MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

Healthcare Organization Application for Claims-Made Professional Liability Insurance

IMPORTANT INSTRUCTIONS—PLEASE READ CAREFULLY

IMPORTANT NOTICE
You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

This application is specifically for medical entities.

COMPLETE ALL QUESTIONS:
A complete application will allow us to process your application as quickly as possible.

ATTACHMENTS:
Certain portions of the application may require information that is already reflected on personal documents, for your convenience we include the option to indicate "Attachment contains this information" rather than require that you type in all information. When you indicate "Attachment contains this information" you **warrant** to MIEC that the information contained in the attachments is true and correct. MIEC is relying upon the information in the attachments to make a determination of whether to issue coverage.

PLEASE PROVIDE CURRENT COPIES OF THE FOLLOWING ITEMS WITH THIS APPLICATION :

☐ Policy Declaration page and applicable endorsements

☐ Articles of Incorporation (including amendments)

☐ Current valued Loss Runs for the previous 10 years

For assistance, you may call our main office at the number below from 8:00 a.m. to 5:00 p.m. PST, Monday-Friday, or E-mail us at the address below. Please include in your E-mail the location of your practice or where you plan to practice including the city, state and zip code.

TEL: 800-227-4527
FAX: (510) 318-6700
E-MAIL: underwriting@miec.com

AGENT INFORMATION (if applicable)**:**

Agent Name: _____ Address 1: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

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ORGANIZATION INFORMATION — ANSWER 1

1. ORGANIZATION INFORMATION

Name of Entity _____ Website Address _____

Federal Tax ID Number _____ NPI Number _____

Primary Office Address _____ City _____ State _____ Zip Code _____

Mailing Address _____ City _____ State _____ Zip Code _____

Preferred Billing Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____

Authorized Representative _____ Email Address _____

Type of Entity/Organization

What type of practice organization applies to your practice?

☐ Professional Corporation ☐ Multi-Shareholder ☐ Single

☐ Partnership ☐ Limited Liability Company ☐ Other (describe): _____

How many years has the entity been in operation? _____

Has the group ever been incorporated or been organized under a name other than that listed above? ☐ Yes ☐ No

If yes, provide details: _____

Does your entity have a Tradename/DBA/Fictitious Name? ☐ Yes ☐ No

If yes, list all names: _____

List all entities for which coverage is requested: ☐ *Attachment contains this information*

Name of Entity _____ Type of Facility _____ Retroactive Date _____

Name of Entity _____ Type of Facility _____ Retroactive Date _____

Name of Entity _____ Type of Facility _____ Retroactive Date _____

Locations

List full street address. If you desire premises coverage for any of these locations, check appropriate boxes "Yes" or "No." Any additional locations may be listed on separate attachment.

#1 Street Address _____ City _____ State _____ Zip Code _____ #1 Premises Coverage Requested? ☐ Yes ☐ No

#2 Street Address _____ City _____ State _____ Zip Code _____ #2 Premises Coverage Requested? ☐ Yes ☐ No

#3 Street Address _____ City _____ State _____ Zip Code _____ #3 Premises Coverage Requested? ☐ Yes ☐ No

COVERAGE AND REQUESTED LIMITS — ANSWERS 2-3

2. COVERAGE REQUESTED

Requested Effective Date _____ (mm/dd/yyyy) Is the organization requesting Prior Acts Coverage? ☐Yes ☐No

Requested Retroactive Date _____ (mm/dd/yyyy) *(Attach proof such as a declarations page or COI)*

3. REQUESTED LIMITS

Do you wish to request a separate limit of liability for the entity? ☐Yes ☐No

If yes,

Please indicate the primary limits of liability requested (Limit per claim / annual aggregate):

☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

Do you wish to request excess limits of liability? ☐Yes ☐No (additional screening may be required). **If Yes,** please select an option:

☐ $1,000,000/$1,000,000 ☐ $2,000,000/$2,000,000

☐ $3,000,000/$3,000,000 ☐ $4,000,000/$4,000,000

Do you wish to request a deductible? ☐Yes ☐No

If yes, please indicate the type of deductible and the amount.

Deductible amount: $ _____ ☐ Indemnity Only ☐ Indemnity & Expense

Have your limits of liability changed (increased or decreased) in the past five years? ☐Yes ☐No

If yes, please describe the change and reason why:

_____

_____

PHYSICIAN AND NON-PHYSICIAN SCHEDULES — ANSWERS 4-6

4. SCHEDULE OF PHYSICIANS FOR WHOM COVERAGE IS REQUESTED ☐ *Attachment contains this information*

Name	Retroactive Date	Specialty	NPI Number	FTE

Provide the number of annual patient encounters/visits:

Location	# of Annual Encounters/Visits Previous Year	# of Annual Encounters/Visits Current Year	# of Annual Encounters/Visits Projected Next Year

5. SCHEDULE OF DEPARTED PHYSICIANS FOR WHOM THE PHYSICIAN GROUP IS REQUESTING COVERAGE

☐ *Attachment contains this information*

Name	Retroactive Date	Specialty	NPI Number	Termination Date

6. INFORMATION ON NON-PHYSICIAN PROVIDERS ☐ *Attachment contains this information*

Do you employ or contract with any individual, that is licensed, certified, or otherwise authorized to deliver advanced level health care **in the absence of direct supervision by a licensed physician** including but not limited to the following: *Certified Registered Nurse Anesthetists, Nurse Practitioners, Nurse Midwives, Physician Assistants, Surgical Assistant, Psychologist, Chiropractors, Optometrist***.** A separate application will be required for each individual listed below.

Name	Type		Hours per week
		☐ Employee ☐ Contractor	
		☐ Employee ☐ Contractor	
		☐ Employee ☐ Contractor	
		☐ Employee ☐ Contractor	

If you employ any Nurse Midwives, how many deliveries are perform annually by these individuals? _____

Indicate the number and type of all other healthcare providers that provide healthcare services on behalf a provider of this group's practice:

Type	Number of Providers	Type	Number of Providers

Do any of your employed providers (licensed, certified, or otherwise) practice at a location geographically separate from yours? ☐ Yes ☐ No

If "Yes," please explain: _____

List all providers that are either owners, employees, or contractors with the group, who will be insured elsewhere and provide proof of coverage. Please provide explanation in comments section:

Name	Specialty/Type	Current Insurer

Comments: _____

7. OPERATIONS

Which best describes how the entity primarily operates?

☐ Holding Company ☐ Medical Group ☐ Hospital ☐ Surgery Center ☐ Laboratory ☐ Medical Facility ☐ Imaging Center

☐ Educational/Institutional ☐ Other: _____

What is the specialty of services primarily provided by this entity, any employees or independent contractors?

_____

Within the next 12 months does the entity plan to:

A. Make an acquisition? ☐ Yes ☐ No

B. Change the number of physical locations where services are offered? ☐ Yes ☐ No

C. Change the number of providers, outside of normal turnover? ☐ Yes ☐ No

If Yes to any of the above, please explain: _____

D. Within the last 3 years has the entity's operational characteristics (services, procedures performed, etc.) changed? ☐ Yes ☐ No

If Yes, please explain: _____

Currently, or within the last 3 years, has the entity's services involved any of the following?

E. Use of locum tenens providers? ☐ Yes ☐ No **If Yes,** how many days per year? _____

F. Performing any of the following procedures:

1. Experimental Surgery ☐ Yes ☐ No
2. Cosmetic Surgery ☐ Yes ☐ No
3. Bariatric Surgery ☐ Yes ☐ No

G. Treatment of patients via virtual or telemedicine? ☐ Yes ☐ No **If Yes,**

1. What percentage of your practice does this comprise? _____%
2. What percentage of patients are physically located in the state of your principal licensure/practice location/primary residence? _____%

If not 100%, then

3. What states are your patients treated via telemedicine located in? _____

Are you licensed in all the states where your patients are physically located? ☐ Yes ☐ No

4. For patients treated via telemedicine, are they ☐ New Patients? ☐ Established Patients? Check all that apply.
5. For patients treated via telemedicine, do you prescribe any controlled substance? ☐ Yes ☐ No **If Yes, then**
6. Do you follow DEA protocols which involves a prior in-person examination? ☐ Yes ☐ No

H. Employment or contract work to serve as a medical director for an organization other than your own? ☐ Yes ☐ No
If yes, please provide name(s) and locations and provide evidence of separate coverage.

_____

I. Work in an Emergency Department for purposes other than maintaining staff privileges or as required by the hospital? ☐ Yes ☐ No

If yes, how many hours each week? _____

J. Work as a Hospitalist? ☐ Yes ☐ No If yes, how many hours each week? _____

K. Performing or assisting in surgical procedures in a non-hospital setting during which anesthesia of any kind is administered? ☐ Yes ☐ No

If yes, explain: _____

L. Home health care or visits to a patient's home? ☐ Yes ☐ No If yes, provide details: _____

M. Involvement or participation in non-IRB-approved clinical research trials? ☐ Yes ☐ No ***If yes,*** *please provide details and include supporting documents.*

_____

N. Professional services at any nursing home or correctional facility? ☐ Yes ☐ No **If yes,** how many hours per week? _____
Please include supporting documents (i.e. your contract with the facility, evidence of coverage for administrative duties).

O. Sharing of office space, employees, common letterhead with other physicians who are NOT employed by you? ☐ Yes ☐ No

P. Professional services or providing treatment to celebrities, collegiate or professional athletes? ☐ Yes ☐ No

If Yes, please explain: _____

8. RISK MANAGEMENT

What percentage of the group's physicians are Board Certified in their specialty? _____%

Does the Physician group have a formal Risk Management Plan? ☐Yes ☐No

If yes, please explain: _____

If yes, who is responsible for the program: _____

Does the Physician Group have a formal Quality Assurance Committee? ☐Yes ☐No

Who does the credentialing? ☐Outside credentialing entity ☐Rely on Contracted Hospital ☐Self ☐Other:

Does the group have written opioid protocols? ☐Yes ☐No

Please provide details: _____

Does the physician group's hiring and screening procedures for staff include the following? (check all that apply):

☐Education Background Checks ☐Previous Employer Checks ☐Medical Professional Claims History (if applicable)

☐Criminal Background Checks ☐Drug/Alcohol Screening ☐Personal Reference Checks

☐Medical License Verification ☐Other:

9. ADDITIONAL INFORMATION

Has the group or any individual or entity proposed for coverage under this insurance:

A. Ever been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐Yes ☐No

B. Ever been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐Yes ☐No

C. Ever been accused of sexual misconduct or had any contact of a sexual nature with a patient or former patient? ☐Yes ☐No

D. Ever been treated for any alcohol, narcotics or any substance abuse? ☐Yes ☐No

E. Ever had a Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐Yes ☐No

F. Ever had hospital privileges reduced, suspended or revoked? ☐Yes ☐No

G. Ever had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐Yes ☐No

H. Ever had a medical professional liability insurance carrier decline, non-renew or cancel insurance coverage? ☐Yes ☐No

I. Ever had a medical professional liability insurance carrier surcharge, reduce or issue coverage with a deductible or other special term? ☐Yes ☐No

If "yes" to any of the above, please explain (use additional comments on page 7 if necessary):

_____

_____

_____

10. INSURANCE HISTORY ☐ *Attachment contains this information*

List **all** professional liability carriers (including current) who have insured you during the last 10 years. Use additional comments or separate sheet of paper, if necessary.

Name of Carrier	Limits	☐ Claims-Made ☐ Occurence	Coverage Dates: From	To	Retro Date

If current policy is claims-made, have you or do you intend to purchase "tail" coverage? ☐Yes ☐No

CLAIMS INFORMATION AND ADDITIONAL COMMENTS — ANSWERS 11-12

11. CLAIMS INFORMATION ☐ *Attachment contains this information*

Within the past 10 years, has any claim or suit for alleged malpractice ever been brought against the entity/organization or any owner/employed/contracted provider, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐Yes ☐No

If yes, complete the following and a claim/suit/incident supplemental form for each claim, suit, or incident or provide loss runs for the past 10 years.

Total Number of Claims and Suits: _____ Number Open/Reserved: _____ Number Closed: _____

Total Number of Incidents: _____ Number Open/Reserved: _____ Number Closed: _____

Have you made any changes to your practice as a result of any claims, suits or incidents? ☐Yes ☐No

If "yes" please explain: _____

12. ADDITIONAL COMMENTS ☐ *Attachment contains this information*

CLAIM/SUIT/INCIDENT SUPPLEMENTAL FORM

CLAIM/SUITINCIDENT SUPPLEMENTAL FORM ☐ *Attachment contains this information*

Attach a detailed loss run, which includes at least the information requested below, or complete this form for **each** claim, suit, or incident within the past 10 years. Provide adequate detail to allow proper evaluation, additional information may be requested.

Last Name of Patient/Claimant _____ Gender _____ Age _____

1. Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon): _____
2. Allegation: _____
3. Date of Incident: _____
4. Location: _____
5. Insurance carrier(s): _____
6. Other defendants: _____
7. Present status: ☐ Open ☐ Closed
8. Indemnity and expenses reserved: _____
9. Loss of: $ _____
10. Expenses paid: $ _____
11. Date Closed: _____ ☐ Settlement ☐ Judgement
12. Conditions and diagnosis at time of incident: _____

_____

13. Dates and description of professional services rendered: _____

_____

14. Condition of patient subsequent to professional services (and dates of follow-up visits, if known): _____

_____

15. Explain what action(s) you have taken to prevent recurrence of this type of claim: _____

_____

IMPORTANT

THE FOLLOWING SECTIONS PROVIDE IMPORTANT INFORMATION RELATING TO VARIOUS ASPECTS OF THE INSURANCE YOU ARE APPLYING FOR.

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned represents that the statements made in this application and any materials submitted herewith are true and correct, that neither the undersigned nor any of the undersigned's employees, agents, or representatives have withheld or failed to disclose pertinent information, and that all have given careful consideration to the statements and information provided. The undersigned further acknowledges that such statements are material representations and that any policy issued by MIEC is issued in reliance upon the truth and accuracy of such statements.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose limits in this application. The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature _____ Date _____

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MIEC UNDERWRITERS, LLC., to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MIEC UNDERWRITERS, LLC. to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MIEC UNDERWRITERS, LLC. as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MIEC UNDERWRITERS, LLC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MIEC UNDERWRITERS, LLC. and the Board of Governors or its Executive Committee shall be borne by MIEC UNDERWRITERS, LLC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with Section 1399 and 1400 or 1401 or 1401.5 of the Insurance Code of the State of California subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This instrument can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber thereto, and all other subscribers to this and any other like agreements.

Signature _____ Date _____