



APPLICATION

FOR PROFESSIONAL
CORPORATION/PARTNERSHIP

PENNSYLVANIA PHYSICIANS' RECIPROCAL INSURERS
RADNOR, PENNSYLVANIA

**APPLICATION FOR PHYSICIANS AND SURGEONS
PROFESSIONAL LIABILITY INSURANCE**

Insurance Coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the Named Insured.

Help us expedite the processing of your application:

- Please print your responses in ink or type.
- Answer every question or mark it “not applicable” (N/A).
- Use the “Remarks” section to amplify your answers where requested.
- Please submit prior carrier loss runs for a minimum of 5 years prior to the requested effective date. Loss runs must be obtained from your former carriers and must be current (less than 6 months old). If you had claims or suits filed against you, please make certain you have completed a claims information form for each claim or suit in the past ten years. Report all claims that have also been resolved (closed, tried or settled) within the past ten (10) years.
- Enclose a copy of your present professional liability insurance declarations page.
- Incomplete answers and/or missing attachments **will** delay our processing of the application.

Please fully complete this application and return it to your broker or to us at:

**Pennsylvania Physicians’ Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11576**

For assistance please call our office at (888) 771-4762 or (516) 869-1200

NOTICE

This information pertains to policies written on a claims-made basis

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

A claims-made policy covers claims actually made against the insured and incidents reported while the policy remains in effect. All coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases extended reporting period coverage.

The rates for extended reporting period coverage will be determined in accordance with the rates in effect at the beginning of the current policy period.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims made or incidents reported after such period of sixty (60) days. The extended reporting coverage provides coverage for claims which are reported during the policy period and which are reported for an unlimited time period after the termination of the policy.

During the first few years of coverage under a claims-made policy, the annual rate is comparatively lower than occurrence rates. However, such annual rate increases significantly, independent of overall rate level increases, until the claims-made rate reaches maturity.

4. List all previous insurance carriers for the past ten (10) years:

- A. Insurance Carrier _____ Policy # _____ Type (CM/OCC) _____
 From _____ To _____
- B. Insurance Carrier _____ Policy # _____ Type (CM/OCC) _____
 From _____ To _____
- C. Insurance Carrier _____ Policy # _____ Type (CM/OCC) _____
 From _____ To _____
- D. Insurance Carrier _____ Policy # _____ Type (CM/OCC) _____
 From _____ To _____
- E. Insurance Carrier _____ Policy # _____ Type (CM/OCC) _____
 From _____ To _____

C. PRACTICE INFORMATION

1. Practice Situation

a. The legal entity you are requesting coverage for is a:

- "Solo" Medical Corporation
- Professional Corporation
- Medical Partnership
- Limited Liability Company
- Other: _____

b. Use of Assumed name (DBA) Yes (Please List) _____ No

2. Name of Shareholders/Partners

Professional Liability Insurance Carrier

Medical Specialty

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Employed Physicians (non-stockholders/partners)

Professional Liability Insurance Carrier

Medical Specialty

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Is coverage desired for Allied Healthcare Professionals?
If yes, please complete the following:

Yes No

Name	Profession	Certification/License No.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. CLAIMS INFORMATION

1. Claims or Suits

Has this entity for which you are requesting coverage ever been named as a defendant in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten (10) years, or is it presently involved in malpractice litigation?

(If YES, submit a separate form for each case in the last ten (10) years, see page)

Yes No

E. REMARKS

Please use this section to list any comments you feel will help us better understand your practice

I do hereby represent that any statements and answers mentioned herein are true, and that I have not misrepresented or withheld any information, which is calculated to influence the judgement of the Company in considering this application for professional liability insurance.

The application duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature form does not bind the applicant or the Company to issue coverage.

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 PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company underwriter, and insurance agent to furnish any information concerning me or my medical practice which the Company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction together with agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

SIGNATURE: _____

Date: _____

**Pennsylvania Physicians' Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11567**

Producer Affirmation: by my signature, I hereby represent that the applicant has granted me full authority to complete and/or submit this application on their behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that the applicant understands and agrees that such representation is binding upon him or her, even though I am completing and/or submitting the application on their behalf. I further acknowledge that any material misrepresentation or omission made on this application may result in the termination of my broker agreement.

PRODUCER SIGNATURE: _____

Date: _____

Please make additional copies of this page as necessary. If you have had claims or suits filed against you, please complete this form for each claim or suit in the past ten (10) years. Provide information on all claims that have also been resolved (closed, tried or settled) within the past ten (10) years. Also include all "incidents".

CLAIM INFORMATION

- 1. Name of Patient _____ 2. Age _____ 3. Sex _____
- 4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
- 5. Allegation _____
- 6. Date of incident _____ 7. Report date _____
- 8. Insurance carrier _____
- 9. Other defendants _____
- 10. Present Status: Open claim Closed claim Date closed _____ Settlement or Judgment Amount _____
- 11. Location of incident _____
- 12. Condition and diagnosis at time of incident _____

- 13. Dates and description of treatment rendered _____

- 14. Condition of patient subsequent to treatment and dates of follow-up treatment _____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: _____ Date Signed: _____

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