# Medical Corporation Professional Liability Insurance Application

**ProAssurance American Mutual, A Risk Retention Group**
PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • 205.877.4400 • Fax 205.868.4040

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With your fully completed, signed and dated application, please submit the following information:

1. Current insurance policy declaration page.
2. Written verification of the purchase of a reporting endorsement (tail) from your present carrier if your current coverage is claims-made and you are *not* applying for prior acts coverage.
3. Articles of Incorporation (including amendments).
4. Current business letterhead.
5. Roster of all health care providers, including paramedicals, who practice with this organization. (See section 4.B. for providers considered paramedical.) Any paramedical or physician requesting coverage must submit a healthcare provider application.
6. Loss runs from prior insurance companies or explanation as to why they are not available.

Note: Submission of a completed application confers no obligation upon the Company to bind coverage.

## 1. Organization Information

Organization Name: _____

Federal Tax ID: _____-_____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Preferred Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ Email: _____

Is this contact the authorized representative for access to policy information at ProAssurance.com? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative: _____

**Please list additional practice locations:**

Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership
☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other: _____

B. Has the Organization ever been incorporated under a name other than that listed above? Yes ☐ No ☐
If yes, please list all previous names and the first use date of each:

_____

C. Is or has the Organization ever been incorporated in a state other than that listed above? Yes ☐ No ☐
If yes, please list states and first use date in each:

_____

D. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

E. List other separate entities for which coverage is requested not listed above:

_____

_____

## 2. Coverage Requested

A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR

B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
Excess Coverage Limits (where available): _____

C. Deductible amount (where available): $_____
☐ Indemnity Only ☐ Indemnity & Expense ☐ None

D. Is the organization requesting Prior Acts Coverage? Yes ☐ No ☐
Requested Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.

## 3. Professional Liability Insurance and Claims History

A. Current Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Have any claims or suits ever been filed against your organization as a result of professional services? Yes ☐ No ☐

D. Are you aware of any conduct, circumstances, occurrences, or incidents likely to give rise to a claim? Yes ☐ No ☐

E. If you are answered "yes" to question 3.C. or D., have the claims, conduct, circumstances, occurrences, or incidents been reported to a previous insurer? (Please complete the Supplementary Claims information form at the end of the application.) Yes ☐ No ☐

F. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes ☐ No ☐
If yes, please describe in the space provided at the end of the application.

## 4. Practice Information

A. List all physicians who will be *insured elsewhere* and provide proof of coverage. Please provide explanation in the space provided at the end of the application.

| Name | Specialty | Current Insurer |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

B. List all paramedicals who will be *insured elsewhere* and provide proof of coverage.

| Name | Specialty | Current Insurer |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*Paramedicals include a person practicing as a nurse midwife, nurse anesthetist, nurse practitioner, physician assistant, surgical assistant, cytotechnologist, or any person licensed, certified or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician.

C. Do physicians/individuals not affiliated with your organization use your facilities and/or equipment? Yes ☐ No ☐

D. Is the organization or any member physician whole or part owner in any medical professional joint venture outside of this practice? Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

E. Is this organization considered a medical spa? Yes ☐ No ☐

## 5. Hospital Affiliations and Privileges of the Group

A. Please list all hospitals where you have active privileges or a pending application.

Hospital 1 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

Hospital 2 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

Hospital 3 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

Hospital 4 Name: _____ Percentage of your patients admitted into this facility: _____%

Location: _____

B. Does your hospital require you to remain in-house for VBAC patients? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

C. Are fetal monitoring strips stored digitally? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

D. Can the physician(s) remotely view the hospitals' electronic fetal monitoring (EFM) strips? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

E. Does the hospital require physicians to have EFM interpretation certification to grant OB privileges? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

F. Do any of these hospitals use laborists? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

G. Does each of the hospital(s) where the physicians deliver require specialty specific certification for their perinatal nurses? Examples include: the Neonatal Resuscitation Program (NRP), the Association for Women's Health, Obstetric and Neonatal Nursing (AWOHNN certification), fetal monitoring, or the Advanced Practice Strategies fetal monitoring course. Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

H. Do physicians and nurses have regularly scheduled case study discussions or training opportunities? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

I. Are debriefings performed when unanticipated clinical outcomes occur? Yes ☐ No ☐
If yes, which hospital(s)? 1 2 3 4

J. Have any of the hospital(s) where the physician(s) deliver adopted Institute of Healthcare Improvement's (IHI's) Elective Induction Safety Bundle? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

K. Have any of the hospitals where the physicians deliver adopted IHI's Elective Augmentation Safety Bundle? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

L. What is the maximum amount of time it takes to perform an emergency C-section once it is determined that one is necessary?

Hospital 1: _____ minutes

Hospital 2: _____ minutes

Hospital 3: _____ minutes

Hospital 4: _____ minutes

M. Please answer the following question regarding access to a C-section/Anesthesia team:

Hospital 1: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐

If no, indicate the team's response time when called: _____

Hospital 2: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐

If no, indicate the team's response time when called: _____

Hospital 3: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐

If no, indicate the team's response time when called: _____

Hospital 4: Is there a C-Section/Anesthesia team on site? Yes ☐ No ☐

If no, indicate the team's response time when called: _____

N. Do the hospital(s) routinely schedule the following obstetrical emergency drills? Yes ☐ No ☐

If yes, which hospital(s)?

Dystocia Drills: 1 2 3 4

Maternal CPR: 1 2 3 4

Clinical Simulation Training: 1 2 3 4

O. Is EFM performed on active labor patients? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

P. Are placentas maintained for at least seven days post-delivery? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

Q. Is structured communication (e.g., SBAR) used between physicians and nursing staff to relay patient information? Yes ☐ No ☐

If yes, which hospital(s)? 1 2 3 4

**Fraud Warning** – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

**Consent to Conditions of Consideration of the Application for Insurance**

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

**Authorization to Release Information**

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees, and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

**Risk Management Agreement Language**

I agree that my office staff and I will comply with all Ob-Gyn Risk Alliance risk management programs administered by ProAssurance companies. Our compliance includes cooperating with ProAssurance and its employees and independent contractors in all risk management assessments and recommendations, participating in educational programming, and committing to work with the Ob-Gyn Risk Alliance to improve patient care and thus reduce losses.

I agree to ensure that my staff will work to further such risk management collaboration and comply with all education and risk management improvement recommendations.

I understand that compliance with this statement is necessary for membership in the Ob-Gyn Risk Alliance Purchasing Group, and failure to comply may jeopardize further participation in the program.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found at ProAssurance.com.

**For Agent's Use Only (if applicable)**

| | |
|---|---|
| Agent's Name | Agency Name |
| Signature | Agency Address |
| Date | Phone |

**Additional Comments**

Please attach additional sheets as necessary.