

COPIC Policyholder Services**DISCLOSURE FORM CLAIMS-MADE POLICY
IMPORTANT NOTICE TO POLICYHOLDER**

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT DESCRIBES SOME OF THE MAJOR FEATURES OF OUR CLAIMS-MADE POLICY FORM. READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

YOUR POLICY

Your policy is a claims-made policy. It provides coverage only for injury or damage occurring after the policy retroactive date (if any) shown on your policy and the incident is reported to your insurer prior to the end of the policy period. Upon termination of your claims-made policy an extended reporting period option is available from your insurer. There is no difference in the kind of injury or damage covered by occurrence or claims-made policies. Claims for damages may be assigned to different policy periods, depending on which type of policy you have. If you make a claim under your claims-made policy, the claim must be a demand for damages by an injured party and does not have to be in writing. Under most circumstances, a claim is considered made when it is received and recorded by you or by us. Sometimes, a claim may be deemed made at an earlier time. This can happen when another claim for the same injury or damage has already been made, or when the claim is received and recorded during an extended reporting period.

PRINCIPAL BENEFITS

This policy provides for defense and indemnification of covered claims arising from medical incidents and for defense costs only for covered proceedings up to the maximum dollar limit specified in the policy. This policy provides for unlimited defense costs only for covered peer review incidents.

The principal benefits and coverages are explained in detail in your claims-made policy. Please read it carefully and consult your insurance producer about any questions you might have.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS

Your claims-made policy contains certain exceptions, reductions and limitations. Please read them carefully and consult your insurance producer about any questions you might have.

RENEWALS AND EXTENDED REPORTING PERIODS

Your claims-made policy has some unique features relating to renewal, extended reporting periods and coverage for events with long periods of potential liability exposure. If there is a retroactive date in your policy, no event or occurrence prior to that date will be covered under the policy even if reported during the policy period. It is therefore important for you to be certain that there are no gaps in your insurance coverage. These gaps can occur in several ways. Among the most common are:

1. If you switch from an occurrence policy to a claims-made policy, the retroactive date in your claims-made policy should be no later than the expiration date of the occurrence policy.
2. When replacing a claims-made policy with a claims-made policy, you should consider the following:
 - a. The retroactive date in the replacement policy should extend far enough back in time to cover any events with long periods of liability exposure, or
 - b. If the retroactive date in the replacement policy does not extend far enough back in time to cover events with long periods of liability exposure, you should consider purchasing extended reporting period coverage under the old claims-made policy.
3. If you replace this claims-made policy with an occurrence policy, you may not have insurance coverage for a claim arising during the period of claims-made coverage unless you have purchased an extended reporting period under the claims-made policy. Extended reporting period coverage must be offered to you by law for at least one year after the expiration of the claims-made policy at a premium not to exceed 200% of your last policy premium.

CAREFULLY REVIEW YOUR POLICY REGARDING THE AVAILABLE EXTENDED REPORTING PERIOD COVERAGE, INCLUDING THE LENGTH OF COVERAGE, THE PRICE AND THE TIME PERIOD DURING WHICH YOU MUST PURCHASE OR ACCEPT ANY OFFER FOR EXTENDED REPORTING PERIOD COVERAGE.



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.

COPIC

7351 E Lowry Boulevard, Ste. 400 ■ Denver, CO 80230

phone 720/858-6000 ■ fax 720/858-6004 ■ tollfree 800/421-1834 ■ www.callcopic.com

**ALLIED HEALTH PROVIDER APPLICATION
(SEPARATE LIMITS OF LIABILITY)**

APPLICANT DATA

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

2. DOB _____ 3. NPI # _____

4. 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 _____

5. Primary practice location _____
 Address _____ City _____ County _____ State _____ ZIP _____
 Office # _____ Primary fax # _____ Website _____

6. Billing Address (if statements should be sent to a different location than practice location):
 Firm Name _____ Address _____
 City _____ County _____ State _____ Zip _____
 Phone # _____

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

8. Name of Primary Group or Employer: _____

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

10. Is your current employer insured by COPIC? Yes No

11. Professional Designation:
 Physician Assistant Surgical Assistant/Tech Nurse Practitioner Certified Nurse Midwife Certified Nurse Anesthetist
 Other: _____

COVERAGE REQUESTED

12. Requested Effective Date _____ Requested Retroactive Date _____

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

13. Liability limits \$500,000/\$1 million \$1 million/\$3 million \$1.5 million/\$3 million \$2 million/\$4 million
 Other: _____

PROFESSIONAL LIABILITY INSURANCE HISTORY

| | | | |
|---|-----------------------------------|--|-------------------------------------|
| 14. Name of Company (current) _____ | Policy Limits \$_____/ \$_____ | Period of Coverage: _____ to _____ (mm/yy) (mm/yy) Retroactive Date: _____ | .. Claims-Made .. Occurrence |
| 14a. If your current insurance is claims-made, will "tail" coverage be purchased? Yes .. No .. N/A | | | |
| 15. 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 | | | |
| 16. Have you ever practiced without professional liability insurance? Yes .. No | | | |

LICENSES

| | | | |
|--|-----------------|-------------------|--------------------|
| 17. 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

| | | | |
|---|--|--|--|
| 18. 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* | | | |
| 19. 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* | | | |
| <i>*"N/A" means that you do not practice within a Fund state and, therefore, this question is not applicable</i> | | | |

PRACTICE HISTORY/TRAINING/EDUCATION

| | | | |
|--|--|--|--|
| You must provide a current C.V. | | | |
| 20. 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

| | | | |
|---|--|--|--|
| 21. Average number of hours worked per week 1-15 .. 16-20 .. 21-25 .. ≥ 26 <i>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</i> | | | |
| 22. Do you maintain any other medical professional liability coverage? Yes .. No If "yes," please explain. _____ | | | |
| 23. 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

| | |
|---|--|
| 24. Do you perform aesthetic or cosmetic procedures? Yes .. No If "yes", please provide documentation of training, patient selection criteria, and patient consent forms. | |
| 25. 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 |

26. 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.

| | | |
|--|------------------------------|-----------------------------|
| 27. 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. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 29. 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..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 30. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 31. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 32. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 33. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 34. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 35. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36. Have you ever been reported to the National Practitioners Data Bank? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

CLAIMS INFORMATION

| | | |
|--|------------------------------|-----------------------------|
| 37. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 38. 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Any other circumstances that might reasonably lead to a claim or suit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. If yes, to any of the above, have they been reported to your current or prior professional liability insurance carrier? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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):

- | | | |
|--|---|---|
| <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Court outcome in your favor | <input type="checkbox"/> Awaiting mediation |
| <input type="checkbox"/> Suit filed but dropped by claimant | | |
| <input type="checkbox"/> Summary judgment in your favor | <input type="checkbox"/> Court outcome in favor of plaintiff: | <input type="checkbox"/> Awaiting court action: |
| | Amount of Loss payment: | Reserve Amount: |
| <input type="checkbox"/> Suit settled out of court | \$ _____ | \$ _____ |
| a. Date claim paid: _____ | | |
| b. Amount paid: \$ _____ | | |
| c. Did you want to settle this claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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.

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 be 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.