REQUESTED EFFECTIVE DATE 12:01AM POLICY NUMBER: ______ COMPANY USE ONLY

THE MEDICAL PROTECTIVE COMPANY

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

FOR FASTER SERVICE, PLEASE ENTER YOUR APPLICATION ONLINE AT WWW.MEDPRO.COM

I. GENERAL INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

PLEASE PRINT LEGIBLY, POLICY IS BASED ON READABILITY OF YOUR NAME. PLEASE ANSWER ALL QUESTIONS; IF A QUESTION IS NOT APPLICABLE, STATE "N/A"

A.

LAST NAME

FIRST NAME (FULL)

MIDDLE NAME SUFFIX DEGREE DATE OF BIRTH MM/DD/YYYY SOCIAL SECURITY NUMBER (OPTIONAL)

B. PRACTICE LOCATIONS (PLEASE LIST PRINCIPAL LOCATION FIRST)

(COMBINED PERCENTAGE OF PRACTICE FOR ALL LOCATIONS MUST TOTAL 100% AND CANNOT BE OF EQUAL VALUES)

% OF PRACTICE **1.** ☐ **OFFICE** ☐ **HOSPITAL:** ☐ ADMITTING ☐ NON-ADMITTING If Non-Admitting Please explain: ______

PRACTICE/HOSPITAL NAME

NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE

COUNTY

% OF PRACTICE **2.** ☐ **OFFICE** ☐ **HOSPITAL:** ☐ ADMITTING ☐ NON-ADMITTING If Non-Admitting Please explain: ______

PRACTICE/HOSPITAL NAME

NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE

COUNTY

% OF PRACTICE **3.** ☐ **OFFICE** ☐ **HOSPITAL:** ☐ ADMITTING ☐ NON-ADMITTING If Non-Admitting Please explain: ______

PRACTICE/HOSPITAL NAME

NUMBER & STREET

SUITE ADDRESS 2

CITY STATE ZIP CODE

COUNTY

I. GENERAL INFORMATION (CONTINUED) *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

C. RESIDENCE ADDRESS

NUMBER & STREET APARTMENT #

ADDRESS 2

CITY STATE ZIP CODE -

COUNTY

D. BILLING AND CORRESPONDENCE ADDRESS

☐ LOCATION # (FROM I.B. ABOVE) ___________ ☐ RESIDENCE ☐ OTHER (PLEASE ENTER BELOW)

NUMBER & STREET SUITE

CITY STATE ZIP CODE -

E. CONTACT INFORMATION

EMAIL ADDRESS

BUSINESS FAX - - BUSINESS PHONE - - RESIDENCE PHONE - -

F. IF WE NEED TO CONTACT YOU FOR ADDITIONAL INFORMATION, PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT:

☐ EMAIL ☐ BUSINESS FAX ☐ BUSINESS PHONE ☐ RESIDENCE PHONE

G. DO YOU HAVE A WEB ADDRESS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE WEBSITE ADDRESS (URL) ______________________________

II. EDUCATIONAL BACKGROUND *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

A. MEDICAL SCHOOL

NAME OF SCHOOL

CITY STATE

COUNTRY

DEGREE **COMPLETED FROM:** MM - YYYY **TO** MM - YYYY

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: ______________________________

____

II. EDUCATIONAL BACKGROUND (CONTINUED) *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS. (i.e., RESIDENCY SPECIALTY TRAINING, ANESTHESIA RESIDENCY TRAINING, etc.)
IF MORE THAN ONE SPECIALTY COMPLETED PLEASE ENTER EACH SPECIFIC SPECIALTY.

1.
NAME OF HOSPITAL/FACILITY
CITY STATE COUNTRY
SPECIALTY TYPE
COMPLETED ? ☐ YES ☐ NO **FROM** MM - YYYY **TO** MM - YYYY

2.
NAME OF HOSPITAL/FACILITY
CITY STATE COUNTRY
SPECIALTY TYPE
COMPLETED ? ☐ YES ☐ NO **FROM** MM - YYYY **TO** MM - YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., FELLOWSHIP, etc.) ☐ YES ☐ NO

1.
NAME OF HOSPITAL/FACILITY
CITY STATE COUNTRY
SPECIALTY TYPE
COMPLETED ? ☐ YES ☐ NO **FROM** MM - YYYY **TO** MM - YYYY

2.
NAME OF HOSPITAL/FACILITY
CITY STATE COUNTRY
SPECIALTY TYPE
COMPLETED ? ☐ YES ☐ NO **FROM** MM - YYYY **TO** MM - YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN 6 MONTHS BETWEEN YOUR MEDICAL SCHOOL, RESIDENCY, OTHER TRAINING, OR FIRST TIME IN PRIVATE PRACTICE:

____

____

E. IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE: MM - DD - YYYY

WILL MEDICAL PROTECTIVE BE COVERING YOUR RESIDENCY OR FELLOWSHIP? ☐ YES ☐ NO

WILL MEDICAL PROTECTIVE BE COVERING YOUR MOONLIGHTING WHILE YOU ARE IN YOUR RESIDENCY OR FELLOWSHIP? ☐ YES ☐ NO
(YOUR POLICY MAY BE ISSUED FOR LESS THAN ONE YEAR IN ORDER TO HAVE THE POLICY EXPIRATION DATE EQUAL THE RESIDENCY ENDING DATE)

F. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? ☐ YES ☐ NO

G. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS? ☐ YES ☐ NO

IF YES, HOW MANY CATEGORY 1 CREDIT HOURS?

H. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE LAST TWELVE (12) MONTHS? ☐ YES ☐ NO

I. ARE YOU A MEMBER OF A MEDICAL SCHOOL FACULTY? ☐ YES ☐ NO
IF YES, WHAT PERCENTAGE OF YOUR TIME IS SPENT TREATING PATIENTS WHOSE TREATMENT IS UNRELATED TO YOUR PHYSICIANS DUTIES AT THE MEDICAL SCHOOL.

III. PRACTICE INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? ☐ YES ☐ NO

(IF THIS IS COVERED BY ANOTHER PROFESSIONAL LIABILITY INSURANCE POLICY, COMPLETE QUESTION I IN SECTION IV.)

IF YES, WHICH STATE(S): ______________________________

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE: (EXCLUDE STATE ABBREVIATION)

PLEASE CHECK THE APPROPRIATE BOX TO INDICATE THE STATUS OF YOUR LICENSE

	STATE	LICENSE #	ACTIVE	INACTIVE	TEMPORARY	PENDING
1.			☐	☐	☐	☐
2.			☐	☐	☐	☐
3.			☐	☐	☐	☐
4.			☐	☐	☐	☐

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING

IF NO PREVIOUS LOCATION(S), PLEASE INDICATE YOUR EARLIEST START DATE AT YOUR CURRENT LOCATION(S): ____ - ______ (MM - YYYY)

1.

NAME OF PRACTICE

CITY STATE COUNTRY

SPECIALTY **FROM** MM - YYYY **TO** MM - YYYY

2.

NAME OF PRACTICE

CITY STATE COUNTRY

SPECIALTY **FROM** MM - YYYY **TO** MM - YYYY

3.

NAME OF PRACTICE

CITY STATE COUNTRY

SPECIALTY **FROM** MM - YYYY **TO** MM - YYYY

D. PLEASE EXPLAIN ANY GAPS GREATER THAN ONE MONTH BETWEEN PRACTICE LOCATIONS: ______________________________

E. TO WHICH MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG? ______________________________

IF NONE, PLEASE EXPLAIN: ______________________________

IV. RATING INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

NOTE: ALL PERCENTAGES REQUESTED BELOW FOR SPECIALTIES, PROCEDURES AND SURGICAL ACTIVITIES ARE OF YOUR TOTAL PRACTICE
****PLEASE ENTER COMPLETE NAME OF SPECIALTY/SUB-SPECIALTY. COMBINED PERCENTAGES MUST EQUAL 100% ****

A. WHAT IS YOUR PRESENT SPECIALTY? ____________ ☐☐☐ **% OF TOTAL PRACTICE**

WHAT IS YOUR SUB-SPECIALTY? ____________ ☐☐☐ **% OF TOTAL PRACTICE**

B. ARE YOU PERMANENTLY RETIRED FROM THE PRACTICE OF CLINICAL MEDICINE? ☐ YES ☐ NO

C. AMERICAN BOARD CERTIFIED? ☐ YES ☐ NO ____________ SPECIALTY BOARD ☐☐ - ☐☐☐☐ DATE CERTIFIED (MM/YYYY)

IF NO, ARE YOU BOARD ELIGIBLE? ☐ YES ☐ NO

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS? ☐☐ - ☐☐☐☐ MM YYYY

IF NO, HAVE YOU EVER TAKEN A SPECIALTY BOARD EXAMINATION AND FAILED TO PASS? ☐ YES ☐ NO

IF YES, HOW MANY TIMES? ____________

IF YES, PLEASE EXPLAIN: ____________

D. INDICATE THE AVERAGE WEEKLY NUMBERS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE. (IF YOU PRACTICE IN MULTIPLE STATES, PLEASE IDENTIFY THE FOLLOWING INFORMATION FOR EACH STATE.)

PLEASE PROVIDE WHOLE NUMBERS (NO RANGES i.e.. > <). IF "NONE" PLEASE ENTER "0" (ZERO) IN THE SPACE PROVIDED BELOW.

PATIENTS SEEN PER WEEK ☐☐☐ HOURS PER WEEK ☐☐☐ WALK-IN PATIENTS PER WEEK ☐☐☐

E. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- ☐ Abdominoplasty - Tummy Tuck
- ☐ Abortions- Elective _______% of total practice
- ☐ Abortions- Therapeutic _______% of total practice
- ☐ Acupuncture - General Anesthetic
- ☐ Acupuncture - Therapeutic/Local Anesthetic
- ☐ Anesthesia General/Spinal/Caudal
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assisting in major surgery - own patients only
- ☐ Assisting in major surgery - own & other than own patients
- ☐ Bariatric Surgery - Laparoscopic
- ☐ Bariatric Surgery - Non-Laparoscopic
- ☐ Biopsy - Endoscopic
- ☐ Blepharopigmentation - ________ % of total practice
- ☐ Blepharoplasty - Cosmetic ________ % of total practice
- ☐ Blepharoplasty - Reconstruction ________ % of total practice
- ☐ Botox ________ % of total practice
- ☐ Brachioplasty
- ☐ Breast Implants - Cosmetic ________ % of total practice
- ☐ Breast Implants - Reconstruction _______ % of total practice
- ☐ Breast Reduction - Cosmetic
- ☐ Bronchoscopy
- ☐ Bronco-esophagology
- ☐ Buttock Implants
- ☐ Calf Implants
- ☐ Cataract Surgery
- ☐ Catheterization - Left Heart
- ☐ Catheterization - Right Heart (other than CVP lines)
- ☐ Catheterization - Swan-Ganz
- ☐ Cheek/Chin/Lip Implants
- ☐ Chelation Therapy
- ☐ Chemical Peels - Superficial
- ☐ Chemical Peels - Medium
- ☐ Chemical Peels - Deep ______% of total practice
- ☐ Cleft Lip Surgery - Reconstructive
- ☐ Cleft Palate Surgery - Reconstructive
- ☐ Colonoscopy
- ☐ Cryosurgery (Cervical)
- ☐ Cryosurgery (non-external lesions)
- ☐ D & C
- ☐ Electromagnetic Therapy
- ☐ Embolization
- ☐ ERCP - Upper GI Endoscopy
- ☐ Face Lifts
- ☐ Face Lifts Mini (done with laser) ____% of total practice
- ☐ Gastrointestinal Endoscopy
- ☐ Gynecology - Major Surgery
- ☐ Hair Transplants - Follicular Unit Transplantations
- ☐ Hair Transplants - Other
- ☐ HVLA on the cervical spine on patients younger than 18 years of age
- ☐ Kyphoplasty
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Laser Therapy (Endoscopic)
- ☐ Laser Therapy (Non-Endoscopic)
- ☐ Lipoinjection ______% of total practice
- Liposuction
  - ☐ Other Than Tumescent Technique
  - ☐ Tumescent Technique Only ______% of total practice
- ☐ Lithotripsy
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- Nerve Blocks
  - ☐ Facet
  - ☐ Intrathecal Pumps
  - ☐ Lumbar Epidural Steroid
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Paraspinal
  - ☐ Paravertebral
  - ☐ Peripheral
  - ☐ Sciatic
  - ☐ Spinal Cord Stimulators
  - ☐ Triggerpoint Injection
- ☐ Needle Biopsy
- ☐ Oxidation Therapy
- ☐ Pacemakers - Epicardial
- ☐ Pacemakers - Endocardial
- ☐ Pacemakers - Temporary
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Polypectomy
- Prenatal /Gynecological Practice
  - ☐ Prenatal Practice - 1st & 2nd Trimester
  - ☐ Prenatal Practice - to term, no delivery
  - ☐ Prenatal Practice - to term, and delivery
  - ☐ Normal Deliveries - total per year ____
  - ☐ Cesarean Deliveries - total per year ____
- ☐ Prolotherapy
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye - Non Ionic Only
- ☐ Radiopaque Dye - Other than Non Ionic
- ☐ Rectal Ozone Therapy
- ☐ Rhinoplasty _____% of total practice
- ☐ Shock Therapy
- ☐ Sigmoidoscopy - 60 cm or less
- ☐ Sigmoidoscopy - Greater than 60 cm
- ☐ Silicone Injections _____ % of total practice
- Skin Flaps/Grafts
  - ☐ Cosmetic _____% of total practice
  - ☐ Reconstruction _____% of total practice
- ☐ Thigh Lift
- ☐ Tubal Ligations
- ☐ Vasectomies - own patients only
- ☐ Vasectomies - own & other than own patients
- ☐ Vertebroplasty
- ☐ Weight Control Medication _____ % of total practice
- ☐ Other Medical Techniques
  List Procedures (do not restate your specialty)
  ____
  ____

IV. RATING INFORMATION (CONTINUED) *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

F. INDICATE THE PERCENTAGE OF YOUR TOTAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

☐ % CARDIAC	☐ % OBSTETRICS	☐ % THORACIC
☐ % ENDOCRINOLOGY	☐ % OPHTHALMOLOGY	☐ % TRAUMATIC
☐ % GYNECOLOGY	☐ % ORTHOPEDIC (INCLUDING BACK)	☐ % UROLOGY
☐ % HAND	☐ % ORTHOPEDIC (NOT INCLUDING BACK)	☐ % VASCULAR
☐ % NEOPLASTIC SURGERY	☐ % OTORHINOLARYNGOLOGY	☐ % OTHER (DESCRIBE) ____
☐ % NEPHROLOGY	☐ % PLASTIC (COSMETIC ENHANCEMENT ONLY)	____
☐ % NEUROSURGERY	☐ % PLASTIC (RECONSTRUCTION ONLY)	____

G. IN THE LAST TEN (10) YEARS,

1. HAVE YOU DISCONTINUED MAJOR SURGICAL PROCEDURES, PERFORMANCE OF OBSTETRICS, OR ANY OTHER MEDICAL ACTIVITY? ☐ YES ☐ NO

   IF **YES**, LIST PROCEDURES/ACTIVITIES, **DATE** DISCONTINUED AND REASON FOR DISCONTINUING. DATE (MM-YYYY) ☐☐ - ☐☐☐☐

   ____

2. HAVE YOU PERFORMED WEIGHT CONTROL SURGERY OR PRESCRIBED WEIGHT CONTROL MEDICATION? ☐ YES ☐ NO

   a. IF **YES**, WHAT PERCENTAGE OF YOUR PRACTICE (% OF PATIENT CARE) **WAS** DEVOTED TO PRESCRIBING ANORECTIC DRUGS?

   ☐ <1% ☐ 1% - 10% ☐ 11%-50% ☐ >50% ☐ NEVER PRESCRIBED WEIGHT CONTROL MEDICATION

   b. IF **YES**, WHAT PERCENTAGE OF YOUR PRACTICE (% OF PATIENT CARE) **WAS** DEVOTED TO PERFORMING WEIGHT CONTROL SURGERY?

   ☐ <1% ☐ 1% - 10% ☐ 11%-50% ☐ >50% ☐ NEVER PERFORMED WEIGHT CONTROL SURGERY

3. DO YOU HAVE OWNERSHIP INTERESTS IN A WEIGHT CONTROL CLINIC? ☐ YES ☐ NO

   IF **YES**, WHAT IS THE NAME OF THE WEIGHT CONTROL CLINIC WITH WHICH YOU ARE AFFILIATED? ____

H. DO YOU SERVE IN A HOSPITAL EMERGENCY ROOM FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE? ☐ YES ☐ NO

1. IF YES, NUMBER OF HOURS PER MONTH: ☐☐☐ (EXCLUDING "ON-CALL" HOURS) INDIANA ONLY: ☐☐☐ % MAJOR SURGERY

   ☐☐☐ % MINOR SURGERY

2. IF YES, ARE THE HOURS YOU WORK IN THE ER THE MINIMUM NUMBER OF HOURS REQUIRED TO MAINTAIN HOSPITAL PRIVILEGES? ☐ YES ☐ NO

   IF YOU HAVE EMERGENCY ROOM ACTIVITIES WHICH ARE COVERED BY ANOTHER PROFESSIONAL LIABILITY INSURANCE POLICY, COMPLETE QUESTION I.

I. WILL YOU BE PERFORMING ACTIVITIES WHICH WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY? ☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING: ☐ EMPLOYEE ☐ INDEPENDENT CONTRACTOR ☐ RESIDENT/FELLOW ☐ FACULTY

PRACTICE NAME AND LOCATION(S): ____

____

NAME OF CARRIER: ____

J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP THE MEDICAL PROTECTIVE COMPANY BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE.

____

V. ADDITIONAL PROFESSIONAL INFORMATION *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

A. DO YOU PERFORM SURGERY ON OR ARE YOU A TEAM PHYSICIAN FOR ANY PROFESSIONAL OR COLLEGIATE ATHLETES? ☐ YES ☐ NO

IF YES, WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED TO THIS ACTIVITY? ____ %

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

B. DO YOU PARTICIPATE IN PHARMACEUTICAL TESTING PROGRAMS/CLINICAL INVESTIGATION STUDIES THAT ARE NOT FDA APPROVED? ☐ YES ☐ NO

IF YES, INCLUDE A COPY OF THE INDEMNIFICATION AGREEMENT PROVIDED BY THE PHARMACEUTICAL COMPANY.

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

C. DO YOU PRACTICE IN A NURSING HOME FACILITY? ☐ YES ☐ NO

IF YES, WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED TO THIS ACTIVITY? ____ %

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

D. DO YOU TREAT OR REVIEW TREATMENT OF FEDERAL PRISON INMATES? ☐ YES ☐ NO

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

E. DO YOU TREAT NON-FEDERAL PRISON INMATES? ☐ YES ☐ NO

IF YES, WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED TO TREATING NON-FEDERAL INMATES? ____ %

DOES THIS FACILITY HAVE A LAW LIBRARY? ☐ YES ☐ NO

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

F. DO YOU USE A COLLECTION AGENCY WHICH HAS THE AUTHORITY TO FILE COLLECTION SUITS WITHOUT YOUR KNOWLEDGE? ☐ YES ☐ NO

G. DO YOU PRACTICE AS A MEDICAL DIRECTOR? ☐ YES ☐ NO

TYPE AND NAME OF FACILITY: ______________________ % OF TOTAL PRACTICE ____

BRIEFLY DESCRIBE YOUR RESPONSIBILITIES: ______________________

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

H. DO YOU DEVISE OR REVIEW PLANT/EMPLOYER SAFETY STANDARDS? ☐ YES ☐ NO

1. WHAT PRODUCTS ARE MANUFACTURED BY THE COMPANY? ______________________
2. COMPANY NAME: ______________________ LOCATION: ______________________

(IF YOU ARE COVERED BY OTHER INSURANCE FOR THIS ACTIVITY, PLEASE COMPLETE SECTION IV, QUESTION I.)

I. HAVE YOU EVER BEEN INDICTED FOR, CHARGED WITH, OR CONVICTED OF, ANY ACT COMMITTED IN VIOLATION OF ANY LAW OR ORDINANCE OTHER THAN TRAFFIC OFFENSES OR HAD YOUR HOSPITAL PRIVILEGES, DEA LICENSE, MEDICAL LICENSE OR REIMBURSEMENT PRIVILEGES REFUSED, DENIED, REVOKED, SUSPENDED, RESTRICTED, SUBJECT TO A REPRIMAND, PLACED ON PROBATION OR VOLUNTARILY SURRENDERED? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND INDICATE THE DATE(S): DATE __ __ (MM) - __ __ __ __ (YYYY) ______________________

J. HAS ANY PROFESSIONAL LIABILITY INSURANCE COMPANY EVER DECLINED, REFUSED, CANCELED, OR NON RENEWED YOUR COVERAGE, OR HAVE YOU EVER HAD AN INVOLUNTARY DEDUCTIBLE OR SURCHARGE ASSESSED AGAINST YOUR POLICY? ☐ YES ☐ NO

IF YES, PLEASE INDICATE THE REASON AND THE DATE(S): DATE __ __ (MM) - __ __ __ __ (YYYY) ______________________

K. HAVE YOU EVER BEEN ACCUSED OF SEXUAL MISCONDUCT OF ANY KIND? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND INDICATE THE DATE(S): DATE __ __ (MM) - __ __ __ __ (YYYY) ______________________

L. HAVE YOU INCURRED OR BECOME AWARE OF HAVING A CONDITION THAT IMPAIRS YOUR ABILITY TO PRACTICE YOUR MEDICAL SPECIALTY? (i.e. CONVULSIVE DISORDERS, MENTAL ILLNESS, MULTIPLE SCLEROSIS, RHEUMATOID ARTHRITIS, ADDICTION OF ALCOHOL, NARCOTICS OR OTHER CONTROLLED SUBSTANCES, etc.) ☐ YES ☐ NO

IF YES, STATE CONDITION, DATE(S) AND IDENTIFY YOUR TREATING PHYSICIAN IN THE SPACE PROVIDED BELOW. IN THE EVENT OF ANY SUCH IMPAIRMENT, **A STATEMENT FROM YOUR PHYSICIAN ATTESTING TO YOUR FITNESS TO PRACTICE YOUR SPECIALTY MUST ACCOMPANY THIS APPLICATION**. FURTHER STATEMENTS MAY BE REQUESTED AS NECESSARY BY THE COMPANY TO COMPLETE THE UNDERWRITING OF YOUR APPLICATION.

TYPE OF ILLNESS: ______________________

DURATION OF ILLNESS: __ __ (MM) - __ __ __ __ (YYYY) **TO** __ __ (MM) - __ __ __ __ (YYYY)

TREATING PHYSICIAN (NAME & ADDRESS): ______________________

____

____

VI. PRACTICE ORGANIZATION INFORMATION

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM

A. INDICATE THE NUMBER OF EACH OF THE FOLLOWING WHO PROVIDE SERVICES IN YOUR OFFICE (PLEASE INCLUDE YOURSELF):

PHYSICIANS		NURSE MIDWIFE ASSISTANTS		PHYSICIAN ASSISTANTS	
DENTISTS		NURSE PRACTITIONERS		PHYSICIAN SURGICAL ASSISTANTS	
CASE MANAGERS		NURSE SURGICAL ASSISTANTS		PODIATRISTS	
CRNAs/ RNAs		OCCUPATIONAL THERAPISTS		PSYCHOLOGISTS	
CHIROPRACTORS		PERFUSIONISTS		RESPIRATORY THERAPISTS	
NURSE MIDWIVES					

B. DO YOU OR ANY MEMBER OF YOUR GROUP CURRENTLY SUPERVISE ANY OF THE SPECIALISTS LISTED ABOVE WITH WHOM YOU DO NOT EITHER EMPLOY OR CONTRACT FOR SERVICES? ☐ YES ☐ NO

IF NO, DO YOU PLAN TO DO SO IN THE FUTURE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE AN EXPLANATION: ______________________________

C. PRACTICE ORGANIZATION:

PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOUR PRACTICE AFFILIATION(S) AND "X" APPLICABLE BOXES UNDER EMPLOYMENT STATUS YOU MUST CHECK AT LEAST ONE BOX.

NOTE (1): TO SECURE SEPARATE ENTITY COVERAGE, PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ SOLO UNINCORPORATED/SOLE PROPRIETOR

ENTITY NAME

EMPLOYMENT STATUS

☐ SOLE PROPRIETOR ☐ EMPLOYEE ☐ SHAREHOLDER/PARTNER ☐ INDEPENDENT CONTRACTOR ☐ OTHER

DATE JOINED/FORMED: MM - YYYY

IF OTHER, PLEASE EXPLAIN: ______________________________

☐ SOLO INCORPORATED

ENTITY NAME

EMPLOYMENT STATUS

☐ EMPLOYEE ☐ SHAREHOLDER/PARTNER ☐ INDEPENDENT CONTRACTOR ☐ OTHER

DATE JOINED/FORMED: MM - YYYY

IF OTHER, PLEASE EXPLAIN: ______________________________

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #:

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? ☐ YES (1) ☐ NO

IF YES, DO YOU HAVE ANY EMPLOYED OR CONTRACTED PHYSICIANS ASSOCIATED WITH YOUR PRACTICE? ☐ YES ☐ NO

IF NO, DO YOU WISH TO SHARE YOUR INDIVIDUAL POLICY LIMITS WITH YOUR SOLO CORPORATION? ☐ YES ☐ NO

IF YES, AND YOU DESIRE TO SHARE YOUR INDIVIDUAL POLICY LIMITS, PLEASE INITIAL HERE:

NOTE: TO QUALIFY FOR SHARED LIMIT SOLO CORPORATION COVERAGE, YOU MUST HAVE NO PHYSICIAN EMPLOYEES OR PHYSICIAN INDEPENDENT CONTRACTORS.

INITIALS

**** IF YOU DESIRE SEPARATE POLICY LIMITS OR YOU DO NOT QUALIFY FOR "SOLO CORPORATION" COVERAGE, PLEASE CONTACT YOUR AGENT TO COMPLETE A SEPARATE ENTITY APPLICATION FOR CONSIDERATION.****

VI. PRACTICE ORGANIZATION INFORMATION (CONTINUED) *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

C. PRACTICE ORGANIZATION: (CONTINUED)

PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOUR PRACTICE AFFILIATION(S) AND "X" APPLICABLE BOXES UNDER EMPLOYMENT STATUS YOU MUST CHECK AT LEAST ONE BOX.

NOTE (1): TO SECURE SEPARATE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ MULTI -SHAREHOLDER CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY

ENTITY NAME

EMPLOYMENT STATUS

☐ EMPLOYEE ☐ SHAREHOLDER/PARTNER ☐ INDEPENDENT CONTRACTOR ☐ OTHER

DATE JOINED/FORMED MM - YYYY

IF OTHER, PLEASE EXPLAIN: ______

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #:

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? ☐ YES (1) ☐ NO

☐ HOSPITAL ☐ INDUSTRIAL ☐ GOVERNMENT - BRANCH: ____________________

ENTITY NAME

EMPLOYMENT STATUS

☐ EMPLOYEE ☐ SHAREHOLDER/PARTNER ☐ INDEPENDENT CONTRACTOR ☐ OTHER

DATE JOINED/FORMED MM - YYYY

IF OTHER, PLEASE EXPLAIN: ______

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #:

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? ☐ YES (1) ☐ NO

☐ STATE LICENSED MEDICAL SURGERY CENTER: ☐ FOR USE BY OTHER PHYSICIANS ☐ YOUR PATIENTS ONLY

ENTITY NAME

EMPLOYMENT STATUS

☐ EMPLOYEE ☐ SHAREHOLDER/PARTNER ☐ INDEPENDENT CONTRACTOR ☐ OTHER

DATE JOINED/FORMED MM - YYYY

IF OTHER, PLEASE EXPLAIN: ______

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #:

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? ☐ YES (1) ☐ NO

VI. PRACTICE ORGANIZATION INFORMATION (CONTINUED) *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

C. PRACTICE ORGANIZATION: (CONTINUED)

PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOUR PRACTICE AFFILIATION(S) AND "X" APPLICABLE BOXES UNDER EMPLOYMENT STATUS YOU MUST CHECK AT LEAST ONE BOX.

NOTE (1): TO SECURE SEPARATE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

☐ **OTHER - PLEASE EXPLAIN: ____**

ENTITY NAME

EMPLOYMENT STATUS

☐ EMPLOYEE ☐ SHAREHOLDER/PARTNER ☐ INDEPENDENT CONTRACTOR ☐ OTHER

DATE JOINED/FORMED
MM - YYYY

IF OTHER, PLEASE EXPLAIN: ____

IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED WITH THE MEDICAL PROTECTIVE COMPANY? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE MEDICAL PROTECTIVE COMPANY INDIVIDUAL, CORPORATION OR PARTNERSHIP POLICY AND GROUP NUMBER, IF KNOWN:

POLICY #: GROUP #: SUB-GROUP #:

IF NO, DO YOU DESIRE COVERAGE FOR THIS ENTITY? ☐ YES (1) ☐ NO

D. IF THE BUSINESS PURPOSE OF THE ENTITY NOTED ABOVE IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN:

____

VII. LOSS INFORMATION (IMPORTANT! PLEASE COMPLETE FULLY) *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

PLEASE COMPLETE THE CLAIM/SUIT INFORMATION FORM, SECTION VIII, FOR EACH CLAIM, POTENTIAL CLAIM OR SUIT.

A. ARE YOU NOW, OR HAVE YOU EVER BEEN INVOLVED, DIRECTLY OR INDIRECTLY, IN A CLAIM, POTENTIAL CLAIM, OR SUIT ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES? ☐ YES ☐ NO

IF **YES**, HOW MANY?

B. ARE YOU AWARE OF ANY COMPLICATION, INCIDENT OR UNEXPECTED ADVERSE OUTCOME RESULTING IN INJURY OR DEATH, THAT MIGHT REASONABLY BE EXPECTED TO RESULT IN A CLAIM OR SUIT BEING MADE AGAINST YOU? ☐ YES ☐ NO

IF **YES**, HOW MANY?

C. IN THE LAST 12 MONTHS, HAVE YOU, OR ANYONE FROM YOUR PRACTICE, RECEIVED A WRITTEN REQUEST FROM AN ATTORNEY, FOR TREATMENT RECORDS, CONCERNING ANY OF YOUR CURRENT OR FORMER PATIENTS? ☐ YES ☐ NO

IF YES, DID ANY OF THE REQUESTS FOR RECORDS PERTAIN TO A PATIENT WHO SUFFERED AN UNEXPECTED, ADVERSE OUTCOME, INCLUDING, BUT NOT LIMITED TO, ANY OF THE FOLLOWING:

- AMPUTATION
- LOSS OF MAJOR ORGAN FUNCTION
- PERMANENT NEUROLOGICAL INJURY
- DEATH
- LOSS OF VISION

IF **YES**, HOW MANY?

VIII. CLAIM/SUIT INFORMATION FORM (PLEASE MAKE COPIES IF ADDITIONAL FORMS ARE NEEDED)

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: ______________________

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION. ALL FIELDS MUST BE COMPLETED.

A. PATIENT/CLAIMANT INFORMATION

LAST NAME

FIRST NAME (FULL)

AGE:

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. (MM,YYYY) __ - ____

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. (MM,YYYY) __ - ____

D. HAS THIS CLAIM/INCIDENT BEEN REPORTED TO YOUR CURRENT OR FORMER INSURER? ☐ YES ☐ NO

IF YES, DATE CLAIM REPORTED TO YOUR CURRENT OR FORMER INSURER. (MM,YYYY) __ - ____

IF YES, PLEASE PROVIDE A COPY OF THE REPORT(S)

E. NAME OF OTHER DOCTOR(S), HOSPITAL(S) OR HEALTH CARE PROVIDER(S), IF ANY, INVOLVED IN THE CLAIM OR SUIT: ______________________

F. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED

IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD (MM,YYYY) __ - ____

G. INDICATE CASE VALUE ESTABLISHED BY CARRIER, IF KNOWN (IN $) ______________________

H. DEFENDING INSURANCE CARRIER NAME: ______________________

I. WAS THIS MATTER CLOSED WITH YOUR CONSENT? ☐ YES ☐ NO

WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WITHDRAWN? ☐ YES ☐ NO

IF YES, INDICATE TOTAL AMOUNT OF SETTLEMENT OR AWARD (IN $) ______________________

AMOUNT PAID ON YOUR BEHALF (IN $) ______________________

J. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: ______________________

TREATMENT PROVIDED: ______________________

ALLEGED NEGLIGENCE: ______________________

ALLEGED INJURY: ______________________

K. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY; YOUR INVOLVEMENT)

IX. COVERAGE INFORMATION *IF ADDITIONAL SPACE IS NEEDED, PLEASE USE SUPPLEMENTAL FORM*

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING. LIST CURRENT INSURER FIRST.

1. ______________________ INSURER ☐ OCCURRENCE ☐ CLAIMS-MADE __-__-____ (MM DD YYYY) TO __-__-____ (MM DD YYYY)
2. ______________________ INSURER ☐ OCCURRENCE ☐ CLAIMS-MADE __-__-____ (MM DD YYYY) TO __-__-____ (MM DD YYYY)
3. ______________________ INSURER ☐ OCCURRENCE ☐ CLAIMS-MADE __-__-____ (MM DD YYYY) TO __-__-____ (MM DD YYYY)

PLEASE EXPLAIN ANY GAPS IN COVERAGE BACK TO YOUR START DATE OF PRACTICE. ______________________

B. COVERAGE DESIRED

1. ☐ OCCURRENCE
2. ☐ CLAIMS-MADE COVERAGE WITHOUT PRIOR ACTS COVERAGE
3. ☐ CLAIMS-MADE COVERAGE WITH PRIOR ACTS COVERAGE
   (A COPY OF CURRENT DECLARATION PAGE SHOWING CURRENT RETROACTIVE DATE MUST BE ATTACHED)

IF 1 OR 2 ARE SELECTED FROM THE ABOVE AND THE MOST RECENT PRIOR COVERAGE WAS ISSUED ON A CLAIMS MADE BASIS, PLEASE COMPLETE ONE OF THE FOLLOWING.

☐ AN EXTENDED REPORTING ENDORSEMENT (TAIL COVERAGE) HAS BEEN PURCHASED (COPY OF TAIL IS ATTACHED)

☐ AN EXTENDED REPORTING ENDORSEMENT HAS NOT AND WILL NOT BE PURCHASED.
I **WILL NOT** PURCHASE TAIL COVERAGE (REPORTING ENDORSEMENT) FROM MY CURRENT CARRIER WHERE I AM INSURED UNDER A CLAIMS-MADE POLICY. I REALIZE THAT MY FAILURE TO PURCHASE SUCH COVERAGE FROM MY CURRENT CARRIER WILL RESULT IN AN UNINSURED EXPOSURE FOR ANY CLAIMS WHICH MAY ARISE AS RESULT OF PROFESSIONAL SERVICES RENDERED WHILE INSURED BY MY CURRENT CARRIER'S POLICY. I UNDERSTAND THAT THE POLICY, FOR WHICH I AM APPLYING FOR WITH THE MEDICAL PROTECTIVE COMPANY, IF OFFERED WILL NOT PROVIDE PRIOR ACTS COVERAGE.

INITIAL HERE ☐

CLAIMS-MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD, FOR SERVICES RENDERED BETWEEN THE RETROACTIVE DATE AND EXPIRATION DATE OF THE POLICY. PLEASE CONTACT YOUR AGENT SHOULD YOU HAVE ANY QUESTIONS PERTAINING TO THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE OR THE ADDITIONAL EXPENSE ASSOCIATED WITH AN "EXTENSION CONTRACT" OR "TAIL COVERAGE."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M. **FROM:** __-__-____ (MM DD YYYY) **12:01 A.M.**
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF YOUR CURRENT POLICY.

ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY. **TO:** __-__-____ (MM DD YYYY) **12:01 A.M.**
(NOTE: IF YOU ARE JOINING AN EXISTING INSURED/GROUP, YOUR COVERAGE MAY BE ISSUED TO A COMMON EXPIRATION DATE)

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS: __-__-____ (MM DD YYYY) **12:01 A.M.**
(NOT REQUIRED FOR OCCURRENCE POLICIES OR CLAIMS-MADE WITHOUT PRIOR ACTS)

E. IF YOU PRACTICE IN THE FUND STATES OF INDIANA, KANSAS, LOUISIANA, NEBRASKA, NEW MEXICO, PENNSYLVANIA, OR WISCONSIN, PLEASE INDICATE YOUR CURRENT FUND RETROACTIVE DATE IF DIFFERENT THAN THE RETROACTIVE STATED ABOVE: __-__-____ (MM DD YYYY)

ARE YOU AWARE OF ANY GAPS IN YOUR FUND COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE EXACT DATES AND AN EXPLANATION: ______________________

F. IF YOU PRACTICE IN MORE THAN ONE STATE, INDICATE THE STATE AND THE LIMITS DESIRED FOR EACH STATE. ADD ADDITIONAL STATES IF NEEDED.

STATE __ **LIMITS DESIRED** ___,___,___/___,___,___ **PER OCCURRENCE/ANNUAL AGGREGATE**

STATE __ **LIMITS DESIRED** ___,___,___/___,___,___ **PER OCCURRENCE/ANNUAL AGGREGATE**

STATE __ **LIMITS DESIRED** ___,___,___/___,___,___ **PER OCCURRENCE/ANNUAL AGGREGATE**

NOTE: REQUESTED LIMITS MAY NOT BE AVAILABLE FROM THIS COMPANY.

NOTE: YOU MAY BE ELIGIBLE FOR FUND COVERAGE IN ACCORDANCE WITH STATE FUND GUIDELINES. LIMITS MAY BE ADJUSTED ACCORDINGLY.

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

BY INITIALING BELOW, I ASSIGN TO THE FOLLOWING EMPLOYER OR NAMED THIRD PARTY (INCLUDE NAME AND ADDRESS)

NAME: ______________________________

ADDRESS: ______________________________

____

INITIAL HERE

BOTH THE RIGHT TO CANCEL MY POLICY AND TO RECEIVE ANY UNEARNED PREMIUM. HOWEVER, I DO REQUEST THAT COPIES OF ALL CORRESPONDENCE, FORMAL NOTICES, etc., BE SENT TO ME AT THE LAST ADDRESS OF RECORD. THIS ASSIGNMENT MAY BE REVOKED BY ME AT ANY FUTURE TIME BY SENDING WRITTEN NOTICE TO THE MEDICAL PROTECTIVE COMPANY'S HOME OFFICE, P.O. BOX 15021, FORT WAYNE, INDIANA 46885-5021.

PLEASE NOTE: YOUR RIGHT TO CANCEL AND RECEIVE ANY PREMIUM REFUND WILL AUTOMATICALLY BE ASSIGNED:

1. TO THE FIRST NAMED INSURED IF YOU ARE COVERED UNDER A GROUP POLICY.
2. TO A THIRD PARTY FINANCE COMPANY IF IT PAYS YOUR PREMIUM ON YOUR BEHALF.

XI. STATE STATUTORY REQUIREMENT

MANDATORY: ***ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

ANY PERSON WHO KNOWINGLY 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 ALSO PUNISHABLE BY CRIMINAL AND/OR CIVIL PENALTIES IN CERTAIN JURISDICTIONS.

INITIAL HERE

XII. PLEASE READ AND SIGN

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT I HAVE NOT KNOWINGLY SUPPRESSED OR MISSTATED ANY MATERIAL FACTS AND I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY. I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN MY PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY OTHER PHYSICIAN OR DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT I HAVE NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED MY COMPLETED APPLICATION; (2) OFFERED ME A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF I PAY MY PREMIUM OR FIRST INSTALLMENT BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS **I WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING MY CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REGARDING ME, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

DATE SIGNED __ __ - __ __ - __ __ __ __
MM DD YYYY

____
APPLICANT'S SIGNATURE

____
PRINT NAME

IF APPLICATION IS BEING SIGNED BY THE APPLICANT'S AGENT: BY MY SIGNATURE, I HEREBY REPRESENT THAT THE APPLICANT HAS GRANTED ME FULL AUTHORITY TO EXECUTE THIS APPLICATION ON HIS OR HER BEHALF. I ALSO REPRESENT THAT I HAVE REVIEWED THE RESPONSES CONTAINED IN THIS APPLICATION WITH THE APPLICANT, AND WE ARE IN AGREEMENT THEY ARE FULL AND COMPLETE TO THE BEST OF OUR COMBINED KNOWLEDGE AND BELIEF. IN ADDITION, I REPRESENT THAT I HAVE DISCUSSED THE REPRESENTATIONS PROVIDED THROUGHOUT THIS APPLICATION WITH THE APPLICANT AND THAT APPLICANT UNDERSTANDS AND AGREES THAT SUCH REPRESENTATIONS ARE BINDING UPON HIM OR HER, EVEN THOUGH I AM EXECUTING THIS APPLICATION ON THE APPLICANT'S BEHALF. I FURTHER ACKNOWLEDGE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY FORM THE BASIS FOR THE COMPANY TO TERMINATE MY AGENCY AGREEMENT WITH CAUSE.

DATE SIGNED __ __ - __ __ - __ __ __ __
MM DD YYYY

____
AGENT'S SIGNATURE

____
PRINT NAME

XIII. SUPPLEMENTAL FORM *(ATTACH A SEPARATE PIECE OF PAPER IF ADDITIONAL SPACE IS NEEDED)*