Print Application | Clear Application

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

MEDICAL PROFESSIONAL APPLICATION

NOTICE TO APPLICANT: THE COVERAGE FOR WHICH THE APPLICANT IS REQUESTING WILL APPLY ONLY TO CLAIMS ARISING WHILE IN THE COURSE OF THEIR EMPLOYMENT FOR THE NAMED INSURED.

SECTION I – GENERAL INFORMATION

Applicant's Last Name:_____ First Name:_____ M.I. _____
Date of Birth:_____
Current Medical License State(s):_____
Current Medical License Number(s):_____

SECTION II – EDUCATION AND TRAINING

1. Name and location of Medical / Dental School Granting Degree:_____
   City State:_____ Year graduated:_____
   If Applicant is a graduate of a non-US medical school, have they obtained an ECFMG Certificate? ☐Yes ☐No
2. Independent memberships and professional societies:

3. Is Application American Board Certified? ☐Yes ☐No

Medical Specialty	Date Certified	Medical Specialty	Date Certified

SECTION III – PROFESSIONAL SERVICES PROVIDED

1. Type of Practice / Services:
   ☐Addiction Medicine ☐Geriatrics ☐OB/GYN ☐Psychiatry
   ☐Dentist ☐Internal Medicine ☐Optometrist ☐Surgery
   ☐Family Medicine ☐Medical Director ☐Primary Care ☐Other:_____
   ☐Alternative / Unconventional Medicine (not mainstream), if applicable, please describe:
2. Status: ☐Employed ☐Contracted ☐Volunteer
3. Hours of Practice on behalf of the Applicant's Employer or Named Insured:
   ☐FULL TIME (≥ 20 hours per week) Professional Services rendered on behalf of Applicant's Employer or Named Insured.
   ☐PART TIME (≤ 20 hours per week) Professional Services rendered on behalf of Applicant's Employer or Named Insured.
   Please specify the exact # of hours rendered on behalf of the Applicant's Employer or Named Insured: #_____hours
4. Does the Applicant's practice include telemedicine activities, e.g., the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? ☐Yes ☐No
   a. If yes, what is the percent of the Applicant's total practice time devoted to this activity? _____%
   b. If yes, on a separate sheet, please explain the exact type of telemedicine.
   c. Is telemedicine done outside the U.S. territories? ☐Yes ☐No
5. Does the Applicant obtain an informed consent, whether signed by patient or guardian before prescribing controlled substances? ☐Yes ☐No
6. Does the Applicant create and maintain medical records for each patient under their care? ☐Yes ☐No
   If no, explain:

7. Does the Applicant participate in a compensation fund or other similar program of state sponsored liability insurance? (Example: MCARE in Pennsylvania) ☐Yes ☐No

Print Application Clear Application

SECTION IV – INSURANCE AND PROFESSIONAL HISTORY

1. Has the Applicant ever been denied professional liability insurance coverage? ☐Yes ☐No
   NOTE: MISSOURI APPLICANTS DO NOT RESPOND
   If **yes**, please attach a separate sheet containing a complete explanation.
2. Has the Applicant's professional liability insurance coverage ever been cancelled or refused renewal? ☐Yes ☐No
   NOTE: MISSOURI APPLICANTS DO NOT RESPOND
   If **yes**, please attach a separate sheet containing a complete explanation.
3. Has the Applicant's application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? ☐Yes ☐No
   If **yes**, please attach a separate sheet containing a complete explanation.
4. Has the Applicant's license ever been suspended or revoked? ☐Yes ☐No
   If **yes**, please attach a separate sheet containing a complete explanation.
5. Has the Applicant ever been convicted of a crime? ☐Yes ☐No
   If **yes**, please attach a separate sheet containing a complete explanation.

SECTION V – PRIOR INSURANCE

List Applicant's insurers or Applicant's employers' insurers the past (3) years. Attach additional pages as needed.

Insurance Carrier	Policy Period	Limits of Liability	Coverage Type (Occurrence / Claims Made)

SECTION VI – PRACTICE LOCATIONS

Current Practice location on behalf of the Applicant's Employer or Named Insured:

Insured's Practice Location	Address	From (MM/YY)	To (MM/YY)

SECTION VII - CLAIMS HISTORY

IMPORTANT: *This section must be completed in its entirety.* ***Any*** *malpractice claims or suits in which Applicant has been involved in during the past seven (7) years must be reported.* ***Any*** *incidents or circumstances of which the Applicant is aware of that are likely to give rise to a claim must be reported. Provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal. If reporting more than one incident, suit or claim, photocopy this form for each.*

☐ N/A (Please proceed to signature section)

1. Has the Applicant ever had any malpractice claim(s) or suit(s) brought against them? ☐Yes ☐No
   If yes, please provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal.
2. Is the Applicant aware of any circumstances, which may result in a malpractice claim or suit? ☐Yes ☐No
   If yes, please provide the details below:
   a. Name of patient: _____
   b. Allegation/incident description:

   _____
   c. Incident date: _____ Report date: _____

If reporting more than one incident, photo copy this form for each.

Print Application Clear Application

SECTION VIII – CLAIMS MADE COVERAGE

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

Additional Notice: If Claims Made coverage is provided, it should be clearly understood that the applicable retro date will be the latter of the medical professional's date of hire or the date that the medical professional coverage is added to the Named Insured's policy.

☐ N/A (Please proceed to signature section)

Policy Effective Date: _____

Line of Business: _____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐ Yes ☐ No
   If yes, please provide details:

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐ Yes ☐ No
   If yes, please provide details:

Print Application Clear Application

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company.**

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRINCIPAL, PARTNER OR OFFICER)

SIGNATURE

DATE

Produced By: (Section to be completed by Producer/Broker)

PRODUCER

AGENCY

PRODUCER LICENSE NUMBER

AGENCY TAXPAYER ID OR SS NUMBER

ADDRESS (STREET, CITY, STATE, ZIP)