Premium Indication Request for Professional Partnerships / Corporations (More than one shareholder.)

Please read carefully before completing:

This is a premium indication request only. It is not an application for medical malpractice insurance coverage and does not, in any way, bind coverage. The information contained in this request will be used to acquire premium indications from one or more insurance carriers as appropriate and will otherwise be held in the strictest confidence.

SIGNATURE
After completing the premium indication request, the signature of an authorized representative of the facility is required, along with the date. Please complete the request completely.

CLAIMS INFORMATION
If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, complete a claim information sheet for each claim. Each Claim Information Sheet must be completed, signed and dated.

RETROACTIVE ("NOSE") COVERAGE
If you wish to obtain nose coverage, a copy of your most recent declarations page from your current carrier indicating the original effective date of coverage and a current paid through date must be attached.

Tegner-Miller Insurance Brokers - CAMM
2001 Wilshire Boulevard Suite 101
Santa Monica, CA 90403
Phone: 800.775.8642
Fax: 310.453.7971
E-mail: insure@tmib.com

OFFICE USE ONLY

Account No. _____

Policy No. _____

Group No. _____

DATE RECEIVED

SECTION I — GENERAL INFORMATION

Check One: The Applicant Entity is a ☐ Partnership ☐ Corporation (More Than One Shareholder)

1. Exact Name of Professional Partnership/Corporation _____
2. Primary Office Address _____

   City _____ State _____ Zip _____
3. Phone Number (_____) _____ Fax Number (_____) _____
4. E-Mail Address _____
5. IRS Tax No. _____
6. ☐ Leased/Rented ☐ Owned Approximate Square Footage _____
7. Secondary Office Address _____

   City _____ State _____ Zip _____
8. Phone Number (_____) _____ Fax Number (_____) _____
9. E-Mail Address _____
10. ☐ Leased/Rented ☐ Owned Approximate Square Footage _____

    LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 7.
11. Name of President/Senior Partner _____
12. Name of Business Manager/Administrator _____
13. Please send billing to: ☐ Primary Office Address ☐ Secondary Office Address

SECTION II — COVERAGE INFORMATION

EFFECTIVE DATE

Desired effective date_____/_____/_____

PROFESSIONAL AND OFFICE PREMISES LIABILITY COVERAGE

CHECK ONE:

☐ $1,000,000 PER CLAIM/$3,000,000 AGGREGATE PER POLICY PERIOD

☐ $2,000,000 PER CLAIM/$4,000,000 AGGREGATE PER POLICY PERIOD

☐ $5,000,000 PER CLAIM/$5,000,000 AGGREGATE PER POLICY PERIOD

Higher limits are available by special request.

RETROACTIVE (NOSE) COVERAGE

Retroactive (Nose) coverage provides protection for professional liability claims first made against the partnership/corporation after the effective date of coverage with the Company, and which arise out of the entity's acts or omissions prior to the effective date of such coverage. If the partnership/corporation does not obtain "Nose" coverage, the partnership/corporation will have no coverage from the Company for professional liability claims arising out of its acts or omissions which arise prior to the effective date of such coverage.

Would you like to include retroactive (Nose) coverage in this premium indication request: ☐ Yes ☐ No

IF YES, A COPY OF THE PARTNERSHIP/CORPORATION'S MOST RECENT DECLARATIONS PAGE FROM THE PRESENT CARRIER INDICATING THE ORIGINAL EFFECTIVE DATE OF COVERAGE AND THE CURRENT PAID THROUGH DATE MUST BE ATTACHED.

14. Retroactive date requested _____/_____/_____
    The partnership/corporation has been continuously insured for professional liability coverage under a claims made and reported policy since this date.
15. Does the partnership/corporation currently have a separate professional liability insurance policy? ☐ Yes ☐ No
16. List the name(s), policy number(s), and policy period(s) for current and all previous claims made insurance carriers:

	INSURANCE CARRIER	POLICY NUMBER(S)	POLICY PERIOD(S) From To
a.			MONTH/DAY/YEAR – MONTH/DAY/YEAR
b.			MONTH/DAY/YEAR – MONTH/DAY/YEAR
c.			MONTH/DAY/YEAR – MONTH/DAY/YEAR

17. Date partnership/corporation was formed _____/_____/_____
18. Does the partnership/corporation have a currently effective Certificate of Registration as a professional partnership/corporation under the Business and Professions Code of the applicable jurisdiction? ☐ Yes ☐ No

19. List the names of all partners (partnership) or shareholders (corporation) and all physicians who are salaried employees of the entity:

NAME	PROFESSIONAL LIABILITY INSURANCE COMPANY	POLICY NUMBER	SOCIAL SECURITY NUMBER

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REMARKS SECTION, PAGE 7.

20. List the names of all physicians who provide services to the entity as independent contractors:

NAME	PROFESSIONAL TITLE/DUTIES	PROFESSIONAL LIABILITY INSURANCE COMPANY

21. If the entity is a corporation, list the following:

    a. Names of all directors:

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    _____ _____

    b. Names of all officers:

    President _____ Secretary _____

    Vice President _____ Treasurer _____

    Other _____

22. **Healthcare Professionals**

CPP-90 policy defines ”healthcare professionals” as follows:

Acupuncturist, Chiropractor, Dentist, Dietician, Optician, Optometrist, Perfusionist, Pharmacist, Podiatrist, Physician Assistant*, Psychological Assistant, Psychologist, Registered Nurse Midwife, and Registered Nurse Practitioner.

Under the CPP-90 policy, only Chiropractors, Dentists, Physician Assistants, Podiatrists, and Registered Nurse Midwives must be listed below and, if approved by the Company, will be specifically named as an insured under coverage B (entity policy) by an endorsement to the policy.

a. List healthcare professionals who provide services at any of the entity’s facilities or offices as salaried employees of the partnership/corporation:

NAME	PROFESSIONAL TITLE/DUTIES

b. List healthcare professionals who provide services at any of the entity’s facilities or offices as independent contractors of the partnership/corporation:

NAME	PROFESSIONAL LIABILITY PROFESSIONAL TITLE/DUTIES	INSURANCE COMPANY

c. Indicate the number of the following types of individuals who provide services in the entity’s office:

HEALTHCARE PROFESSIONAL	NUMBER	HEALTHCARE PROFESSIONAL	NUMBER
Administrative Personnel		Physiotherapist	
Dental Hygienist		Technician (Dialysis, Lab, Pathological)	
Medical/Dental Assistant		Technician (X-Ray, Radium)	
Nurse (Registered or Licensed Vocational)		Other (Describe in Remarks Section, Page 7)	
Licensed Nurse Anesthetist **			

* Attach a copy of the Physician Assistant’s license and the Supervising Physician’s license to this application.

SECTION III — MISCELLANEOUS INFORMATION

23. Does the partnership/corporation maintain an outpatient surgical facility? ☐ Yes ☐ No

    IF **YES**, DOES THE PARTNERSHIP/CORPORATION CURRENTLY HAVE A SEPARATE PROFESSIONAL LIABILITY INSURANCE POLICY FOR THE SURGICAL FACILITY? ☐ Yes ☐ No

    Name of Carrier _____ Policy Number _____

24. Has any insurance company canceled, declined coverage, modified (i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any similar partnership/corporation insurance? ☐ Yes ☐ No

    IF **YES**, DESCRIBE, GIVING COMPANY NAME AND POLICY NUMBER IN REMARKS SECTION, PAGE 7.

25. Has the partnership/corporation ever been investigated by the State Board of Medical Examiners and/or the State Licensing Authority, Narcotics Bureau, State Board of Dental Examiners, or other governmental agency? ☐ Yes ☐ No

    IF **YES**, DESCRIBE IN REMARKS SECTION, PAGE 7, AND FORWARD A COPY OF ANY FORMAL ACCUSATION OR DECISION.

26. Has a claim or suit for any alleged malpractice and/or business liability ever been made or brought against the partnership/corporation in the past ten (10) years? ☐ Yes ☐ No

    IF **YES**, COMPLETE A CLAIM INFORMATION SHEET FOR EACH CLAIM (PAGE 8).

27. Does the partnership/corporation manufacture, sell or distribute any drug, pharmaceutical or medical device or other product to persons other than its patients or patients of its physician members? ☐ Yes ☐ No

    IF **YES**, DESCRIBE THE PRODUCT OR THE ACTIVITIES OF THE PARTNERSHIP/CORPORATION IN CONNECTION WITH THE PRODUCT IN THE REMARKS SECTION, PAGE 7.

28. Does the partnership/corporation own any other corporation or is the partnership/corporation under common ownership or the control of any subsidiary corporation? ☐ Yes ☐ No

    IF **YES**, DESCRIBE OWNERSHIP AND ACTIVITIES OF THE PARTNERSHIP IN REMARKS SECTION, PAGE 7.

29. Is the partnership/corporation a party to any joint venture agreement or any other contract under which professional or business activities are or will be conducted in conjunction with any other person or partnership/corporation? ☐ Yes ☐ No

    IF **YES**, DESCRIBE THE AGREEMENT AND ACTIVITIES IN THE REMARKS SECTION, PAGE 7.

30. Does any facility of the partnership/corporation conduct treatment, storage or disposal of hazardous wastes on-site in a manner which requires a permit under either federal or state hazardous waste control laws? ☐ Yes ☐ No

31. Has any facility of the partnership/corporation ever been alleged to be in non-compliance with the substantive or procedural requirements of either federal or state hazardous waste control laws? ☐ Yes ☐ No

    IF **YES**, PLEASE DESCRIBE EACH SUCH ALLEGATION AND ITS RESOLUTION IN THE REMARKS SECTION, PAGE 7.

32. Has the partnership/corporation been named as a defendant in any administrative or judicial proceeding in which it is alleged that the company is liable for response costs incurred or natural resource damages arising from the actual or threatened release of hazardous substances? ☐ Yes ☐ No

    IF **YES**, PLEASE DESCRIBE EACH SUCH PROCEEDING AND THE ALLEGATIONS MADE AGAINST THE PARTNERSHIP/CORPORATION IN THE REMARKS SECTION, PAGE 7.

33. Please attach a copy of the partnership/corporation's letterhead.

SECTION IV — REMARKS (INDICATE QUESTION NUMBER REFERRED TO)

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED

SECTION V — CLAIMS INFORMATION

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED

NOTE: Please provide sufficient information for underwriters to evaluate the medical aspects of the case especially relating to your involvement.

1. Name of Patient _____ 2. Age _____ 3. ☐ Male ☐ Female

4. Allegation _____

_____

_____

_____

5. Date claim was made or filed _____ 6. Date of incident leading to allegation _____

7. Insurance company _____

8. Additional defendants _____

9. Location of occurrence _____

10. Disposition of claim ☐ OPEN ☐ CLOSED a. Exact date closed _____

b. Total settlement or judgment $ _____

c. Amount paid on your behalf $ _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of the claimant's office and hospital records, laboratory reports and any other information that would be appropriate. Attach additional sheets as required.

11. Condition and diagnosis at time of incident (**Include dates of visits**) _____

_____

_____

_____

12. Date and description of treatment rendered (**Include dates of visits**) _____

_____

_____

_____

_____

13. Condition of patient subsequent to treatment (**Include dates of follow-up treatment**) _____

_____

_____

_____

Date _____ Signed _____

SECTION VI — SIGNATURE

REPRESENTATIONS AND AUTHORIZATIONS OF APPLICANT

Applicant authorizes the release and exchange of information involving past and future underwriting and claims matters between the Company and the present, and any past professional association/society of each of Applicant's members or employees, the county association/society in the county in which any such member or employee practices or practiced, their respective committees and insurance consultants, any hospital with which any such member or employee presently or previously held staff privileges and any prior insurance company, and any state licensing board or other governmental agency.

Applicant also agrees that the Company and, to the extent requested by the Company, the county association/society in the county in which Applicant is domiciled or in which any member or employee of Applicant practices or practiced, or the appropriate committee or representative of any such county association/society, any committee of the Company and/or any other authorized representatives of the Company, may participate in the processing and review of this Application, of any future information submitted by Applicant to the Company and of any matter relating to any incidents or claims of alleged medical malpractice while Applicant is insured by the Company.

APPLICANT HEREBY REPRESENTS THAT THE STATEMENTS AND ANSWERS MADE WITHIN THIS APPLICATION ARE FULL, COMPLETE AND TRUE.

APPLICANT UNDERSTANDS THAT THIS IS NOT A BINDER OF INSURANCE, BUT IS INSTEAD A REQUEST FOR A PREMIUM INDICATION.

_____ _____

Print Name of Partnership/Corporation Date

By _____ _____

Signature of Partner or Authorized Officer Title