COPIC
Better Medicine • Better Lives

COPIC Application for Medical Professional Liability Insurance

Allied Health Provider Separate Limits

Claims-made policy

With your completed application, you are required to submit the following information:

- § Current declarations page which provides a retroactive date and indicates limits of liability for which you are requesting coverage.
- § Written confirmation of the purchase of or your intent to purchase a reporting endorsement ("tail coverage") from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
- § Curriculum Vitae (C.V.)
- § A loss run report. To obtain this information, please call your prior carrier(s) and request a currently valued loss run for the past five (5) years.

Additional information may be requested.

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COPIC
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ALLIED HEALTH PROVIDER APPLICATION
(SEPARATE LIMITS OF LIABILITY)

APPLICANT DATA

1. Last name _____ First name _____ M.I. _____ Gender ¨ M ¨ F

2. DOB _____ 3. SSN _____ 4. NPI # _____

5. Legal Residence (Physical Street/Home Address) _____

City _____ State _____ ZIP _____ Cell phone# _____

Rural Mailing Address/P.O. Box (if applicable) _____ City _____ State _____ ZIP _____

Home phone # _____ Personal/Confidential e-mail address _____

6. Primary practice location _____

Address _____ City _____ County _____ State _____ ZIP _____

Office #_____ Primary fax #_____ Website _____

7. Billing Address (if statements should be sent to a different location than practice location):

Firm Name _____ Address _____

City _____ County _____ State _____ Zip _____

Phone # _____

8. Practicing as (check one): ¨ Individual ¨ Joining Group ¨ Forming Group

9. Name of Primary Group or Employer: _____

10. Name of Secondary Group(s) or Employer(s): _____

11. Is your current employer insured by COPIC? ..... ¨ Yes ¨ No

12. Professional Designation:

¨ Physician Assistant ¨ Surgical Assistant/Tech ¨ Nurse Practitioner ¨ Certified Nurse Midwife ¨ Certified Nurse Anesthetist

¨ Other: _____

COVERAGE REQUESTED

13. Requested Effective Date _____ Requested Retroactive Date _____

Note: If you are requesting prior acts coverage, a separate Supplemental Prior Acts Application will be required.

14. Liability limits ¨ $500,000/$1 million ¨ $1 million/$3 million ¨ $1.5 million/$3 million ¨ $2 million/$4 million

¨ Other: _____

PROFESSIONAL LIABILITY INSURANCE HISTORY

15. Name of Company (current)	Policy Limits	Period of Coverage: _____ to _____ (mm/yy) (mm/yy)	¨ Claims-Made
_____	$_____/$_____	Retroactive Date: _____	¨ Occurrence

15a. If your current insurance is claims-made, will "tail" coverage be purchased? ..... ¨ Yes ¨ No ¨ N/A

16. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate or required that you accept a deductible, or issued coverage with any restrictions or exclusions? *Missouri applicants do not answer this question ..... ¨ Yes ¨ No

17. Have you ever practiced without professional liability insurance? ..... ¨ Yes ¨ No

LICENSES

18. List all states in which you have ever been licensed to practice medicine, the license number for that state, the date the license was issued and the number of hours you will work in each state as of the requested effective date of coverage. (If extra space is needed, please attach additional sheets.)

State_____ License # _____ Date issued_____ # hours/week _____

State_____ License # _____ Date issued_____ # hours/week _____

IF YOU PRACTICE IN A STATE WITH A PATIENT COMPENSATION FUND

19. If approved for COPIC coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under the Act? ..... ¨ Yes ¨ No ¨ N/A*

20. Have you been a qualified health care provider under the Fund at all times subsequent to the retroactive date requested above and as show on the insurance declarations page(s) attached to the application? ..... ¨ Yes ¨ No ¨ N/A*

**"N/A" means that you do not practice within a Fund state and, therefore, this question is not applicable*

PRACTICE HISTORY/TRAINING/EDUCATION

You must provide a current C.V.

21. Do you have had any gaps in practice over 90 days? ..... ¨ Yes ¨ No ¨ N/A
If Yes, please provide an explanation below or submit a separate document with explanation.

_____
_____

PRACTICE CHARACTERISTICS

22. Average number of hours worked per week..... ¨ 1-15 ¨ 16-20 ¨ 21-25 ¨ ≥ 26

When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds

23. Do you maintain any other medical professional liability coverage? ..... ¨ Yes ¨ No

If "yes," please explain. _____

24. Will you be scheduled to work at a separate location from your supervising or collaborating physician? ..... ¨ Yes ¨ No ¨ N/A

If "yes", please provide additional information. _____

PROCEDURES PERFORMED

25. Do you perform aesthetic or cosmetic procedures? ..... ¨ Yes ¨ No
If "yes", please provide documentation of training, patient selection criteria, and patient consent forms.

26. Do you perform procedures or use equipment not used by a majority of practitioners in your specialty?
If "yes", please provide additional information..... ¨ Yes ¨ No

Procedure	Do you maintain Hospital Privileges?
_____	¨ Yes ¨ No
_____	¨ Yes ¨ No

27. Certified Nurse Midwives Only

Do you perform:

Do you offer obstetric ultrasound images or videos created solely for non medical reasons or without an ultrasound report for the medical record or any non medical use of ultrasound imaging, such as "keepsake ultrasounds"?	¨ Yes	¨ No
Do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)?	¨ Yes	¨ No
Do you perform obstetrical procedures in a surgical suite more than one hour or 50 miles from a hospital?	¨ Yes	¨ No
Do you perform elective home delivery?	¨ Yes	¨ No
Do you perform Vaginal Birth after Cesarean (VBAC)?	¨ Yes	¨ No
If yes, is a physician is physically on premises and immediately available for the entire course of care?	¨ Yes	¨ No

Average number of deliveries performed per year _____

OTHER INFORMATION

All "yes" answers require an explanation. Please attach additional sheets, if necessary.

28. Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.	¨ Yes	¨ No
29. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way?	¨ Yes	¨ No
30. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law.	¨ Yes	¨ No
31. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity?	¨ Yes	¨ No
32. Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry?	¨ Yes	¨ No
33. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action?	¨ Yes	¨ No
34. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, health plan, managed care organization or other medical review committee?	¨ Yes	¨ No
35. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness?	¨ Yes	¨ No
36. Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee or an employee of a hospital or surgery center; or have you been accused by a patient of or been investigated by any state regulatory authority in connection with boundary violations of a sexual nature?	¨ Yes	¨ No
37. Have you ever been reported to the National Practitioners Data Bank?	¨ Yes	¨ No

CLAIMS INFORMATION

38. Have you ever been involved in a malpractice claim or suit, either directly or indirectly?	¨ Yes	¨ No

39. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome?	¨ Yes	¨ No
c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	¨ Yes	¨ No
d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	¨ Yes	¨ No
e. Any other circumstances that might reasonably lead to a claim or suit?	¨ Yes	¨ No
f. If yes, to any of the above, have they been reported to your current or prior professional liability insurance carrier?	¨ Yes	¨ No

If you answer "yes" to question 38 or 39 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 4)

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations:_____

_____

_____

6. What is the present condition of the patient?_____

_____

_____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ¨ **Yes** ¨ **No**

8. Status of claim (check applicable answer):

- ¨ **Suit threatened, no action taken**
- ¨ **Suit filed but dropped by claimant**
- ¨ **Summary judgment in your favor**
- ¨ **Court outcome in your favor**
- ¨ **Court outcome in favor of plaintiff:**
  Amount of Loss payment:
  $_____
- ¨ **Awaiting mediation**
- ¨ **Awaiting court action:**
  Reserve Amount:
  $_____
- ¨ **Suit settled out of court**
  - **a. Date claim paid:** _____
  - **b. Amount paid: $**_____
  - **c. Did you want to settle this claim?** ¨ **Yes** ¨ **No**

9. To your knowledge, was any settlement paid by another party (provider or entity) involved?..... ¨ **Yes** ¨ **No**

If "yes," amount was $_____

Signature: _____ **Date:** _____

Name (Printed): _____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! As a condition of being insured, I understand and agree to the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare that all answers and statements in this application are true and complete and that no material fact or circumstance has been omitted or withheld. I understand that these answers and statements are material and, as such, will be relied upon by the company to determine whether to issue my liability insurance. If I or any other person making application or providing information on my behalf misstate (s) or fail to disclose any material information, my application may be declined. If my application is approved and it includes any material misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the material misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and in consideration for issuing this liability insurance, COPIC and/or its assigns may conduct a professional/peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by the COPIC Practice Quality personnel, as COPIC may request or direct. I agree to abide by any recommendations arising from that review.

I authorize any state board of medical examiners or medical board, or any licensure, hospital board or committee, hospital records department, insurance company, professional society or association, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC or its assigns. This authorization applies regardless of whether I am currently affiliated with the above persons or entities, or have been in the past. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC policy, I hereby consent to COPIC's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to medical boards and boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: my name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank. To the fullest extent permitted by law, I hereby release all providers of such information, including COPIC, its employees and agents, from any and all liability therefore.

Provider signature _____ **Date** _____

Please PRINT your name _____

RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 in formation 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.

DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

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 of the third degree.

KENTUCKY

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.

LOUISIANA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

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 denial of insurance benefits.

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may subject to civil fines and criminal penalties.

NEW YORK

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 for each such violation.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

RHODE ISLAND

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.

Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

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 include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.