NORCAL MUTUAL®

575 Market St, Suite 1000
San Francisco, CA 94105
p: 844.4NORCAL
f: 877.686.0558
submissions@norcal-group.com
norcalmutual.com

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

HEALTH CARE EXTENDERS

This application is for claims-made coverage. It is subject to review and acceptance by The Company and does not bind coverage. Additional information may be requested by The Company.

Agency Name:
Agency Location:
Producer Name:

REQUESTING ADDITION TO A CURRENT NORCAL MUTUAL POLICY

If accepted, coverage will be extended only while you are acting within the course and scope of your duties for the group and will be subject to the terms, conditions, and limitations of the policy. A copy of the policy will be made available to you upon request.

Name of Entity/Organization or Physician	Policy Number

APPLICATION CHECKLIST

Please complete the entire application, sign, and date. Indicate not applicable (n/a) where appropriate.

- ☐ Answer all questions fully and completely. Alternatively, you may attach a credentialing application or application for another insurer that you have completed within the past 90 days and complete this application beginning with Section V, Claims Information.
- ☐ A copy of the Declarations page and endorsements from your most recent insurance policy. If an extended reporting endorsement (tail) has been purchased, please provide a copy as well.
- ☐ Loss runs for the past 10 years, or since the date you began practicing medicine if you began in the last 10 years.
- ☐ A copy of your current Curriculum Vitae (CV).
- ☐ Please download and print the NORCAL Mutual Business Associate Agreement at http://www.norcalmutual.com/resources and file with your other HIPAA compliance documents. Revised regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Privacy, Security, Enforcement and Breach Notification Rules, requiring NORCAL Mutual to enter into a revised Business Associate Agreement with all business associates who manage or distribute protected health information.

SECTION I: GENERAL INFORMATION

GENERAL INFORMATION

First Name	Middle Name	Last Name		
Date of Birth (mm/dd/yyyy)	DEA License #	FEIN License #	☐ Male ☐ Female	
Name of NORCAL Insured Entity/Organization/Physician		Relationship ☐ Employee ☐ Independent Contractor ☐ Other:		
Primary Office Phone	Home Phone	Cell Phone		Fax
Primary Office Address	City	State	Zip Code	☐ Preferred Mailing
Home Address	City	State	Zip Code	☐ Preferred Mailing
Billing Address	City	State	Zip Code	☐ Preferred Mailing
Other Address	City	State	Zip Code	☐ Preferred Mailing

HEALTH CARE PROFESSIONAL LICENSE

State	License #	Expiration Date	% of Practice	Status of License
				☐ Active ☐ Inactive ☐ Pending
				☐ Active ☐ Inactive ☐ Pending
				☐ Active ☐ Inactive ☐ 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 ☐ Shared ☐ Separate	Hours (per week)

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:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No
From: To:		☐ Occurrence ☐ Claims-made Retro:	Amount: ☐ Shared ☐ Separate		☐ Yes ☐ No

SECTION III: SPECIALTY AND PRACTICE INFORMATION

SPECIALTY INFORMATION

1. Please indicate your specialty below:

   ☐ Certified Registered Nurse Anesthetist (CRNA) ☐ Midwife ☐ Nurse Practitioner
   ☐ Optometrist ☐ Perfusionist ☐ Physician Assistant
   ☐ Radiology Assistant ☐ Surgical Assistant ☐ Other:

2. 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:

3. Do you have a collaborative agreement? ☐ Yes ☐ No Physician Name:

   If yes, please attach a copy of the agreement.

PRACTICE INFORMATION

4. 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?**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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*
		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other:	☐ Yes ☐ 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	☐ Male ☐ Female
Date of Incident (mm/dd/yyyy)	Location of Incident	
Name of Insurer	Date Reported to Insurer (mm/dd/yyyy)	

Type: ☐ Suit ☐ Demand for Money ☐ Incident Only ☐ Notice of Intent to Sue
☐ Request for Records ☐ 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:

☐ Open Describe current status and defense strategy:

☐ Closed without indemnity payment ☐ Settled ☐ Judgment/Verdict for defense ☐ Judgment/Verdict for plaintiff

If closed, date closed (mm/dd/yyyy):

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: $

6. Has there been a change in practice as a result of this claim, suit, or incident? ☐ Yes ☐ No If yes, explain below:

I understand this information is part of my Application.

Signature Printed Name Date (mm/dd/yyyy)

Save Print Submit Form