COREWELL HEALTH PHYSICIANS INSURANCE COMPANY (CHPIC)

PHYSICIAN MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM

Medical Staff Member Application
and
Participation Agreement
PHYSICIAN MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM
To participate in the insurance program, an eligible medical staff member must complete in full and sign this application and agreement which, in part, describes the terms of the risk management and loss prevention programs, and the common defense feature of the professional liability insurance provided.

SECTION A: GENERAL INFORMATION

Contact Information

Name of Applicant: ________________________________________M.D./D.O./Other ______

At which Corewell Health hospital(s) do you currently have privileges?
 Dearborn    Farmington Hills    Grosse Pointe    Royal Oak
 Taylor      Trenton       Troy           Wayne

Medical Staff Membership:  □ Active  □ Attending  □ Associate  □ Ambulatory
Other, please explain:____________________________ Staff ID#: __________________

Specialty/Type of Practice: _____________________________________________________

Medical License Number: _________________ State: _________ Date of Birth: ___________

Applicant’s Email Address: ___________________________________ Gender: ___________

Pager Number: _________________________  Cell Phone Number: ___________________

Name of Practice/P.C./Partnership: ______________________________________________

Practice Website Address: ______________________________________________________

Office Manager/Contact Person: ________________________________________________

Office Manager Phone: ________________  Office Manager Email: ____________________

Main Office Address: __________________________________Suite/Building #: _________

City, State, Zip: ______________________________________________________________

Office Phone Number: ___________________  Office Fax Number: ___________________

Other office address(es): _______________________________________________________

City, State, Zip: ________________________

Office Phone Number: ___________________

Name of Practice/P.C./Partnership: ______________________________________________

Practice Website Address: ______________________________________________________

Office Manager/Contact Person: ________________________________________________

Office Manager Phone: ________________  Office Manager Email: ____________________

Main Office Address: __________________________________Suite/Building #: _________

City, State, Zip: ______________________________________________________________

Office Phone Number: ___________________  Office Fax Number: ___________________

Other office address(es): _______________________________________________________

City, State, Zip: ________________________

Office Phone Number: ___________________

Residence Address: ___________________________________________________________

City, State, Zip: ________________________

Res. phone number: _____________________
**Education/Training**

<table>
<thead>
<tr>
<th>Facility Medical School</th>
<th>City, State</th>
<th>Start Date</th>
<th>End Date</th>
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<tr>
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<td>Residency:</td>
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<tr>
<td>Fellowship:</td>
<td>___________</td>
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**Hospital Medical Staff Membership** *(Please list both Corewell Health and Non-Corewell Health Facilities)*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Classification of Membership</th>
<th>Approximate % of Patients Admitted</th>
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<tbody>
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<td>____________________________</td>
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<td>3.</td>
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1. Are you currently employed by any hospital?  _____ Yes  _____ No
   If yes, please indicate the name of the hospital(s) _______________________________________
   If yes, please provide the number of hours worked per week per your employment agreement. _______

2. For the coverage you are requesting from CHPIC, on average, what are your total hours worked including,
   but not limited to, hospital, office, home visits, nursing homes, etc. per week? __________
   *If you are employed by another hospital AND malpractice coverage is provided to you as part of your employment agreement,
     please do not include those hours in this total.*

3. Do you share or lease office space with another independently practicing physician?  ____Yes  ____No
   *(not as an employee, employer or independent contractor)*  If Yes, please explain/provide name of physician:
   ____________________________________________________________________________________

4. Will you be insured by any other medical professional liability insurance program while this insurance is in effect?
   [ ] No
   [ ] Yes  *If Yes, please attach proof of coverage from the other insurer and explain.*

5. Are you a member of Beaumont ACO, a physician and health system partnership?  (Formerly Beaumont Care Partners). *(For more information, visit www.beaumont-aco.org)*
   [ ] No
   [ ] Yes
SECTION B: PROFESSIONAL INFORMATION

IF THE ANSWER TO ANY OF THE QUESTIONS IN SECTION B. IS YES, ATTACH SEPARATE DETAILED PARTICULARS.

1. Are you licensed to practice medicine, dentistry or podiatry in the State of Michigan? YES NO
2. Please list each state and dates that you have ever been licensed and practiced in?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

3a. Please identify the current specialty that applies to your practice. (See Attachment 1 for listing)

Specialty: ___________________
Subspecialty: ___________________

No Surgery  Minor Surgery  Major Surgery

YES   NO

3b. Has your scope of specialty changed? YES NO If so, please attach an explanation with dates.
For example: 1. OB/GYN and you no longer perform deliveries
2. Orthopedic Surgeon and you no longer perform neck/back surgery

4. Have you ever had any State medical license or Federal narcotic license denied, revoked, suspended, restricted or voluntarily surrendered, or have you been subject to a consent order, probation or any conditions or limitations by any state licensing board? YES NO

5. Have you ever had your driver's license suspended or revoked due to alcohol or substance abuse or other physical disability? YES NO

6. Have you ever had or been treated for alcoholism, narcotics addiction or mental illness? YES NO

7. Have you ever been convicted of a felony or crime arising out of your medical practice? YES NO

8. Have you ever received a reprimand or been fined by any state licensing board? YES NO

9. Have you ever been investigated by any payer, including the Federal Government, related to your billing and business practices? YES NO

10. Have you ever been excluded from participating with any payer, including the Federal Government, related to your billing and business practices? YES NO

11. Have you ever been convicted at the State or Federal level related to your billing and business practices? YES NO

12. Have you ever had a chronic illness or physical defect? YES NO

13. Have you ever had any hospital staff or similar privileges refused? YES NO
SECTION B: PROFESSIONAL INFORMATION (CONTINUED)

IF THE ANSWER TO ANY OF THE QUESTIONS IN SECTION B. IS YES, ATTACH SEPARATE DETAILED PARTICULARS.

14. Have you ever had any defined hospital staff or similar privileges restricted, modified, suspended or revoked, or voluntarily surrendered in lieu of the aforementioned actions being taken?  YES  NO

15. Have you ever had your membership in a professional society refused, suspended or revoked?  YES  NO

16. Have you ever had a grievance filed against you with any licensing board or medical society?  YES  NO

17. Have you had medical professional liability insurance refused, canceled or non-renewed within the last five years?  YES  NO

18. To your knowledge, is your license to practice currently under investigation?  YES  NO

19. Have you had a claim, received a "notice of intent" or been sued for medical professional liability within the last five years and/or do you have any outstanding claims, “notices of intent” or lawsuits? (See attachment 4 for a supplemental claim form; complete a form for each claim/notice/suit)

If you have been claim free within the last five years, you are required to submit a loss run from your insurance carrier dated within the last 30 days.

20. Is your practice currently recognized as a Patient Centered Medical Home (PCMH)?  YES  NO

21. Does your office utilize Electronic Health Record (EHR) technology?  YES  NO

If YES, what is the official name of the EHR Company?_______________________________

22. Do you do stress testing in your office?  YES  NO

If yes, are you currently ACLS Certified?  YES  NO

23. Do you provide laboratory services in your office?  YES  NO

If yes, please provide the level of CLIA** certification your office holds.

**Clinical Laboratory Improvement Amendments (CLIA) level of certification should be one of the following: Certificate of Waiver, Certificate for Provider Performed Microscopy (PPM) Procedures, Certificate of Registration, Certificate of Compliance or Certificate of Accreditation

24. Do you perform any procedure involving general or regional anesthetics?  YES  NO

25. Do you reduce fractures?  YES  NO

26. Do you practice in an emergency room, trauma, urgent care or surgical center?  YES  NO

If Yes, please explain: _____________________________________________________________

27. Do you have an urgent care clinic or provide urgent care services in your office?  YES  NO
SECTION B: PROFESSIONAL INFORMATION (CONTINUED)

IF THE ANSWER TO ANY OF THE QUESTIONS IN SECTION B. IS YES, ATTACH SEPARATE DETAILED PARTICULARS.

28. Do you perform proctoscopy and/or sigmoidoscopy?   YES  NO

29. Do you perform scopic procedures which penetrate the skin or enter into the body cavity?   YES  NO
   (including, but not limited to, flexible sigmoidoscopy with biopsy, colonoscopy, gastroscopy, bronchoscopy)
   If YES, please identify those scopic procedures:

30. Do you perform biopsies?   YES  NO

31. Do you perform kyphoplasty in your office?  If yes, please provide evidence of appropriate training. Additional information may be requested.

32. Do you perform any procedures in your office or other non-hospital facility that require the use of general or regional anesthetics or intravenous sedation?   YES  NO
   If YES, who administers? _______________________________________
   AND, please attach evidence of license and appropriate training.

33. Do you deliver babies?   YES  NO

34. On average, what are your total hours worked including, but not limited to, hospital, office, home visits, nursing homes, etc. per week? _____
   If reduced due to semi-retirement, partial disability, dependent care or pregnancy, please complete Section F.

35. Have you completed your postgraduate training within the last 3 years?   YES  NO
   If YES, provide year completed __________ and complete Section H.

36. Do you perform any laser procedures in your office or other non-hospital facility?   YES  NO

37. Do you perform any dermatological procedures in your office or other non-hospital facility, including (but not limited to) Botox injections, chemical peels or Microdermabrasion?  If YES, please attach a comprehensive list of all dermatology procedures.

38. Do you participate in any pharmaceutical testing, clinical trial or clinical research programs? If YES, please attach a description.

39. Do you perform any of the following services including, but not limited to, physical therapy/rehabilitation, sleep clinic, CT’s, MRI’s or medical spa in your office?   YES  NO

40. Do you engage in any “moonlighting” activity apart from your practice?  If Yes, please explain:   YES  NO

41. Do you practice medicine on the internet or via a telemedicine program?  If YES, what is the website address and in what state(s)?   YES  NO

42. Do you practice Alternative/Supplemental Care in addition to your routine specialty in your office?  If YES, please explain and attach certification.

43. If you are not a radiologist,
   a. Do you take and/or interpret your own X-rays or perform other imaging procedures?   YES  NO
      If YES, estimated number per year: _________
      If YES, does a radiologist over-read your X-rays?   YES  NO
SECTION C: INFORMATION SECURITY & PRIVACY INSURANCE (Cyber)

Provides a comprehensive solution to privacy breaches and information security exposures, specifically tailored to the needs of physician groups.

Refer to the Summary for additional information on the Cyber policy.

Coverage is only available if all physicians employed by your practice are insured with CHPIC. If all physicians are insured with CHPIC, then your group will be issued a separate policy at no additional premium. If not all are insured, then you can either 1) request a quote for coverage (subject to additional premium) by providing the information below or 2) reject coverage. Coverage under the Cyber policy is on a claims made basis. Consequently, in the event that the Cyber policy is cancelled or non-renewed, the physician or physician group should consider purchasing tail coverage, and CHPIC will provide a premium quote. Note that the cancellation or non-renewal of the medical professional liability insurance policy will also result in the cancellation or non-renewal of the Cyber policy, unless a separate Cyber policy is purchased.

Are all physicians in your practice insured by Corewell Health Physicians Insurance Company?

☐ YES

☐ NO If NO and you would like this coverage for your group, please provide their names, insurers and limits (attach additional pages, if necessary) and we will provide you with the additional premium for the group. Otherwise, please check the box to reject the coverage offering: Reject coverage

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<tr>
<th>NAME</th>
<th>INSURER</th>
<th>LIMITS</th>
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You acknowledge and agree that any misrepresentation with respect to the above will nullify and void the information security and privacy liability insurance (Cyber) coverage issued by the Company in reliance upon this information.
SECTION D: CURRENT MEDICAL PROFESSIONAL LIABILITY INSURANCE

Insurance Co: __________________________________________________________
Policy Number: ________________________
Policy Period: ________________________
Retroactive Date: ________________________

NOTE: Physicians who currently have claims made coverage will maintain the same retroactive date on your new policy as your current policy, regardless of your desired effective date.

DOCUMENTATION REQUIRED: A copy of your current insurance “face sheet” or policy declarations page evidencing retroactive date, limits, etc. MUST be attached to this application.

Coverage Form (please check): □ Claims Made*  □ Modified Claims Made  □ Occurrence
*If Claims Made, you must complete Attachment 2 – page 15.

Current Limit of Liability: □ $100,000 per claim/$300,000 annual aggregate
□ $200,000 per claim/$600,000 annual aggregate
□ Other: _______________________________

SECTION E: MEDICAL PROFESSIONAL LIABILITY COVERAGE REQUESTED

1. Desired effective date of coverage: ______________________________

2. Coverage Form: □ Modified Claims Made  □ Claims Made

   Modified Claims Made – provides coverage for claims based upon medical incidents that occurred while the insured participated in the program regardless of when the claim is made, even if reported after the physician leaves the program. This extended reporting period (“tail”) coverage will be provided automatically through policy renewal in future years. There will be no additional premium for this enhanced “tail” coverage.

   Claims Made – provides coverage for claims reported to the insurer during that policy year which are based upon medical incidents that occurred subsequent to the effective date of coverage with the insurer issuing the policy. If the insurance is cancelled or non-renewed, there is no coverage for claims subsequently made unless extended reporting period (“tail”) coverage is purchased for an additional premium.

3. Primary Coverage: □ $100,000 per claim/$300,000 annual aggregate
□ $200,000 per claim/$600,000 annual aggregate
□ $300,000 per claim/$900,000 annual aggregate

4. Excess Coverage: □ $800,000 excess of $200,000 per claim/$600,000 aggregate Primary Coverage

Available only when $200,000/$600,000 limits are purchased from this Program and applies only to claims arising out of treatment at Corewell Health scheduled facilities. Subject to a $1,000,000 total policy aggregate. In the event the $600,000 annual aggregate limit of liability is exhausted, there shall not be any excess coverage.
SECTION F: PC/LLC/PARTNERSHIP COVERAGE

Your Professional Corporation, Limited Liability Company or Partnership will be covered as an additional insured under medical professional liability at NO ADDITIONAL charge to you. The applicable policy limits will not be increased. In all cases, professional corporation, partnership and LLC coverage extends to the entity only for liability arising out of covered activities of insured physician.

Please provide the complete Professional Corporation, Limited Liability Company or Partnership name:  
__________________________________________________________________________________________________________________________________________

Please advise your relationship with a Medical Corporation/Professional Organization as one of the following:

☐ Sole Proprietor  ☐ Employee  ☐ Other________
☐ Sole Practitioner (Incorporated)  ☐ Independent Contractor
☐ Sole Practitioner (NOT Incorporated)

Please provide the number of physicians working at the Professional Corporation, Limited Liability Company or Partnership? ______

Please list all physicians employed by the Professional Corporation, Limited Liability Company or Partnership? ____________________________________________________________________________
________________________________________________________________________________________________________________________________________

Please indicate the number of the following allied healthcare providers employed by your practice:

__ Nurse Anesthetist  __ Nurse Midwife  __ Physician Asst.  __ Nurse Practitioner
__ Perfusionist  __ Surgical Asst.  __ Nurse  __ Physical Therapist
__ EMT-Paramedic  __ Medical Asst.  Other: ______________________________

NOTE: Certain allied healthcare providers may be required to purchase their own policy. (i.e. CNM’s)

(Please continue to next page)
If you employ or otherwise supervise allied health professionals, such as physician assistants and nurse midwives, please complete the following chart identifying the allied health professionals employed by your PC, LLC or Partnership, and the level of supervision. Also include individuals who may not be employed by your PC, LLC or Partnership and whom you supervise.

<table>
<thead>
<tr>
<th>Name</th>
<th>Licensure</th>
<th>Type of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td>Physician Assistant</td>
<td>General Direct Personal</td>
</tr>
</tbody>
</table>

**General supervision** means the services of the allied health professional are furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the services.

**Direct supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the services of the allied health professional. It does not mean that the physician must be present in the room when the allied health professional performs his or her services.

**Personal supervision** means a physician is in attendance in the room during the performance of the allied health professional’s services.

1. Do you supervise any healthcare providers other than those employed by your practice?  
   If YES, please list facility, specialty, licensure, number supervised and type of supervision:

2. Do you supervise any residents or interns in your office?  
   If YES, please list facility, specialty and number supervised: 

3. Do you contract with any third party to provide medical services in your office?  
   If YES, please attach a description of the medical service provided including the name of the third party.

4. Do you wish to purchase ADDITIONAL limits of liability for your medical organization? **There is an additional charge for this coverage.**  
   If YES, please complete Attachment 3 – page 16.
SECTION G: SUPPLEMENTAL APPLICATION FOR PART-TIME PHYSICIAN RATES AND STATEMENT OF ELIGIBILITY REQUIREMENTS

Part-time status is verified, and attested to by a witness, upon the initial application and each renewal and may be verified, as requested, by the Program either through payroll records, periodic statement of hours worked or an on-site (office) audit.

A physician is eligible for part-time coverage if he or she satisfies general participation eligibility requirements and:

1. The physician must either:
   a. be semi-retired to age (55 or older);
   b. have reduced practice due to partial disability; or
   c. have reduced practice due to pregnancy or dependent care
   d. for any other reason, have reduced practice to 30 hours per week or less

2. I am eligible for part-time rates by virtue of Criteria________
   (Please insert the appropriate letter a, b, c or d from 1. above).

3. On average, what are your total hours worked including, but not limited to, hospital, office, home visits, nursing homes, etc. per week? __________

I certify that I have read and understand the above part-time criteria.
I agree to cooperate and assist the program in verifying my part-time status.

Applicant Signature: ________________________   Date: ______________________
Witness Signature:  _________________________  Date: ______________________

SECTION H: SUPPLEMENTAL APPLICATION FOR POST-TRAINING PHYSICIAN RATES AND STATEMENT OF ELIGIBILITY CRITERIA

A physician is eligible for post-training rates if he or she satisfies general participation eligibility requirements and:

The physician must be entering private practice within three years of having completed his/her post graduate training (residency, fellowship or military service) without having had any previous practice.

I certify that I have read and understand the above post-training criteria and I state that I am eligible for such premium discount by virtue of having completed my ________________ (training) at ____________________________ (institution) on ___________ (date).

Applicant Signature: ________________________   Date: ______________________
SECTION I: RISK MANAGEMENT, LOSS ASSESSMENT AND COMMON DEFENSE

I agree that I will adhere to the following program requirements:

1. To participate in the complimentary office assessment, including facility and patient record review.

2. Comply with risk management and quality assurance programs and recommendations made by any Corewell Health affiliated hospital or Corewell Health Physicians Insurance Company and to cooperate with each of them in achieving loss prevention and risk management objectives.

To accept defense counsel selected by Corewell Health Physicians Insurance Company for all claims against me. I understand that joint defense will be provided by counsel selected by Corewell Health Physicians Insurance Company should a claim be asserted against me and any Corewell Health affiliated hospital and/or other insured physicians. I also understand that separate counsel for me will be selected by Corewell Health Physicians Insurance Company if it determines that joint defense may not be appropriate in a given situation. In the event I desire to select independent co-counsel, the expense of that co-counsel will be borne by me.

3. To cooperate in the defense and investigation of all claims against or involving me.

Applicant Signature: ________________________   Date: ______________________

REMINDER.....

PLEASE ATTACH THE FOLLOWING DOCUMENTS TO THIS APPLICATION:

- Please provide a list of your clinical privileges at all hospitals at which you hold staff privileges.
- Please provide a copy of your current insurance “face sheet” or policy declarations page.
- Please provide your complete loss history from current insurer dated within last 30 days, which should include a minimum of all claims reported since January 1, 2017.
- Supplemental Claim Information Form (Attachment 4) for each notice of intent, claim or lawsuit, regardless of outcome.

If any of these documents are unavailable, please attach an explanation.
SECTION J: AUTHORIZATION, CERTIFICATION AND ACKNOWLEDGEMENT

Authorization: I authorize and release Corewell Health Physicians Insurance Company, its designee(s), their directors, or agents (herein called “insurer”) from all liability for obtaining information from individuals or institutions concerning me, my competence or qualifications and eligibility for the insurance program.

I also authorize and release the insurer from all liability for obtaining from any hospital any and all information regarding any proceedings or action taken by any hospital regarding appointment, reappointment and/or clinical privileges (including the grant, extension, reduction, suspension or termination thereof), utilization review or quality assurance information and any other information concerning my competence and qualifications that the insurer feels is pertinent. I also authorize insurer to share with Corewell Health and its affiliated hospitals any and all information it obtains in connection with reviewing my application and, if applicable, providing coverage to me that relates to my professional competence or conduct.

I consent to the release of all individuals from any liability who submit information at the request of the insurer to facilitate the assessment of my qualifications for insurance coverage which include my professional competence, character and ethics. I release from liability and hold harmless the insurer for acts in good faith and without malice in connection with the evaluation of my qualifications.

The authorization, release and consent set forth above apply to this application and any subsequent renewal application submitted by me or someone acting on my behalf.

Certification: I certify that all information provided in connection with this application is true, accurate and complete to the best of my knowledge. I understand that any material misrepresentation or omission in this application shall automatically void any and all coverage which may be issued to me.

I further certify that I meet the following eligibility requirements: (1) active, attending, associate or ambulatory medical staff of a Corewell Health affiliated hospital; (2) valid Michigan license; (3) actively support and participate in risk management and quality assurance programs; and (4) participate in office assessments.

Acknowledgment: I acknowledge that I am obligated to notify the insurer, within thirty (30) days of the date of change, of any change in the scope of my practice, my clinical privileges at any institution, the procedures I perform, or other factors which may affect the risk under all policies by which I am insured.

NOTE: THIS APPLICATION WILL NOT BE PROCESSED UNTIL IT IS FULLY COMPLETED. "FULLY COMPLETED" MEANS YOU HAVE FILLED IN ANSWERS TO ALL QUESTIONS, PROVIDED SEPARATE EXPLANATIONS WHERE NECESSARY, SIGNED IN THE APPROPRIATE PLACES, COMPLETED SUPPLEMENTARY CLAIM FORM FOR EACH OUTSTANDING CLAIM/LAWSUIT AND ALL CLOSED CLAIMS/LAWSUITS AND ATTACHED THE CURRENT DECLARATIONS PAGE FROM EXISTING INSURANCE CARRIER.

_____________________________________ __________________
Applicant Signature   Date
ATTACHMENT 1: SPECIALTY CLASSIFICATION

For classification assignment purposes, the following phraseology is defined:

1. The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia, proctoscopy, sigmoidoscopy, or laparoscopy), and who do not ordinarily assist in surgical procedures.

2. The term "minor surgery" applies to general practitioners and specialists who perform minor surgery (including obstetrical procedures not constituting major surgery) or assist in major surgery on their own patients. Minor surgery will include laser procedures, catheterization, cardioelectrophysiology, endoscopy (other than proctoscopy or sigmoidoscopy) and vasectomies.

3. The term "major surgery" applies to general practitioners and specialists who perform surgery, other than minor surgery, and to those who assist at major surgery on other than their own patients. Tonsillectomies, adenoidectomies, hemorrhoidectomies, diagnostic D&C's and vacuum curettage abortions during the first trimester of pregnancy are considered major surgery.

CLASSIFICATIONS: (Please mark all classifications which apply to your practice.)

[ ] Abdominal Surgery  [ ] Neurosurgery
[ ] Aerospace Medicine  [ ] Nuclear Medicine
[ ] Allergy  [ ] Nutrition
[ ] Anesthesiology  [ ] OB/GYN
[ ] Broncho-Esophagology Surgery  [ ] Obstetrical Surgery
[ ] Cardiac Surgery  [ ] Occupational Medicine
[ ] Cardiology  [ ] Oncology
[ ] Cardiovascular Disease  [ ] Ophthalmology
[ ] Colon & Rectal Surgery  [ ] Oral Surgery
[ ] Dermatology  [ ] Orthopedic Surgery
[ ] Diabetes  [ ] Orthopedic Surgery – No Neck or Back
[ ] Emergency Medicine  [ ] Otology
[ ] Endocrinology  [ ] Otorhinolaryngology
[ ] Family Practice  [ ] Pathology
[ ] Forensic/Legal Medicine  [ ] Pediatrics
[ ] Gastroenterology  [ ] Pharmacology
[ ] General Practice  [ ] Physical Medicine/Rehabilitation/Physiatry
[ ] General Surgery  [ ] Plastic Surgery
[ ] Geriatrics  [ ] Plastic/Otorhinolaryngology Surgery
[ ] Gynecology (No OB)  [ ] Podiatry
[ ] Hand Surgery  [ ] Psychiatry
[ ] Head & Neck Surgery  [ ] Pulmonology
[ ] Hematology  [ ] Radiology
[ ] Infectious Disease  [ ] Rheumatology
[ ] Intensive Care Medicine  [ ] Rhinology
[ ] Internal Medicine  [ ] Thoracic Surgery
[ ] Laryngology  [ ] Trauma Surgery
[ ] Nephrology  [ ] Urology
[ ] Neurology  [ ] Vascular Surgery
ATTACHMENT 2: STATEMENT OF NO KNOWN INCIDENTS

Physicians who currently have claims made coverage must sign and date the following Statement of No Known Incidents in order to maintain the same retroactive date on your new policy as your current policy.

STATEMENT OF NO KNOWN INCIDENTS
I am requesting claims made coverage with a retroactive date of: _______________

My signature below confirms: As of the date hereof, I am not aware of any medical incidents which could reasonably result in a claim being made against me, arising out of the rendering or failure to render professional services on or after the retroactive date listed above. I have no knowledge of any request for medical records which might result in a claim. No prior professional liability carrier has refused coverage for, or declined to accept a report of a medical incident, threat of a claim, letter of intent, adverse result notice or attorney contract. Further, I have reported any and all previously received notices of intent or other assertions of claims to my current insurer.

________________________________________  ___________
Applicant Signature                     Date
ATTACHMENT 3: ADDITIONAL PC/LLC/PARTNERSHIP LIMIT OF LIABILITY

Professional Corporation, Limited Liability Company or Partnership coverage ("medical organization") is available for an additional premium should you desire to purchase separate limits of liability for your medical organization. All physician, dentists, or podiatrist members and employees of your medical organization must obtain coverage with the same limits of liability through the program in order to purchase the additional limits. Only primary limits are available to the medical organization.

Do you wish to purchase ADDITIONAL limits of liability for your medical organization?
There is an additional charge for the coverage.

YES  ☐  NO  ☐

1. Please provide name of Professional Corporation, Limited Liability Company or Partnership:

________________________________________________________________________

2. Please list all medical staff (each licensed, certified or registered physician, nurse, nurse practitioner, surgical assistant, physician’s assistant, certified nurse midwife or other allied health personnel you employ, sponsor or supervise*) members who participate in the professional corporation, limited liability company or partnership (provide additional listing if needed).

<table>
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<tr>
<th>Name</th>
<th>Licensure</th>
<th>Type of Supervision</th>
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<tbody>
<tr>
<td>Ex: John Smith, M.D.</td>
<td>Physician</td>
<td>General: N/A</td>
</tr>
<tr>
<td>Ex: Jane Doe</td>
<td>Physician Assistant</td>
<td>Direct: X</td>
</tr>
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*General supervision means the services of the allied health professional are furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the services.

*Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the services of the allied health professional. It does not mean that the physician must be present in the room when the allied health professional performs his or her services.

*Personal supervision means a physician is in attendance in the room during the performance of the allied health professional’s services.

*This list is for underwriting purposes only and does not result in coverage for those listed hereon.
ATTACHMENT 4: SUPPLEMENTAL CLAIM INFORMATION FORM

Copy this form as needed; a separate form must be completed for each claim, “notice of intent” or lawsuit reported.

1. Age and gender of patient: _________________________________________________
   *(PLEASE DO NOT PROVIDE PATIENT NAME)*

2. Date of first consultation: __________________________________________________

3. Physical condition and diagnosis on above date: __________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

4. Dates of treatment given and nature of same: _____________________________________
   _______________________________________________________________________
   _______________________________________________________________________

5. Date of claim, “notice of intent” or lawsuit and allegations made against you:
   _______________________________________________________________________

6. Disposition of claim (i.e. open, closed dismissed) and amount of judgement, reserves or settlement:
   _______________________________________________________________________

7. What professional liability insurance company, if any, is covering this claim on your behalf:
   _______________________________________________________________________

8. What limits: $_____________________/$_____________________

9. Subsequent condition of patient: _____________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

10. Provide names of other physicians/hospitals, if any, involved in the claim, notice or lawsuit:
    _______________________________________________________________________
    _______________________________________________________________________

11. Provide name and phone number of someone we contact for additional information about this claim, notice or lawsuit:
    _______________________________________________________________________
    _______________________________________________________________________

_____________________________________ __________________
Applicant Signature   Date
ATTACHMENT 5: INSTALLMENTS

The program includes an installment payment option for payment of premium if your premium is in excess of $5,000 and you join the program between January 1 and June 30. You have no obligation to elect the installment payment option, and if you wish, you may choose to pay 100 percent of your annual premium within 30 days of the effective date of your coverage for that policy year (the “Effective Date”). If you elect to pay the premium in one lump sum you will pay a lower cash discount base rate. If you choose the installment payment option, a slightly higher base premium rate will apply. The differential added to yield this higher rate is the time charge for the additional administrative costs associated with processing installment payments and also recognizes the delayed timing of cash flow.

If you elect the installment payment option, your premium, at the higher base rate applicable to this option, must be paid as follows:

a) 40% of total annual premium for a policy year due and payable within 30 days of the Effective Date;
b) 30% of total annual premium due and payable on or prior to 90 days after the Effective Date; and
c) 30% of total annual premium due and payable on or prior to 180 days after the Effective Date.

You have no obligation to prepay any payment. If you elect the installment payment option, full payment of all the annual premium on or prior to the dates specified in paragraphs a) through c) above will be a condition precedent to coverage under the policy for you, and nonpayment of any of the foregoing amounts on or prior to ten days after the date on which written notice of cancellation is mailed to you, with postage fully prepaid thereon, will cause immediate termination of all of your coverage as of the date specified in the notice of cancellation as to all claims (including covered expenses) made on or after the date of cancellation specified in the notice of cancellation. If coverage has been terminated as described in this paragraph, later payments will not reinstate any such coverage.

IF YOU ELECT THE INSTALLMENT PAYMENT OPTION, YOU ARE AGREEING TO ALL OF THE TERMS AND CONDITIONS SET FORTH IN THIS SECTION. YOUR SIGNATURE IS ALSO AN ACKNOWLEDGEMENT THAT YOU DESIRE TO PURCHASE INSURANCE COVERAGE FOR YOUR PROFESSIONAL ACTIVITIES, THAT ALL OF THE TERMS AND CONDITIONS OF YOUR PAYMENT OPTION SET FORTH IN THIS SECTION HAVE BEEN FULLY EXPLAINED TO YOU AND YOU UNDERSTAND AND AGREE TO ALL SUCH TERMS AND CONDITIONS.

☐ I elect to pay my premium in full within 30 days of the Effective Date of my coverage.  
☐ I elect to pay my premium through the installment option as described above.  
   (Subject to eligibility and minimum premium of $5,000)

(Please note: If neither payment option is checked, then premium will be due in full within 30 days of the Effective Date of coverage)

________________________________________    __________________________
Applicant Signature      Date