SPG SPECIALTY PROGRAM GROUP

# Application

# PHYSICIANS EXTENDED REPORTING PERIOD POLICY

**THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDES CLAIMS MADE AND REPORTED COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. READ THE POLICY AND THIS APPLICATION CAREFULLY AND CONTACT YOUR PRODUCER WITH ANY QUESTIONS.**

For the purposes of this Application, "Retroactive Period" means the period of time requested in question 14 of this Application, during which a "Professional Services Wrongful Act" must be committed or allegedly committed.

**Instructions:**

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.

- Applicant's curriculum vitae (CV)
- Applicant's current medical professional liability policy
- Currently valued carrier loss runs for the previous seven (7) years

## A. ACCOUNT INFORMATION

| | | | |
|---|---|---|---|
| 1. Applicant Name | | | |
| 2. Date of Birth | | 3. Federal DEA Number | |
| 4. Mailing Address | Street: | | |
| | City: | State: County: | Zip: |
| | Telephone Number: | Email Address: | |

5. List all locations where the Applicant practiced during the requested "Retroactive Period:" (please attach a separate sheet for additional locations)

a. Practice Name: _____ Period: _____

Practice Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Telephone Number: _____ Website Address: _____ Email Address: _____

b. Practice Name: _____ Period: _____

Practice Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Telephone Number: _____ Website Address: _____ Email Address: _____

c. Practice Name: _____ Period: _____

Practice Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Telephone Number: _____ Website Address: _____ Email Address: _____

6. Practice Type:

Check all applicable types of practice during the requested "Retroactive Period:"

- ☐ Employed physician
- ☐ Solo physician
- ☐ Partnership
- ☐ Independent contractor
- ☐ Professional corporation
- ☐ Other: _____

7. Applicant's current specialty: _____ Practice %: _____

Applicant's current sub-specialty: _____ Practice %: _____

8. Did the Applicant's specialty and/or types of procedures performed change during the requested "Retroactive Period?" ☐ Yes ☐ No

If "Yes," please explain:

9. Did the Applicant performed any procedure that is outside the practice of his/her specialty or sub-specialty during the requested "Retroactive Period?" ☐ Yes ☐ No

If "Yes," please explain:

10. Is the Applicant board eligible or board certified? ☐ Yes ☐ No

If "Yes," please provide the name of the board, the date of certification and the expiration date of certification:

_____

If "No," please explain: _____

11. Please provide the following information regarding the Applicant's medical education and training:

a. Medical school

Name of school: _____ City: _____ State: _____

Year graduated: _____ Degree: _____

b. Internship

Name of school: _____ City: _____ State: _____

From: _____ To: _____

c. Residency

Name of hospital: _____ City: _____ State: _____

Year completed: _____ Specialty: _____

12. Is the Applicant a foreign medical school graduate? ☐ Yes ☐ No

If "Yes," please provide all information pertinent to the Applicant's ECFMG certification: _____

## B. CURRENT AND REQUESTED COVERAGE - Please note that requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

13. Briefly describe the reason(s) why the requested coverage is needed:

_____

14. Retroactive period: From: _____ To: _____

15. Requested effective date of coverage: _____

16. Duration of coverage: ☐ 1 Year ☐ 3 Years ☐ 5 Years ☐ 7 Years ☐ Unlimited ☐ Other: _____

17. Limits requested: Each claim: _____ Aggregate: _____

18. Limit structure requested:

☐ Limits for insured physician only

☐ Separate limits for insured physician and separate limits for insured entity (if applicable)

☐ Shared limits for insured physician and insured entity (if applicable)

Note: In all cases, any non-physician insureds share in the insured physician or insured entity limits, as applicable, unless otherwise scheduled.

Separate limits may be subject to a policy maximum aggregate limit.

19. Deductible requested: Each claim: _____ Aggregate: _____

20. **MISSOURI RESIDENTS - DO NOT ANSWER THIS QUESTION**. Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? ☐ Yes ☐ No

If "Yes," please provide details:

21. Does the Applicant's current medical professional liability policy allow the Applicant to report known facts, circumstances, situations, transactions, events, acts, errors or omissions that could give rise to a claim that would fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "No," please explain: _____

22. List current and previous medical professional liability policies for the past seven (7) years:

| Insurance Carrier | Policy Period MM/DD/YY – MM/DD-YY | Limits | Ded/SIR | Retroactive Date | Premium |
|---|---|---|---|---|---|
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## C. PRACTICE INFORMATION

23. Has the Applicant or any individual or entity proposed for coverage under this insurance ever:

a. Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐ Yes ☐ No

b. Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐ Yes ☐ No

c. Been treated for any alcohol, narcotics or substance abuse? ☐ Yes ☐ No

d. Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐ Yes ☐ No

e. Had hospital privileges reduced, suspended or revoked? ☐ Yes ☐ No

f. Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐ Yes ☐ No

If "Yes" to any of the above, please explain:

24. List all states where the Applicant is licensed to practice and the applicable license number and status:

State: _____ License number: _____ ☐ Active ☐ Inactive

State: _____ License number: _____ ☐ Active ☐ Inactive

State: _____ License number: _____ ☐ Active ☐ Inactive

State: _____ License number: _____ ☐ Active ☐ Inactive

25. During the requested "retroactive period," did the Applicant work part-time? ☐ Yes ☐ No

If "Yes," please explain:

26. Did the Applicant's practice during the requested "Retroactive Period" include the following?

☐ No surgery ☐ Minor surgery (including minor invasive procedures) ☐ Major surgery

27. Did the Applicant's practice during the requested "Retroactive Period" include any of the following:

If "Yes," please provide the percentage of practice where applicable.

a. Obstetrics? ☐ Yes ☐ No _____ % of practice

b. Weight loss/bariatric surgery? ☐ Yes ☐ No _____ % of practice

c. Pediatrics? ☐ Yes ☐ No _____ % of practice

d. Cosmetic surgery? ☐ Yes ☐ No _____ % of practice

e. Services for any professional sports organizations? ☐ Yes ☐ No _____ % of practice

If "Yes" to any of the above, please explain:

☐ Yes ☐ No

28. Within the requested "Retroactive Period," did the Applicant use any locum tenens physicians?
If "Yes," please explain:

29. During the requested "Retroactive Period," did the Applicant own, operate or control any specialized medically related unit including, but not limited to, a pharmacy, laboratory, physical therapy center or surgery center? ☐ Yes ☐ No

If "Yes," please explain:

30. Allied Health Care Providers:

Please provide the number of healthcare professionals described below who were employed by or worked under the control of the Applicant during the requested "Retroactive Period:"

_____ Certified registered nurse anesthetists

_____ Physician assistants

_____ Nurse practitioners

_____ Physical/occupational therapists

_____ Surgical assistants

_____ Psychologists

_____ Registered nurses/licensed practical nurses

_____ Other (describe): _____

## D. CLAIMS HISTORY

31. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide a completed Physician Claim Supplement for each such claim.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 31 IS EXCLUDED FROM THE PROPOSED INSURANCE.

32. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such entity, or any such individual has reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please attach details for this Application.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 32 IS EXCLUDED FROM THE PROPOSED INSURANCE.

## E. FRAUD WARNINGS

*NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY*

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.
If the coverage for which application is made is for claims made coverage, the undersigned declares that the person(s) and organization(s) proposed for this insurance understand that

(i) The coverage for which application is made applies only to "Claims" first made during the "Policy Period."

(ii) The limits of liability contained in the policy shall not be reduced by “Claim Expenses” and the Company will not be liable for the amount of any judgment or settlement to the extent that such amount exceeds the limits of liability in the policy.

WARRANTY
I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.
Must be signed by the Applicant within 60 days of the proposed effective date.

| | |
|---|---|
| _____ | _____ |
| Name of Applicant | Title |
| _____ | _____ |
| Signature of Applicant | Date |

Notice to 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 the person to criminal and civil penalties.

## F. SIGNATURE AND AUTHORIZATION

| | | |
|---|---|---|
| Applicant Signature | | |
| Print Name | | Date |

| | |
|---|---|
| Produced By (Insurance Agent) | |
| Insurance Agency | |
| Insurance Agency Taxpayer ID | |
| Agent License No. or Surplus Lines No. | |
| Address | Street:<br>City: State: Zip: |
| Email Address | |

| | |
|---|---|
| Submitted By (Insurance Agency) | |
| Insurance Agency Taxpayer ID | |
| Agent License No. or Surplus Lines No. | |
| Address | Street:<br>City: State: Zip: |

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.