

SECTION I: GENERAL INFORMATION

GENERAL INFORMATION

First Name		Middle Name		Last Name	
Date of Birth (mm/dd/yyyy)	DEA License #	FEIN License #		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name of NORCAL Insured Entity/Organization/Physician			Relationship <input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other:		
Primary Office Phone		Home Phone		Cell Phone	
Primary Office Address		City		State	Zip Code
Home Address		City		State	Zip Code
Billing Address		City		State	Zip Code
Other Address		City		State	Zip Code

HEALTH CARE PROFESSIONAL LICENSE

State	License #	Expiration Date	% of Practice	Status of License
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> 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 reporting endorsements (tails) that you may have purchased.

Claims-made WITHOUT prior acts 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 <input type="checkbox"/> Shared <input type="checkbox"/> Separate	Hours (per week)
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Will you also carry insurance with another company? Yes No If yes, please explain in the Remarks Section.

COVERAGE HISTORY

List all previous medical professional liability insurance you have had for the past 5 years, beginning with the most current.

Coverage Period (mm/dd/yyyy)	Insurer	Coverage Type	Limit Amount	Premium	Tail Purchased
From: To:		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Retro:	Amount: <input type="checkbox"/> Shared <input type="checkbox"/> Separate		<input type="checkbox"/> Yes <input type="checkbox"/> No
From: To:		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Retro:	Amount: <input type="checkbox"/> Shared <input type="checkbox"/> Separate		<input type="checkbox"/> Yes <input type="checkbox"/> No
From: To:		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Retro:	Amount: <input type="checkbox"/> Shared <input type="checkbox"/> Separate		<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION III: SPECIALTY AND PRACTICE INFORMATION

SPECIALTY INFORMATION

- Please indicate your specialty below:

<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)	<input type="checkbox"/> Midwife	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Optometrist	<input type="checkbox"/> Perfusionist	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Radiology Assistant	<input type="checkbox"/> Surgical Assistant	<input type="checkbox"/> Other:
- Do you perform any procedures other than incisions of boils, cysts, circumcisions (newborns), or other superficial abscesses or suturing minor lacerations? Yes No
 If yes, please list the procedures:
- Do you have a collaborative agreement? Yes No Physician Name: _____
 If yes, please attach a copy of the agreement.

PRACTICE INFORMATION

- Do you practice, or have you practiced in the past 5 years, at any locations other than the primary office location listed previously? Yes No
 If yes, please describe:

Practice Name	Location (City, State, Zip)	Hours (per week)	Start (mm/dd/yyyy)	Complete (mm/dd/yyyy)	Coverage Desired?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Do you or will you work in an operating room? Yes No
 If yes, in what capacity: Observe Only Assist Other:
6. Do you or will you work in a labor and delivery room or birthing center ? Yes No
 If yes, in what capacity: Observe Only Assist Other:
7. Have you seen or will you see patients in a nursing home? Yes No Hrs per week:
 If yes, please explain:
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*
		<input type="checkbox"/> Staff <input type="checkbox"/> Courtesy <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Staff <input type="checkbox"/> Courtesy <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Staff <input type="checkbox"/> Courtesy <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Comments:

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, Claims Information.

	School/Facility	Location	Complete Date (mm/dd/yyyy)	Degree/Program
Professional School				
Additional Training				
Additional Training				

2. Are you certified in: ACLS ATLS PALS Other:

SECTION V: CLAIMS INFORMATION

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:

Have you made any changes to your practice as a result of any claims, suits, or incidents? Yes No

If yes, please explain:

SECTION VI: 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 been charged or convicted of any crime other than minor traffic violations? Yes No
4. Have you ever had your license to practice as a health care professional or DEA license revoked, limited, refused, suspended, or denied? Yes No
5. Have your hospital privileges ever been surrendered, limited, or revoked, whether voluntarily or involuntarily? Yes No
6. Have your hospital privileges been expanded or reduced in the last 12 months? Yes No
7. Has your membership in any Professional Association or Society ever been refused, revoked, or limited in any way? Yes No
8. Have you ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society? Yes No
9. 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.

10. 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.

11. Have you ever been accused of sexual misconduct? Yes No
12. Have you ever had any contact of a sexual nature with a patient or former patient? Yes No
13. Do you know of any individual who works on your behalf that has a prior history or propensity for sexual misconduct? Yes No
14. Have you treated or will you treat celebrities or professional athletes? Yes No

15. 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

16. Do you enter into arbitration or similar agreements with your patients? Yes No

If yes, please attach a copy of the agreement(s).

17. Do you participate in clinical trials? Yes No

If yes, please complete our clinical trials questionnaire.

18. Do you use any non-FDA approved devices, drugs, or procedures? Yes No

REMARKS SECTION

Please provide any additional information/explanations for your application below.

AGREEMENTS AND NOTICES

I understand that any claims whose circumstances were known before the effective date of coverage are specifically excluded from coverage under any policy of insurance that may be issued by NORCAL Mutual (The Company).

I understand that the NORCAL Mutual policy requires any disputes arising from it to be submitted to binding arbitration unless specifically prohibited by applicable law.

I understand that, as a condition precedent to approval for coverage, The Company may perform a detailed inquiry and investigation of the applicant's background, competence, and qualifications. I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to The Company and its duly authorized agents and representatives. I further expressly authorize all individuals and entities to whom such legal inquiry is made by The Company and its duly authorized agents and representatives to provide the same with all information within their possession or under their control that pertains to the applicant's background, competence, and qualifications. I expressly release and discharge the aforesaid entities and individuals and their agents and representatives from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation, as well as in the evaluation of information so received from whatever source.

All information requested in this application is considered material and important. I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of The Company in considering this application for insurance. I understand that any material misrepresentation in this application that The Company relies on to its detriment could void coverage. I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to me by The Company.

I understand that I must notify The Company immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf and that The Company may withdraw or modify any outstanding quotations or authorization or agreement to bind insurance.

I understand that this application is subject to acceptance by The Company and does not bind coverage.

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	<input type="checkbox"/> Male <input type="checkbox"/> Female												
Date of Incident (mm/dd/yyyy)		Location of Incident													
Name of Insurer		Date Reported to Insurer (mm/dd/yyyy)													
Type: <input type="checkbox"/> Suit <input type="checkbox"/> Demand for Money <input type="checkbox"/> Incident Only <input type="checkbox"/> Notice of Intent to Sue <input type="checkbox"/> Request for Records <input type="checkbox"/> Other:															
1. Summary of condition/diagnosis at time of incident: 2. Description of treatment rendered, including dates: 3. Allegations: 4. Other persons and entities involved: 5. Status/Disposition: <input type="checkbox"/> Open Describe current status and defense strategy: <input type="checkbox"/> Closed without indemnity payment <input type="checkbox"/> Settled <input type="checkbox"/> Judgment/Verdict for defense <input type="checkbox"/> Judgment/Verdict for plaintiff If closed, date closed (mm/dd/yyyy): <table style="width: 100%; border: none;"> <tr> <td style="width: 40%;">Amount reserved for you:</td> <td style="width: 30%;">Indemnity: \$</td> <td style="width: 30%;">Defense: \$</td> </tr> <tr> <td>Amount reserved for other defendants:</td> <td>Indemnity: \$</td> <td>Defense: \$</td> </tr> <tr> <td>Amount paid on your behalf:</td> <td>Indemnity: \$</td> <td>Defense: \$</td> </tr> <tr> <td>Amount paid on behalf of other defendants:</td> <td>Indemnity: \$</td> <td>Defense: \$</td> </tr> </table> 6. Has there been a change in practice as a result of this claim, suit, or incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain below:				Amount reserved for you:	Indemnity: \$	Defense: \$	Amount reserved for other defendants:	Indemnity: \$	Defense: \$	Amount paid on your behalf:	Indemnity: \$	Defense: \$	Amount paid on behalf of other defendants:	Indemnity: \$	Defense: \$
Amount reserved for you:	Indemnity: \$	Defense: \$													
Amount reserved for other defendants:	Indemnity: \$	Defense: \$													
Amount paid on your behalf:	Indemnity: \$	Defense: \$													
Amount paid on behalf of other defendants:	Indemnity: \$	Defense: \$													
<hr/> I understand this information is part of my Application.															
Signature	Printed Name	Date (mm/dd/yyyy)													