Compsolutions Agency, Inc.

PO Box 3337 Wayne , NJ 07474-3337
800-951-0199
F 973-587-7889

Date:

To:
Phone:
Fax:

From:
Phone:
Fax:

Re:

Pages:

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MFHA-IPA Corporation Inc

Physicians' & Surgeons'

Medical Professional Liability Insurance Program

Application Form

With your fully completed, signed and dated application, you ***must*** submit the following information:

- ☐ Copy of last **five (5) years currently valued**, first-dollar loss experience including paid and reserved losses. Provide complete details (incident date, report date, description of incident, and all codefendants) for any loss paid or reserved for all Open and Closed Claims **over $25,000**.
- ☐ Copy of Current Declarations page;
- ☐ If educated outside of the United States, please attach a copy of your ECFMG Certification;
- ☐ Copy of current Medical License(s) & Board Certification(s);
- ☐ Current Copy of Curriculum Vitae ("CV") or Professional Resume

FAILURE TO PROVIDE THE INFORMATION ABOVE MAY RESULT IN A DELAY IN THE COMPLETION OF THE UNDERWRITING PROCESS.

You must be a member of the MFHA-IPA Corporation, Inc. to receive additional premium credits applicable to the MFHA-IPA Corporation, Inc. Medical Malpractice Insurance Program.

NOTE:

A submission of a completed application confers no obligation upon the Company to bind coverage.

MFHA-IPA Corporation Inc

Physicians' & Surgeons'
Medical Professional Liability Insurance Program Application Form

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

SECTION I

Requested Effective Date:___________________________

A. GENERAL INFORMATION:

Applicant Name: (First, MI, Last) ________________________________

Degree: ☐ M.D. ☐ D.O. ☐ D.P.M. Date of Birth: ____________________

Social Security Number: ____________________

B. OFFICE INFORMATION:

1.) **Primary**
Office Address: ______________________________
____
City County State Zip

Office Phone: ( ) ________________
Office Fax: ( ) ________________
E-Mail: ____________________

Percent of Practice at Primary Office Location: ____ %

2.) **Secondary**
Office Address: ______________________________
____
City County State Zip

Office Phone: ( ) ________________
Office Fax: ( ) ________________
E-Mail: ____________________

Percent of Practice at Secondary Office Location: ____ %

If additional locations are applicable, please attach a schedule of locations with percentages and number of hours and patients seen per week at each location. Percentage of Practice for all locations combined (including Primary and Secondary Locations) must equal 100%.

3.) Mailing Address: ☐ Primary Office ☐ Secondary Office ☐ Other: *(Please provide full address below)*

____

C. TYPE OF PRACTICE: **Check (√) type of practice for which you are applying.**

☐ Individual/Solo Practice (*Unincorporated*) ☐ Individual/Solo Practice (*Incorporated*)

☐ Professional Corporation, Limited Liability Corporation or Professional Limited Liability Corporation

☐ Employed Physician ☐ Partner, Shareholder or Member

☐ Independent Contractor ☐ Other: (Please explain) _____

1.) If you have checked any boxes above *other than* "Individual/Solo Practice (Unincorporated)", please provide the following information:

Name(s) of Entity(ies) / Employer(s)	Is Coverage Desired for the Entity?
	☐ Yes ☐ No

Coverage for your Professional Corporation is not automatic. It must be approved by underwriting and endorsed on your policy for coverage to be applicable.

Please Note: If you are an Individual/Solo Practitioner who is incorporated, there is not an additional cost associated with your Professional Corporation to share in your limits of liability.

SECTION II

D. EMPLOYEE INFORMATION: **If "None" applies, check here:** ☐

Description	Number
Nurses	________
Medical Assistants	________
X-Ray Technicians	________
Physical Therapists	________
Other: (Describe Below)	________

____

E. PHYSICIAN EXTENDER INFORMATION: **If "None" applies, check here:** ☐

Description	Number Employed	Number Contracted	Number you supervise, but are neither employed nor contracted by you
Nurse Practitioner(s)			
Physician Assistant(s)			
Certified Registered Nurse Anesthetist(s)			
Certified Nurse Midwives			

1.) Do you desire coverage for your employed/contracted Physician Extender(s) (i.e., NP's, CRNA's, CNM's, PA's)? ☐ Yes ☐ No

Please note: If coverage is being requested for your Physician Extender(s), the Physician Extender(s) must please complete a JMW Physician Extender Medical Professional Liability Application. <u>If you employ a Physician Extender(s) and coverage will be maintained with another insurance carrier, please include a copy of the Physician Extender's policy declarations with your application submission. Failure to provide this documentation could delay your underwriting analysis.</u>

SECTION III

F. MEDICAL LICENSES & REGISTRATIONS:

1.) Please list all state medical licenses including pending, expired and inactive. Please attach additional pages as necessary.

Medical License Number	State	Expiration Date:	☐ Active ☐ Inactive/Expired ☐ Pending
Medical License Number	State	Expiration Date:	☐ Active ☐ Inactive/Expired ☐ Pending

2.) DEA Registration Number: ____________ Expiration Date (mm/yyyy): ______________

G. HOSPITAL AND/OR AMBULATORY SURGERY CENTER PRIVILEGES:

If "None" applies, check here: ☐

Below, please list all of the hospitals and/or ambulatory surgery centers at which you are currently a staff member or to which you are applying for privileges. If additional facilities are applicable, please attach additional pages.

FACILITY TYPE	NAME OF FACILITY	CITY	TYPE OF PRIVILEGES
☐ Hospital ☐ Ambulatory Surgery Center			☐ Active Type/Extent: ☐ Pending
☐ Hospital ☐ Ambulatory Surgery Center			☐ Active Type/Extent: ☐ Pending
☐ Hospital ☐ Ambulatory Surgery Center			☐ Active Type/Extent: ☐ Pending

SECTION IV

H. COVERAGE REQUESTED:

1.) Medical Specialty

Primary Specialty	Percent of Primary Specialty Practice	Sub-Specialty	Percent of Sub-Specialty Practice
	%		%
☐ No Surgery ☐ Minor Surgery ☐ Major Surgery		☐ No Surgery ☐ Minor Surgery ☐ Major Surgery	

The following specialties require a Specialty Specific Supplemental Questionnaire be completed.

- Anesthesiology
- Ophthalmology (if Surgical)
- Plastic Surgery
- Cosmetic and/or Aesthetics
- Orthopedics (if Surgical)
- Radiology
- Gynecology
- Pain Management
- Sports Medicine
- Obstetrics
- Physical Med & Rehab

2.) Requested Coverage Type: ☐ Occurrence ☐ Claims Made

3.) Request for Prior Acts ("Nose") Coverage:
☐ Yes ☐ No

The following criteria must be met for requesting Prior Acts Coverage:

√ You are presently covered on a Claims Made basis; *and*
√ You are not purchasing "Tail" coverage from your prior carrier; *and*
√ You are applying for Claims Made coverage with JMW; *and*
√ There is no coverage lapse/gap between the cancellation date of your current Claims Made policy and the requested effective date of your JMW coverage.

4.) Requested Retroactive Date: ____________________
Month/Day/Year

Please note: If prior acts coverage is requested please complete "***Supplemental A***" (Prior Acts Supplement) included within this application. *Please attach a copy of your current, Policy Declarations to this application.*

5.) Requested Limits of Liability:

☐ $1,000,000 / $3,000,000
☐ $1,300,000 / $4,900,000
☐ $2,000,000 / $6,000,000
☐ $1,000,000 / $4,000,000 (CT ONLY)
☐ $2,000,000 / $4,000,000
☐ $2,300,000 / $6,900,000 (NY ONLY)
☐ $1,300,000 / $3,900,000
☐ $2,000,000 / $5,000,000

6.) Total Number of Hours worked per week for all locations to which this coverage should apply. _____hrs./week*

* *Number of hours reflected should include patient care, hospital rounds, completion of patient medical records and consultations.*

7.) ***PART-TIME APPLICANTS ONLY:*** *If the total number of hours worked each week for all locations is less than or equal to 20 hours per week, you may qualify for a part-time premium credit. Please complete the following for determination of eligibility. Additional documentation may be required, at the underwriter's discretion.*

Date in which you began practicing 20 hours or less per week. _____ (MM/DD/YYYY)

Will you be practicing 20 hours or less per week for at least the next year? ☐ Yes ☐ No _____(*Initial here*)

SECTION V

If you have answered "Yes" to any questions below, please explain in the *REMARKS* section on Page 8 of this application.

I. UNDERWRITING QUESTIONS:

Question	Yes	No
1.) Has your license to practice medicine in any state or country or your permit to prescribe drugs ***EVER*** been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it ***EVER*** been or is it currently under investigation?	☐ Yes	☐ No
2.) Have you ***EVER*** been (or are you currently being) reviewed investigated or fined by any state licensing board of medical examiners, DEA, or governmental body or accrediting agency (public or private)? *If "Yes", please attach a copy of the applicable documents.*	☐ Yes	☐ No
3.) Have you ***EVER*** been denied a license or certification to practice?	☐ Yes	☐ No
4.) Have you ***EVER*** been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	☐ Yes	☐ No
5.) Have you ***EVER*** been treated for alcoholism or other chemical dependency?	☐ Yes	☐ No
6.) Have you ***EVER*** been convicted of a criminal offense?	☐ Yes	☐ No
7.) Have you ***EVER*** incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair your ability to practice medicine?	☐ Yes	☐ No
8.) Have you ***EVER*** been investigated for or had any sexual misconduct or battery allegations filed against you?	☐ Yes	☐ No
9.) Have you practiced continuously for the past ten (10) years?	☐ Yes	☐ No
10.) Have your practice specialties and/or procedures changed in the past five (5) years?	☐ Yes	☐ No
11.) Do you perform any work, either full-time or part-time, for any state government or the federal government?	☐ Yes	☐ No
12.) Are you on active duty in the U.S. military service?	☐ Yes	☐ No
13.) Are you engaged in any "moonlighting" activities?	☐ Yes	☐ No
14.) Are you providing any other medical services for which you do not need coverage with JMW?	☐ Yes	☐ No
15.) Do you provide any "call coverage" for physicians outside of your practice specialty?	☐ Yes	☐ No
16.) Do you operate, own or have majority interest in a nursing home, hospital, sanitarium, laboratory, med spa or any surgical center facilities?	☐ Yes	☐ No
17.) Do you normally staff an emergency room other than on rotational call? If "Yes", how often:____	☐ Yes	☐ No
18.) Do you normally take on-call rotation in the ER? When on call, frequency of rotation and average hours in the ER per month:______________	☐ Yes	☐ No
19.) Do you provide medical services at any Nursing Home?	☐ Yes	☐ No
20.) Do you have any Medical Director responsibilities of which coverage is needed?	☐ Yes	☐ No

Question	Yes	No
21.) Have you ***EVER*** had privileges at any hospital, ambulatory surgery center or any other institution reduced, suspended or revoked?	☐ Yes	☐ No
22.) Has your current medical malpractice insurance company insured you for at least the last five (5) consecutive years?	☐ Yes	☐ No
23.) Have you ***EVER*** practiced without medical malpractice insurance or allowed your claims-made policy to lapse without the purchase of tail or prior acts ("nose") coverage?	☐ Yes	☐ No
24.) Have you ***EVER*** had medical professional liability insurance refused, declined, cancelled or non-renewed?	☐ Yes	☐ No
25.) Have you been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last five (5) years, including any expression of an intent (i.e., closed records requests, incident reports and Notices of Intent, even if suit was never filed), or are you presently involved in a malpractice litigation?	☐ Yes	☐ No
a. A request for records from a patient and/or attorney related to an adverse outcome?	☐ Yes	☐ No
b. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient?	☐ Yes	☐ No
c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities?	☐ Yes	☐ No
d. Have any unexpected or potentially problematic results or incidents occurred in the past five (5) years in the following categories:	☐ Yes	☐ No
(i.) Cardiac arrest	☐ Yes	☐ No
(ii.) Postoperative coma	☐ Yes	☐ No
(iii.) Postoperative neurological deficits	☐ Yes	☐ No
(iv.) Unexpected death within 48 hours postoperatively	☐ Yes	☐ No
(v.) All others)____	☐ Yes	☐ No
26.) Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis?	☐ Yes	☐ No
27.) Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits (even if you believe the outstanding claim or suit would be without merit) that have not been reported to your current or prior professional liability carrier?	☐ Yes	☐ No
28.) Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? If "Yes", please describe below.	☐ Yes	☐ No

Please note: The JMW policy specifically excludes Clinical Trials and the use or prescription of Non-FDA approved drugs, substances or medical devices.

29.) List any unusual procedure that you perform within or outside of your specialty: If "None" applies, check here: ☐

If you have answered "Yes" to any questions above, please explain in the REMARKS section on Page 8 of this application.

REMARKS:

Question #	

IMPORTANT NOTICE

Information provided within this application will be the basis on which a policy will be issued. Therefore, all questions must be answered fully and accurately. Your submission to the Insurer of a completed application provides no guarantee that the Insurer will bind coverage for you.

If coverage is bound, the Policy will be issued by J.M. Woodworth Risk Retention Group, Inc. Your Risk Retention Group may not be subject to all the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for J.M. Woodworth Risk Retention Group, Inc. Therefore, these funds will not pay your claims to protect assets if the J.M. Woodworth Risk Retention Group, Inc., the Insurer, becomes insolvent and is unable to make payments as promised.

J.M. Woodworth Risk Retention Group, Inc. is a stock association captive insurance company authorized by the Commissioner of Insurance of the state of Nevada. The Risk Retention Group was formed to insure the liability risks of its physician and surgeon members.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGINGLY 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 ACT, WHICH IS A CRIME AND MAY SUBECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM OR EACH SUCH VIOLATION.

NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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THE APPLICANT REPRESENTS THAT ALL WRITTEN STATEMENTS, SUPPLEMENTAL APPLICATIONS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND WILL BECOME PART OF THE POLICY AS IF IT WERE ATTACHED.

____

Signature of Applicant *Date*

____

Printed Name

"SUPPLEMENT A"

REQUEST FOR PRIOR ACTS COVERAGE FORM

This form must be completed, signed or dated if requesting prior acts from JM Woodworth RRG, Inc. Additional information should be placed in the REMARKS section of this application on Page 8.

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1. Name of Applicant: ________________________________
2. Retroactive coverage effective date applying for: ______________
3. Limits of Liability Requested: ______________________________
4. Did you practice as part of a partnership or corporation during the prior acts period? ☐ Yes ☐ No

   If yes, name(s) of corporation/partnership: ________________________________
5. Have you reported any incidents/potential claims to a carrier during the prior acts period? ☐ Yes ☐ No ☐N/A
6. Did you practice in another state during the prior acts period requested? ☐ Yes ☐ No

   If yes, please list states: ______________________________
7. Did you function as a Medical Director for any facility during the prior acts period requested? ☐ Yes ☐ No

   If yes, name of facility: ______________________________

   Length of time there: Medical Director **FROM:** ______________ **TO:** ______________

   Did you/do you admit patients to the above facility? ☐ Yes ☐ No
8. Are you a hospitalist? ☐ Yes ☐ No

   If yes, state the name of the facility: ______________________________
9. Do you treat or admit patients at a nursing home? ☐ Yes ☐ No

   If yes, how many patients per month? ______________________

I understand that, if granted prior acts coverage by JMWRRG, such coverage will apply only to liability arising out of incidents which happened prior to the effective date and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

1. Any claim which has been reported to another insurance carrier prior to the effective date.
2. Any claim known to the Insured at the effective date, which has not been reported to a prior carrier.
3. Any claim which may arise out of an incident, which has been reported to another insurance carrier prior to the effective date.
4. Any incident which the Insured has reason to believe might result in a claim, but which has not been reported to a carrier.

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge, and that I know of no other relevant facts which might affect the underwriter's judgment when considering the application or which might be material to the underwriter's risk. I further authorize release of any underwriting or claim information from all prior and current carriers, professional societies or associations, or hospitals to the JM Woodworth RRG, Inc.

______________________________ ______________________________

Signature of Applicant Date

No coverage will be bound until after the Insurer has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment in advance of review of the application is not an expression of the Insurer's intent to provide coverage. If coverage is refused by the Insurer, any advance payment will be returned.

SUPPLEMENTAL CLAIMS INFORMATION FORM

Please Type or Print clearly.

Check here if "None" and sign below: ☐

1. Name of Patient ______________________ 2. Age ________ 3. Sex: ☐ Male / ☐ Female

4. Your relationship to patient (i.e., attending physician, primary surgeon, assistant surgeon): ______________________

5. Allegation(s) as stated by patient/plaintiff: ______________________

6. Date of Incident: __________ 7. Date Reported to Carrier ________ 8. Location: ______________________

9. Insurance Carrier(s): ______________________

10. Other Defendants: ______________________

11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? ☐Yes ☐ No

12. Present Status ☐Incident Only ☐Pending Suit ☐Closed ☐ Settlement / ☐ Judgment

Date Closed:______ Amount Paid:$_____

13. Condition and diagnosis at time of treatment:

14. Dates and description of treatment rendered:

15. Condition of patient after treatment (include DATES & FOLLOW-UP TREATMENT): ______________________

16. Defense Counsel: ______________________

17. Plaintiff's Counsel: ______________________

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE:____________________________________

DATE: ________________________