



APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

for PHYSICIANS and ALLIED HEALTH PROFESSIONALS

Limits of Liability: \$500,000 Per Occurrence/\$1,500,000 Per Annual Aggregate

INSTRUCTIONS: Please complete all sections of this form either electronically or in ink. All sections requiring a signature or initials must be signed in ink.

- _____ Signed, dated and fully completed application
- _____ Curriculum vitae
- _____ Copy of the **declaration page** from your current malpractice insurance carrier's policy
- _____ Copy of your current license to practice medicine in Pennsylvania
- _____ Copy of your current DEA registration
- _____ "Policy History Reports", "Claim History Reports", or "Loss Runs" covering the past ten years. These may be obtained from your current or prior carrier's).
- _____ A copy of your letterhead
- _____ A copy of any advertisements for your services
- _____ Check payable to CPPRRG, Inc. in the amount of \$100 per application for the non-refundable processing fee.

This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services or the use of your professional office premises, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval. No coverage exists until a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

Send completed application with associated documentation and processing fee to:

Tom Martone
Murray Insurance Associates, Inc.
PO Box 1728 ♦ 39 North Duke Street
Lancaster, PA 17608-1728

If you have any questions regarding the application process or any information contained in this packet, please contact Tom Martone, at (717) 397-9600 ext. 303 or e-mail at tmartone@murrayins.com

The policy you are applying for will be 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 guarantee funds are not available for your risk retention group.

Procedures and practices: (Check the "Yes" box if applicable during any part of the coverage period, including any retroactive period, if applicable:

<input type="checkbox"/>	No surgery (see last page for definition)
<input type="checkbox"/>	Minor surgery (see last page for definition)
<input type="checkbox"/>	Major surgery (see last page for definition)
<input type="checkbox"/>	Assist in major surgery on your own patients
<input type="checkbox"/>	Assist in maj. surgery in patients other than your own
<input type="checkbox"/>	Administration of general, caudal or spinal anesthesia
<input type="checkbox"/>	Deep radiation/X-ray therapy (over 120 kv)
<input type="checkbox"/>	Intestinal surgery for obesity
<input type="checkbox"/>	Laser surgery
<input type="checkbox"/>	Colon-rectal surgery: ___ % of surgical practice

<input type="checkbox"/>	Normal obstetrical deliveries
<input type="checkbox"/>	Supervision on nurse midwives
<input type="checkbox"/>	Left heart catheterization
<input type="checkbox"/>	Right heart catheterization
<input type="checkbox"/>	Interventional radiology
<input type="checkbox"/>	Caesarian sections
<input type="checkbox"/>	Abortions
<input type="checkbox"/>	Endoscopic procedures other than sigmoidoscopy
<input type="checkbox"/>	Prenatal care: up to ___ weeks
<input type="checkbox"/>	Remote services (internet or telemedicine)

Practice Organization:

Check which type of practice applies:	Average workload/volume per week	
<input type="checkbox"/> Solo Unincorporated	Less than 8 hours	
<input type="checkbox"/> Solo professional corporation	9 to 16 hours	
<input type="checkbox"/> Member of limited liability company	17 to 24 hours	
<input type="checkbox"/> Member of a professional association	More than 24 hours per week	
<input type="checkbox"/> Shareholder or employee in a professional corporation	Patient visits per week	
<input type="checkbox"/> Employee or contractor for a professional corporation, hospital, clinic, etc.	Major surgeries per week	
<input type="checkbox"/> Other: _____	Obstetrical deliveries per week	

Corporate Coverage:

Do you wish coverage for your Professional Corporation or Partnership?	Yes	No
If yes, ONE separate corporation/partnership application is required for each entity.		
If no, is the corporation/partnership insured elsewhere?	Yes	No

Current Office Locations: List all current office or clinic practice locations in this section. Include all locations whether or not CPPRRG, Inc. insurance is desired at that location. If additional space is required to show more than four practice locations, please attach a separate sheet or your brochure.

<u>Name of Location</u>	<u>City and State</u>	<u>County</u>	<u>% of practice</u>

List Associates: (If more space is required, attach roster)

<u>Associate</u>	<u>Specialty</u>	If non-affiliated physicians are utilized to cover your practice, please describe those arrangements including the name(s) of the practitioner utilized.

 Applicant's Signature (All pages must be signed)

 Date

WORK HISTORY

Starting with your current practice, list all employment since completion of post-graduate training.

<u>Name of Location</u>	<u>City and State</u>	<u>From (Date)</u>	<u>To (Date)</u>

HOSPITAL PRIVILEGES

Please provide the following information on your CURRENT hospital privileges

	<u>Hospital Name</u>	<u>City, State</u>	<u>Type of privileges</u>	<u>Specialty or department</u>
1.				
2.				
3.				
4.				

INSURANCE HISTORY

<u>You must attach the declarations page from your current policy</u>	<u>Current Policy</u>	<u>First Prior Policy</u>	<u>Second Prior Policy</u>
Insurance Carrier			
Type of policy (Claims-made or Occurrence)			
Effective Date			
Expiration Date			
Retroactive date (Claims-made only)			

If your current policy is a "Claims-Made" policy, you MUST either purchase prior acts coverage from your new carrier OR obtain a reporting endorsement from your current carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of coverage.	I decline or don't need retroactive coverage:
	Applicant Signature

 Applicant's Signature (All pages must be signed)

 Date

ADDITIONAL UNDERWRITING INFORMATION

Please answer the following questions. Yes responses REQUIRE additional explanation in the area provided. If additional space is needed, please use the area provided on the last page of this application.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other State?

Medical or professional license	Yes	No
DEA or CDS/BNDD registration	Yes	No
Hospital medical staff membership	Yes	No
Clinical privileges or other rights on any hospital medical staff	Yes	No
Employment by any hospital, institution or the military	Yes	No
Professional society memberships	Yes	No
Participation in any private, federal or state health program (i.e., Medicare, Medicaid)	Yes	No
Participation in an HMO, PPO or other managed care organization	Yes	No
Board certification	Yes	No

At any time, have you ever been:

Convicted of a criminal offense	Yes	No
Convicted of a felony	Yes	No
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of a trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country	Yes	No

Have you ever at any time or are you currently:

Under indictment for any crime	Yes	No
The subject of an investigation by any private, federal, state or health insurance program or state licensing board	Yes	No
Under investigation by any state licensing board or federal agency	Yes	No
The subject of any adverse action reports to a state or federal databank	Yes	No

Have you either voluntarily or involuntarily:

Withdrawn your application for medical staff membership at any facility	Yes	No
Withdrawn your request for any clinical privileges at any facility	Yes	No

Health Status:

Are you able to perform the professional duties of the position with or without reasonable accommodation? (A "Yes" answer to this question does not require additional documentation)	Yes	No
Are you currently using illegal substances or illegally using substances?	Yes	No

 Applicant's Signature (All pages must be signed)

 Date

PROFESSIONAL LIABILITY HISTORY

Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?	Yes	No
Has any claim or suit for alleged malpractice been brought against you in the past ten years?	Yes	No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?	Yes	No

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING SECTION:

CASE 1	Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved	
	Your status in this case		Status of case		
	Primary defendant		Pending	Dismissed/dropped	
	Co-defendant		Found for plaintiff	Settled, if settled, state amount:	
			Found for defendant	Amount:	
	Alleged harm to patient:				
	Circumstance of patient's illness:				
	Any other pertinent details:				
CASE 2	Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved	
	Your status in this case		Status of case		
	Primary defendant		Pending	Dismissed/dropped	
	Co-defendant		Found for plaintiff	Settled, if settled, state amount:	
			Found for defendant	Amount:	
	Alleged harm to patient:				
	Circumstance of patient's illness:				
	Any other pertinent details:				

 Applicant's Signature (All pages must be signed)

 Date

CASE 3	Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved
	Your status in this case		Status of case	
	Primary defendant		Pending	Dismissed/dropped
	Co-defendant		Found for plaintiff	Settled, if settled, state amount:
			Found for defendant	Amount:
	Alleged harm to patient:			
	Circumstance of patient's illness:			
Any other pertinent details:				
CASE 4	Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved
	Your status in this case		Status of case	
	Primary defendant		Pending	Dismissed/dropped
	Co-defendant		Found for plaintiff	Settled, if settled, state amount:
			Found for defendant	Amount:
	Alleged harm to patient:			
	Circumstance of patient's illness:			
Any other pertinent details:				
CASE 5	Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved
	Your status in this case		Status of case	
	Primary defendant		Pending	Dismissed/dropped
	Co-defendant		Found for plaintiff	Settled, if settled, state amount:
			Found for defendant	Amount:
	Alleged harm to patient:			
	Circumstance of patient's illness:			
Any other pertinent details:				

 Applicant's Signature (All pages must be signed)

 Date

CASE 6	Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved
	Your status in this case		Status of case	
	Primary defendant		Pending	Dismissed/dropped
	Co-defendant		Found for plaintiff	Settled, if settled, state amount:
			Found for defendant	Amount:
	Alleged harm to patient:			
	Circumstance of patient's illness:			
	Any other pertinent details:			

DEFINITIONS:

<p>MAJOR SURGERY: Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis; any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.</p>
<p>MINOR SURGERY: Any operation not defined as major surgery</p>
<p>NO SURGERY: The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.</p>

The undersigned agrees to fully comply with the conditions of membership in CPPRRG and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to and form part of this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

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 a person to criminal and civil penalties.

Applicant Signature

Date

The policy you are applying for will be 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 guarantee funds are not available for your risk retention group.