only for its proper business purposes and, unless otherwise required by law, not to release such information to third parties without the Applicant's approval. Applicant authorizes Centurion Medical Liability Protective Risk Retention Group, Inc. to discuss such information within its committees and boards and to communicate conclusions relating there to Applicant and administrative or executive personnel of Applicant's employer or prospective employer.

Signing this application does not bind the Company to provide medical liability insurance coverage for the Applicant. The Company may use the information in this application to obtain a credit score rating. All information requested in this application is considered material and important. If Centurion Medical Liability Protective Risk Retention Group, Inc. issues any policy or certificate to the Applicant, that policy will be void and unenforceable if any of the information provided in this Application is false or misleading in any respect, or if the Applicant has failed to provide whatever additional information which may be necessary in order to make the information which was provided hereinnot misleading.

The undersigned Applicant hereby certifies that any and all claims or potential claims against Applicant, of which the Applicant is aware, have been reported in writing to the Applicant's current or previous professional liability carrier, or described herein or attached as exhibits to this Application.

The undersigned Applicant further understands that, if a policy is issued for acts which occurred prior to the Effective Date (or if purchased, prior to a Retroactive Date) of the policy, no coverage will be provided by Centurion Medical Liability Protective Risk Retention Group, Inc. for any claim or potential claim of which the Applicant became or should reasonably have become aware, if that claim was not disclosed in this Application.

All of the information requested in this application is considered material and important. The undersigned Applicant hereby certifies that all of the answers given, and all of the exhibits which are attached hereto, are true, correct and complete in all respects.

REQUESTED LIMITS OF LIABILITY

- ○ $100,000 / $300,000 Per Single Incident / Per Policy Period
- ○ $200,000 / $600,000 Per Single Incident / Per Policy Period
- ○ $250,000 / $750,000 Per Single Incident / Per Policy Period (FL Only)
- ○ $1,000,000 / $3,000,000 Per Single Incident / Per Policy Period (AZ & GA Only)

PROFESSIONAL ASSOCIATION _____

(Enter Entity Name if coverage is desired for your PA, Professional Corporation, LP, LPP, PLLC)

REQUESTED EFFECTIVE DATE _____

REQUESTED RETROACTIVE DATE _____

_____

Applicant Name (please print)

_____ _____

Signature of Applicant Date

CLAIMS FORM

IMPORTANT: THE WORD "CLAIM" REFERS TO:

A. ANY SUIT OR CLAIM, SETTLED OR PENDING, REGARDLESS OF THE RESULT, ARISING FROM YOUR PROFESSIONAL ACTIVITY AND BROUGHT AGAINST YOU OR ANY PARTNER, ASSOCIATE OR EMPLOYEE; OR

B. CIRCUMSTANCES WHICH HAVE BEEN BROUGHT TO YOUR ATTENTION BY A PATIENT OR REPRESENTATIVE OF A PATIENT, IN SUCH MANNER AS TO INDICATE THE POSSIBILITY OF LEGAL ACTION AGAINST YOU, ANY PARTNER, ASSOCIATE OR EMPLOYEE.

IF THERE HAS BEEN MORE THAN ONE CLAIM, PLEASE USE A SEPARATE FORM FOR EACH.

PATIENT NAME _____ AGE _____ ☐ MALE ☐ FEMALE

DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO ALLEGATIONS AGAINST YOU: _____

DATE CLAIM/INCIDENT NOTICE RECEIVED: _____ DATE CLAIM/INCIDENT REPORTED TO CARRIER: _____

DEFENDING INSURANCE CARRIER NAME: _____

ADDITIONAL DEFENDANTS _____

DESCRIPTION OF CLAIM: (PROVIDE ENOUGH INFORMATION TO ALLOW EVALUATION, AND USE ADDITIONAL SHEET IF NEEDED)

ALLEGED ACT, ERROR OR OMISSION UPON WHICH CLAIMANT BASES CLAIM: _____

DESCRIPTION OF CASES AND EVENTS: _____

DESCRIPTION OF THE TYPE AND EXTENT OF INJURY OR DAMAGE ALLEGEDLY SUSTAINED _____

IF A MEDICAL CLAIM, PROVIDE THE TYPE OF INJURY CLAIMED ◯ EMOTIONAL ONLY ◯ PERMANENT DISABILITY

◯ TEMPORARY DISABILITY ◯ COSMETIC ◯ DEATH ◯ Other _____

WHAT IS THE PRESENT CONDITION OF THE PATIENT? _____

DID YOU IN ANY WAY ALTER, EMBELLISH, DELETE, CHANGE AND/OR DESTROY ANY RECORDS, MEDICAL OR OTHERWISE, PERTAINING TO THIS CLAIM? ☐ YES ☐ NO

PRESENT STATUS OF THE CLAIM (CHECK APPLICABLE ANSWER)

◯ DISMISSED: (ACTION DROPPED WITHOUT ANY PAYMENT TO CLAIMANT OR STATUTE OF LIMITATIONS HAS EXPIRED)

◯ ABANDONED (NO ACTIVITY FROM CLAIMANT FOR OVER 3 YEARS)

◯ WON BY DEFENSE ◯ WON BY CLAIMANT AMOUNT PAID ON YOUR BEHALF _____

◯ OPEN ◯ SETTLEMENT AMOUNT PAID ON YOUR BEHALF _____

I UNDERSTAND INFORMATION SUBMITTED HEREIN BECOMES A PART OF MY PROFESSIONAL LIABILITY APPLICATION AND IS SUBJECT TO THE SAME WARRANTY AND CONDITIONS.

_____ _____

Signature of Applicant Date