FOR COPIC USE ONLY	
Name	UW/Date
Endt	

Application for Entity Professional Liability Insurance

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

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

1. Current declarations page which provides a retroactive date and indicates limits of liability for any entity for which you are requesting coverage **(for new applicants only)**
2. 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 **(for new applicants only)**
3. Current business letterhead.

Our underwriting process involves a thorough evaluation of your application and requires 7 to 10 business days on average to complete. Please consider this time frame when requesting a coverage effective date.

COPIC
7351 E Lowry Boulevard, Ste. 400 ■ Denver, CO 80230
phone 720/858-6000 ■ *fax* 720/858-6004 ■ *toll free* 800/421-1834 ■ www.callcopic.com

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.

1. Name of Primary Entity to be insured: ____

   All other legal entities to be insured: ____

   ____

2. Check one: ❑ Partnership ❑ Professional Corporation ❑ Sole Ownership ❑ DBA ❑ LLP ❑ LLC ❑ Other (describe)____

3. Administrator of Entity: ____

4. Date Entity Established: ____

5. Primary physical practice address: ____

   City ________________________ County ________________ State__________ ZIP ______________

   Primary phone # ____________Secondary phone # _____________ Admin. Cell phone # ______________

   Primary fax #_________________________________ Secondary fax #___________________________

   Business e-mail address _________________________ Web site address __________________________

6. Rural mailing address/P.O. Box, if applicable:____

   P.O. Box __________________City _______________________ State__________ ZIP ______________

7. Desired mailing address

   All correspondence will be mailed to the primary practice address supplied above unless you indicate that it should be mailed to the rural mailing address/P.O. Box.

   ❑ Please send all correspondence to the rural mailing address/P.O. Box

8. Requested Effective Date ____ / _____ / _____

9. Liability limits (check one) ❑ $1 million/$3 million ❑ $1.5 million/$3 million ❑ $2 million/$4 million

10. **Premium Payment Plan:**

    You have the option of choosing the payment plan that best meets your needs. Please note that only one option may be selected per policy.

    If this section is left blank, you will continue to be billed under your current plan.

    - ❑ Quarterly (Four installments, three months apart)
    - ❑ Semi-Annual (First half due at beginning, second half due in six months)
    - ❑ Annual (Payment in full at beginning of policy year)

    Mid-term policy changes will affect the actual installment amount.

11. Are any of the entities identified in question #1:
   a.) a freestanding facility or clinic?.. ❑ Yes ❑ No

   If “yes” and more than one entity is listed in question #1, please list the name of the entity(ies) here:

   b.) utilized by medical providers outside of your group affiliation?...................................... ❑ Yes ❑ No

   If “yes” and more than one entity is listed in question #1, please list the name of the entity(ies) here:

   Please attach additional sheets, if necessary.

12. **For the entity(ies) to be insured on this policy, please complete the following tables (include additional sheets as necessary):**

Physician Owners	**Physician Employees**	**Physician Independent Contractors**

Non-Physician Owners	**Non-Physician Employees**	**Non-Physician Independent Contractors**

If any physicians or non-physicians named in #12 are not COPIC insured, please indicate their names and specialties here, and attach a current Certificate of Insurance for each:

13. Do any of the people identified in questions #12 and #15 provide medical or consultative services for which you are requesting COPIC coverage outside of your principal state of practice or have plans to do so in the next twelve months?.. ❑ Yes ❑ No

   If “yes,” please indicate their names, the state(s) in which the services are to be rendered, and the number of hours per week devoted to those services here:

Name:	**State(s)**	**Hours per week**

NOTICE: COPIC will not insure the following procedures. On your business letterhead, please explain any that are currently performed.

14. Do any of the people identified in question #12 perform:

Procedure	Response
Autologous fat injections into penises	❑ Yes ❑ No
Chelation therapy (other than for treatment of heavy metal poisoning)	❑ Yes ❑ No
Chymopapain disc injection	❑ Yes ❑ No
Elective home delivery	❑ Yes ❑ No
Intravascular absolute alcohol embolization except for renal pathology	❑ Yes ❑ No
Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity	❑ Yes ❑ No
Mesotherapy	❑ Yes ❑ No
Rapid opiate detoxification	❑ Yes ❑ No
Sclerotherapy (the injection of sclerosing agents) into the vertebral column	❑ Yes ❑ No
Sperm banks for other than interim storage for insemination of your own patients	❑ Yes ❑ No
Transsexual surgery	❑ Yes ❑ No
For non-physicians you supervise or employ, the management of active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC) patients unless a responsible physician is physically on premises and immediately available for the entire course of care	❑ Yes ❑ No
Obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"	❑ Yes ❑ No

15. Will any entity to be insured employ or contract with any allied health practitioners who will work at any of your office locations? ❑ Yes ❑ No

If "yes," please provide the census information requested below.

Classification	**# to be insured**	Classification	**# to be insured**	Classification	**# to be insured**
Acupuncturists	____	Advanced Practice Nurses	____	Aestheticians	____
Anesthesiologist Assistants	____	Child Health Associates	____	Clinical Nurse Specialists	____
CRNA/Nurse Anesthetists	____	Cytotechnologists	____	Electrologists	____
Embryologists	____	Emergency Med. Techs	____	Endermologists	____
Laser Technicians	____	Microdermabrasionists	____	Nurse Midwives	____
Nurse Practitioners	____	Optometrists	____	Orthopaedic Physician Assistants	____
Perfusionists	____	Pharmacists	____	Physician Assistants	____
Physicists	____	Physiologists	____	Psychologists	____
Psychotherapists	____	Radiology Practitioner Assistants	____	Surgical Assistants	____
Surgical Technicians	____				

Note: *The COPIC policy provides no individual coverage to any employee or independent contractor in any of the classifications working in your office listed above unless he/she is specifically named on the Declarations Page. The policy also provides no coverage to you if you are named in a claim or suit for their acts or omissions unless their names specifically appear on the Declarations Page. If you employ anyone in any of the classifications listed above and they are insured elsewhere, COPIC may be willing to extend coverage to you for their acts or omissions subject to underwriting.*

16. Please indicate if your entity **employs or contracts** with an allied health practitioner or physician extender who performs any of the following procedures at any of your office locations:

Botox Injections	❑ Yes	❑ No	Laser Hair Removal	❑ Yes	❑ No
Chemical Peels	❑ Yes	❑ No	Micro-Dermabrasion	❑ Yes	❑ No
Collagen Injections	❑ Yes	❑ No	Micro-Pigmentation	❑ Yes	❑ No
Endermology	❑ Yes	❑ No			

If you answered "yes" to any of the procedures listed above, please attach a copy of the documentation of training for each employee or independent contractor performing these procedures.

17. Do or will any of your entity's employees practice at a location geographically separate from either the primary or secondary practice address identified on page 1 of this application?.. ❑ Yes ❑ No

If "yes," please explain on your business letterhead. Please include in your explanation the distance of the employee's separate practice location from the practice address referenced above and a summary of the employee's duties and responsibilities while practicing there. In addition, please explain how these employees are supervised consistent with their duties and the frequency of and methods by which that supervision occurs.

18. List **all** entities to receive certificates of insurance (e.g., hospitals, HMOs, IPAs, etc.) for the Primary Entity identified in question #1:

Name	Address (including city, state and zip code)

Please indicate on your business letterhead if certificates of insurance are to be issued for any other entities to be insured. By adding a certificate holder's name and address to the above list, you give COPIC permission to allow the certificate holder to obtain your certificate of insurance.

19. Do you advertise your name, phone number, and specialty in any manner other than a one-line listing in the Yellow or White pages?... ❑ Yes ❑ No

If "yes," please attach a copy of your ad(s) and all other media advertisements. If you use radio or television, please attach a separate information sheet regarding these activities.

20. Web site address: ____ ❑ N/A (no web site address)

PROFESSIONAL LIABILITY INSURANCE HISTORY

21.

Name of Company	Policy Limits	Period of Coverage / Retroactive Date	Type
Name of Company (current)	Policy Limits $_____/$_____	Period of Coverage: _______ to _______ (Mo./Yr.) (Mo./Yr.) Retroactive Date: _____/_____/_____ (MM) (DD) (YYYY)	❑ Claims-Made ❑ Occurrence
Name of Company	Policy Limits $_____/$_____	Period of Coverage: _______ to _______ (Mo./Yr.) (Mo./Yr.) Retroactive Date: _____/_____/_____ (MM) (DD) (YYYY)	❑ Claims-Made ❑ Occurrence
Name of Company	Policy Limits $_____/$_____	Period of Coverage: _______ to _______ (Mo./Yr.) (Mo./Yr.) Retroactive Date: _____/_____/_____ (MM) (DD) (YYYY)	❑ Claims-Made ❑ Occurrence

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

23. If "no," are you requesting prior acts coverage?... ❑ Yes ❑ No ❑ N/A

If "yes," does your current insurance policy allow you to report incidents that have not yet resulted in a claim or suit, but that could in the future?.. ❑ Yes ❑ No

If "no," is your current insurance policy written on a "demand for damages" basis such that it requires a written or verbal demand for damages before coverage attaches under the policy?.. ❑ Yes ❑ No

CLAIMS INFORMATION

Important information regarding questions 24 through 26 (including sub-questions):

1. The word "claim" as used in Questions 24 through 26 below refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from the professional activity of and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention or to the attention of any person employed by your entity by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to question 24, 25 or 26 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 7).

24. Have any of the entity(ies) identified in question #1 <u>ever</u> been involved in a malpractice claim or suit, either directly or indirectly? ❑ Yes ❑ No

25. Please indicate if you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against any of the entity(ies) identified in question #1 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
    b. A letter from an attorney regarding your medical treatment of a patient? ❑ 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

26. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ❑ Yes ❑ No ❑ N/A*

    **For purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

    a. If "yes," how many? ______________ Please attach documentation of all such reports.
    b. If "no," please explain on your business letterhead.

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. Name of entity(ies) named in claim or suit: ______________________________
2. Patient's name: ______________________________
3. Date reported to insurance company: ______________________________
4. Name of insurance company: ______________________________
5. Date of incident and your treatment: ______________________________
6. Allegations: ______________________________
   ____
   ____
7. What is the present condition of the patient? ______________________________
   ____
   ____
8. Did anyone involved in the claim in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that anyone involved in the claim did so? .... ❑ Yes ❑ No
9. 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: ❑ Yes ❑ No	❑ Awaiting mediation ❑ Awaiting court action
❑ Suit settled out of court a. Date claim paid: ________ b. Amount paid: $ ________ c. Did you want to settle this claim? ❑ Yes ❑ No	Court outcome in favor of plaintiff: Amt. of Loss Payment: $ ________	Reserve Amount: $ ________

10. To your knowledge, was any settlement paid by another party 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!

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

Further, I recognize and agree that as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC and/or its assigns may conduct a peer review investigation of me and/or my practice or the practice of any associated physicians. 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 Practice Quality, as COPIC may request or direct. I agree to abide by any recommendations arising from that review. For Colorado and Nebraska insureds only: I have been provided, understand, and will comply with the Participatory Risk Management Guidelines of COPIC.

I authorize any state board of medical examiners or licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present, 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. 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 the subject matter of this insurance to credentials verification organizations, health plans, hospitals, health care organizations, professional liability insurance carriers, and state and federal regulatory entities, including but not limited to boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank and to the fullest extent permitted by law, hereby release all providers of such information, including COPIC, its employees and agents, from any and all liability therefore. This release applies to the following information: my entity's name, business address, social security numbers, NPI numbers, license numbers, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive dates, specialties and PLI rate classes of any affiliated physicians, 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.

Authorized Representative ____ Date ______________
(Signature Required)

Please PRINT your name ____

WE SUGGEST YOU 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.