



- Medical Professional Mutual Insurance Company
- ProSelect Insurance Company
- ProSelect National Insurance Company, Inc.

**PART I - PRODUCER INFORMATION**

Agency Name			Submitted By		
Agency License Number	State	Telephone	Most Recent Coverys Policy Number		

**PART II - APPLICANT INFORMATION**

First Name	Middle Initial	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Email Address				Website	
Contact Person/Insured Representative				National Provider Identifier	
Office Address One			Residence Address		
Address One		Percentage of practice: _____	Address One		
Address Two			Address Two		
City	State	Zip	City State Zip		
Phone	Fax		Phone Fax		
Office Address Two			Mailing Address <i>(if different than Office Address One)</i>		
Address One		Percentage of practice: _____	Address One		
Address Two			Address Two		
City	State	Zip	City State Zip		
Office Address Three			Billing Address <i>(if different than Office Address One)</i>		
Address One		Percentage of practice: _____	Address One		
Address Two			Address Two		
City	State	Zip	City State Zip		

**PART III - PRACTICE LOCATION(S)**

License Number	State	% of Activities in each state	Coverage Needed	Additional Malpractice Insurance
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there any part of your practice that is covered by any other professional liability?  Yes  No  
 If yes, please provide details and copy of declaration page of policy: \_\_\_\_\_

Name and location of all healthcare facilities where you have medical staff or courtesy privileges:

Facility Name	City	State	JCAHO Approved?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART IV - COVERAGE INFORMATION**

Type of Coverage (choose one)  
 Occurrence       Claims Made      Retroactive date desired\* \_\_\_\_\_  
 Moonlighting Only (When selected, please complete and submit APP 017, Moonlighter Credit Addendum.)  
 Coverage Effective Date  
 From \_\_\_\_\_ To \_\_\_\_\_  
 Do you wish to purchase Prior Acts Coverage?  Yes  No (If yes, please complete and submit APP 015, Prior Acts Application.)

\*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Professional Liability  
 Each Claim \$ \_\_\_\_\_ Annual Aggregate \$ \_\_\_\_\_

**For New Jersey Applicants Only**

In accordance with the New Jersey Medical Care Access and Responsibility Patients First Act, you may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from \$5,000 to \$1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy the deductible must be fully collateralized. Would you like more information on deductibles?  Yes  No

**PART V - EDUCATION**

Country	State/Province	School of Graduation	Type of Degree:
			Graduated: (month) (year)

**Name of location where internship was served:**  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Graduated: (month) (year)

**Name of location where residency was served:**  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Graduated: (month) (year)

**Name of location where fellowship was served:**  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Graduated: (month) (year)

If foreign medical school graduate, are you certified by the educational council for foreign medical graduates?  Yes  No  
 Have you participated in any continuing medical education within the last five years? If yes, please attach a description or a copy of a certificate of completion.  Yes  No  
 Are you certified by an approved specialty board?  Yes  No  
 If so, list specialty and attach a copy of the certificate(s): \_\_\_\_\_ Date Certified: (month) / (year)  
 Which professional organizations are you a member of?  AMA  State medical  County medical (list counties): \_\_\_\_\_  
 Other \_\_\_\_\_

**PART VI - CURRENT PRACTICE**

Type of practice:  Individual  Postgraduate year one (intern)  Resident  Fellow  
 Partnership  Professional Corporation  Solo Corporation  Locum Tenens

**Residents and Fellows (complete this section)**  
 Indicate specialty this year \_\_\_\_\_  
 Date program ends (month) (year)

**Separate Limit of Liability for Partnership or Corporation**  Yes  No  
 Not available on solo corporations (except in PA). Current practice must be partnership or corporation.  
 If yes, please complete and submit **APP 008, Partnership & Corporation Professional Liability Application.**

**Partnership or Corporation (complete this section)**  
 Name of Partnership or Corporation \_\_\_\_\_  
 Name of partner(s) or other members \_\_\_\_\_

If you are employed by others, or perform services on behalf of others as an independent contractor, list the names of those other persons or entities.	Employment Status
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor

Are you covered by the Federal Tort Claims Act? (If yes, please complete and submit APP 024, FTCA Restricted Coverage.)  Yes  No  
 Do you practice 20 hours or less a week or 80 hours or less a month in direct patient care?  Yes  No  
 (If yes, please complete and submit APP 020, Limited Practice Credit.)  
 Do you hold a full time teaching appointment with regular clinical supervision responsibilities? (If yes, please complete and submit APP 021, Academic Credit.)  Yes  No  
 Do you use Locum Tenens?  Yes  No  
 If yes, indicate the number of days per year: \_\_\_\_\_ days

**PART VII - PRACTICE ACTIVITIES**

Surgeons, please provide breakdown of surgical activities:	Please state your medical specialty: _____		
<b>% (Surgery)</b>	Indicate below the percentage of time devoted to the following medical activities.		
_____ Abdominal	%	%	%
_____ Bariatric	_____ Aerospace	_____ Hematology/Oncology	_____ Otorhinolaryngology
_____ Cardiac	_____ Allergy/Immunology	_____ Hospitalist	_____ Pain Management
_____ Colon/Rectal	_____ Anesthesiology	_____ Hypnosis	_____ Pathology
_____ General	_____ Broncho-esophagology	_____ Infectious Disease	_____ Pediatrics
_____ Gynecology	_____ Cardiovascular	_____ Intensive Care	_____ Pharmacology - clinical
_____ Hand	_____ Dermatology	(including patients of others)	_____ Physiatry/Physical Medicine & Rehab
_____ Head/Neck	_____ Diabetes	_____ Intensivist (hospital based only)	_____ Podiatry
_____ Laparoscopic Surgery	_____ Emergency Medicine	_____ Internal Medicine	_____ Psychiatry
_____ Neurosurgery	_____ Endocrinology	_____ Neoplastic Disease	_____ Psychoanalysis
_____ OB/GYN	_____ Family Practice	_____ Nephrology	_____ Psychosomatic Medicine
_____ Ophthalmology	(excludes all OB)	_____ Neurology	_____ Public Health
_____ Orthopedic (incl. spinal surgery)	_____ Family Practice	_____ Nuclear Medicine	_____ Pulmonary Diseases
_____ Orthopedic (no spinal surgery)	(includes OB)	_____ Nutrition	_____ Radiation Oncologist
_____ Otorhinolaryngology	_____ Forensic	_____ Obstetrics	_____ Radiology - diagnostic
_____ Plastic	_____ Gastroenterology	_____ OB/GYN	_____ Radiology - interventional
_____ Plastic Otorhinolaryngology	_____ General Preventive	_____ Occupational Medicine	_____ Rheumatology
_____ Podiatric	_____ Geriatric Medicine	_____ Ophthalmology	_____ Urgent Care
_____ Thoracic	_____ Gynecology	_____ Orthopedics (office practice only)	_____ Urology
_____ Traumatic	_____ Other, specify: _____		
_____ Urological			
_____ Vascular			

Do you perform robotic surgery?  Yes  No

Have your practice specialties/procedures, etc., changed in the past five years?  Yes  No

Specialty/Procedure	Describe Change	Date of Change

Select one of the following as applicable:

No Surgery - Includes incision of boils and superficial abscess, or suturing of skin or superficial fascia, or Mohs surgery.

Minor Surgery - Includes obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered *major surgery*. If assisting on own patients, indicate average time per month: \_\_\_\_\_

Major Surgery - Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures, the removal of any gland or organ, and plastic surgery.

Assisting in Major Surgery - On the patients of others. If assisting, indicate the percentage of total practice spent assisting: \_\_\_\_\_ %  
*(Do not include if you occasionally assist on an emergency basis.)*

**All Specialties:** Identify the medical techniques/procedures that you perform by indicating the number per month.

_____ Angiography - aortic	_____ Lymphangiography
_____ Angiography - cerebral, extremity	_____ Mohs micrographic surgery
_____ Arteriography	_____ Myelography
_____ Catherization: cardiac OR	_____ Needle biopsy - other than liver, breast, kidney, or bone marrow biopsy. Indicate type: _____
_____ Insertion of permanent pacemakers	_____ Phlebography
_____ Catherization: arterial, diagnostic, swan ganz, or umbilical OR	_____ Pneumatic or mechanical esophageal dialation (not with bougie or olive)
_____ Insertion of temporary pacemakers	_____ Polypectomy
_____ Circumcisions	_____ Purcutaneous lithotripsy
_____ Colonoscopy	_____ Radiation therapy
_____ Cryosurgery - other than use on benign or pre-malignant dermatological lesions	_____ Rigid bronchoscopy
_____ ERCP (Endoscopic retrograde cholangiopancreatography)	_____ Other: _____
_____ Hair transplants	_____ None of the Above
_____ Lasers - ablative	
_____ Laser lithotripsy	
_____ Liposuction/suction lipectomy	

Have you ever performed any of these techniques/procedures in the past five years?  Yes  No

**Obstetricians, Family & General Practitioners**

Give the number of the following you perform per year

Deliveries: Babies delivered by normal vaginal delivery only: \_\_\_\_\_ Babies delivered by C-Section: \_\_\_\_\_  
 Babies delivered vaginally after a C-Section: \_\_\_\_\_ C-Section Assists: \_\_\_\_\_  
 Are you assisting with C-Sections on patients of others?  Yes  No Are you a laborist only?  Yes  No

**Otorhinolaryngologists**

Do you perform plastic surgery?  Yes  No Do you perform cosmetic plastic surgery?  Yes  No  
 If yes, do you do reconstructive or any other plastic surgery procedure in an area of the anatomy other than the ear, nose, throat area?  Yes  No  
 If yes, please specify or attach an explanation: \_\_\_\_\_

**All Specialties**

Do you perform surgical procedures in your office?  Yes  No  
 Do you own, operate or use surgi-center facilities?  Yes  No  
 Do you normally staff an emergency room?  Yes  No  
 If yes, are you board certified in emergency medicine?  Yes  No  
 Give number of hours in emergency medicine per month: \_\_\_\_\_ hours  
 Do you or any of your employees perform Botox or Collagen injections? (If yes, please complete and submit APP 042, Botox/Cosmetic Procedures Addendum.)  Yes  No  
 Do you participate in any medical research, clinical trials or off-label use of drugs or devices?  Yes  No  
 (If yes, please complete and submit APP 040, Clinical Trials Addendum.)  
 Do you provide services at a correctional facility?  Yes  No  
 (If yes, list where: \_\_\_\_\_)  
 Do you participate in any telemedicine activities? (If yes, please complete and submit APP 043, Telemedicine Addendum.)  Yes  No  
 Do you participate on any committees that conduct quality assurance, peer, or utilization review?  Yes  No  
 (If yes, please complete the chart below.)

Name	City	State	Type of Review
			<input type="checkbox"/> Quality Assurance <input type="checkbox"/> Peer Review <input type="checkbox"/> Utilization Review
			<input type="checkbox"/> Quality Assurance <input type="checkbox"/> Peer Review <input type="checkbox"/> Utilization Review
			<input type="checkbox"/> Quality Assurance <input type="checkbox"/> Peer Review <input type="checkbox"/> Utilization Review

**PART VIII- EMPLOYEES/ADDITIONAL INSURED**

Please list the following for any physicians, surgeons or certified nurse midwives you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete APP 041, Independent Contractor Addendum.

<b>First Name</b>				
<b>Middle Initial</b>				
<b>Last Name</b>				
<b>Insurer</b>				
<b>Policy #</b>				
<b>Social Security #</b>				
<b>NPI #</b>				
<b>Date of Birth</b>				
<b>Independent Contractor</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Coverys Insured</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*(continued next page)*

Applying for Coversys Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty				
Surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery
Assisting with Surgery	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Graduation Date	month year	month year	month year	month year
Residency Date	month year	month year	month year	month year
Fellowship Date	month year	month year	month year	month year

If you employ non-physician healthcare providers, please list job category and number of each. If you employ nurses, please specify between RNs, LPNs, Nurse Practitioners, etc.

Job Title/Specialty	Number of Employees

Does any one physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives?  Yes  No  
 If yes, please submit either a letter outlining practice guidelines or a copy of practice guidelines.

Do you want employee coverage under separate limits?  Yes  No

Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete **APP 026, Employee Limit of Liability Application**.

**PART IX - HISTORY**

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	From	To	From	To	From	To	From	To
Insurer								
Policy #								
Coverage								
Premium								
Tail Purchased	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retroactive Date								
Limit								
Facility								
State								
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.**

Have you ever been denied a medical license?  Yes  No

Has your medical license ever been restricted, suspended, voluntarily surrendered or revoked in any state?  Yes  No

Has your DEA certification ever been restricted, suspended, voluntarily surrendered or has probation been invoked?  Yes  No

Has any hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges, or probation?  Yes  No

Have you ever been involved in or are you aware of any future involvement in any local, state or federal investigation or proceeding by a regulatory agency or peer review board?  Yes  No

Have you ever had a complaint or claim brought against you for sexual misconduct?  Yes  No

Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree?  Yes  No

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy?  
(If yes, please list company, date and reason for this action below.)

Yes  No

Company	Date	Reason
---------	------	--------

Company	Date	Reason
---------	------	--------

Have you ever been indicted and/or convicted of a crime other than minor traffic violations?

Yes  No

Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)?

Yes  No

Do you know of any pending claims, incidents or activities, including any request for patient records, that might give rise to any claim in the future?

Yes  No

**If you answered yes to any of the above questions, you must provide a detailed written narrative.**

Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such?

Yes  No

**If yes, please accompany this application with a letter outlining dates of treatment, results of treatments, and current status.**

**This letter should be from your treating physician or institution.**

#### PART X - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

##### Professional Contractual Liability (not available in PA)

Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance.* There is a charge based on a percentage of your professional liability premium.

Yes  No

##### Commercial General Liability

Do you wish to purchase Commercial General Liability coverage?

Yes  No

If yes, please complete and submit **APP 007, Commercial General Liability Application.**

##### Billing Errors and Omissions

Do you wish to purchase Billing Errors and Omissions coverage?

Yes  No

*Billing Errors and Omissions Coverage is a claims made coverage which provides a separate limit for claims made by both public and private entities with respect to billing errors.*

##### For New Jersey Applicants Only - Consent to Settle

This endorsement is automatically attached to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with the New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for 1% premium credit to your policy. Would you like to remove this endorsement?

Yes  No

##### PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- Copy of current Declaration Page
- Curriculum vitae (C.V.) for applicant and each employed or contracted physician
- Loss runs from all carriers for prior 15 years, or since the start of the practice, whichever is greater
- A narrative of all past claims - a *Claim Information Form* may be used when necessary
- Signed Notice to New Applicants (APP 028 or 029) for claims made policies
- Signed Anti-Fraud Statement (Maine and New Jersey)
- Copies of each physician's license to practice and board certification.

#### READ CAREFULLY BEFORE SIGNING

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

#### REPRESENTATIONS AS TO ACCURACY OF APPLICATION, THE AUTHORITY OF PERSON SIGNING, AND APPLICANT'S OBLIGATION TO SUPPLEMENT INFORMATION

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.\*

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

**NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE**

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

**AUTHORIZATION TO OBTAIN INFORMATION**

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

**DISTRICT OF COLUMBIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**\*MAINE APPLICANTS:** THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL.

IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

**\*MARYLAND APPLICANTS:** THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**\*NEW HAMPSHIRE APPLICANTS:** THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

**NEW JERSEY APPLICANTS:** IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**PENNSYLVANIA AND RHODE ISLAND 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 PERSON TO CRIMINAL AND CIVIL PENALTIES.

**VIRGINIA APPLICANTS:** IN ACCORDANCE WITH VIRGINIA CODE 52-40, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Producer (*signature is required for N.H. producers only*)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date