Corporate Application

This application is for claims made coverage. Please read the policy carefully.

I. Applicant Organization Information

Organization Name: _____

Year established: _____ Federal Tax ID # : _____

Type of Corporation: ☐Professional Corporation ☐Partnership ☐Limited Liability Company
☐Multi-Shareholder Corporation ☐Non-Profit Organization ☐Other (Describe)

Is there any other name under which you practice (i.e. DBA)? _____

Authorized Representative for Insurance Matters:

Name: _____ Title:_____

Phone: _____ Email:_____

CEO: _____ please include CV/Resume with application

Risk Manager: _____ please include CV/Resume with application

Medical Director: _____ please include CV/Resume with application

Requested Effective Date: _____ **Requested Retroactive Date**: _____

Are you purchasing tail coverage from your current carrier? ☐ Y ☐ N If yes, please provide a copy.

II. Address

Office Address

_____
Street City County State Zip Code

Phone: _____ E-mail:_____

Website(s): _____ Fax: _____

Which is the best way to contact you? ☐ Phone ☐ Email ☐ Other: _____

Billing Address-*If same as Office Address, check here*: ☐

_____
Street City County State Zip Code

Phone: _____ Fax: _____ E-mail: _____

III. Corporation Information

List all owned (50% or more) entities for which coverage is to be provided. If you have more than 5, please provide on a separate form and submit with application

Name: Type/Purpose of Facility Retroactive Date:

_____

_____

_____

_____

Within the next 12 month period, does your group plan to grow by acquisition of another group or entity? ☐ Y ☐ N

IV. Limits of Liability – Please identify the limit you are requesting:

Limits of Liability: $_____(per claim) $_____(aggregate)

Deductible: ☐ None ☐ Capped Deductible _____/_____ ☐ Uncapped Deductible: _____

Self-insured Retention: $_____(per claim) $_____(aggregate)

Is there a Trust? ☐ Y ☐ N

Is there an Insurance Captive? ☐ Y ☐ N

What organization handles claims for the SIR? _____

What legal firm is responsible for defending claims against the insured? _____

V. Practice Locations

List all current Practice Locations: (If more than 3, please attach information on a separate sheet of paper)

Location 1:

Office Name _____ Office Manager: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Location 2:

Office Name _____ Office Manager: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Location 3:

Office Name _____ Office Manager: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Within the next 12 month period, does your group plan to add any additional locations? ☐ Y ☐ N

VI. Previous Insurance – Please provide ten (10) years of previous insurance information

Current Carrier		Effective Date		Limit of Liability	
		Expiration Date		Type of Coverage	
		Retroactive Date		Premium	
Prior Carrier		Effective Date		Limit of Liability	
		Expiration Date		Type of Coverage	
		Retroactive Date		Premium	
Prior Carrier		Effective Date		Limit of Liability	
		Expiration Date		Type of Coverage	
		Retroactive Date		Premium	
Prior Carrier		Effective Date		Limit of Liability	
		Expiration Date		Type of Coverage	
		Retroactive Date		Premium	

VII. Practice Information

Entity is:
- ☐ Multi-Physician Shareholder Medical Corporation
- ☐ Medical Partnership with formal written agreement
- ☐ Staffing agency / Locum Tenens Firm
- ☐ Other (IPA, PPO, Association, etc.) Specify: _____

Extent of professional relationship between the physician members (check all that apply)

- ☐ Common letterhead
- ☐ Common billing statements (as opposed to utilizing the same billing service)
- ☐ Share profits
- ☐ Share professional employees (e.g. R.N., Technician)
- ☐ See each other's Patients on a regular basis
- ☐ Share overhead expenses
- ☐ All physicians' names appear together on the office door
- ☐ Other: _____

List the state(s) you are registered and licensed to practice: _____

_____

Specialty: ☐ Single specialty:_____
☐ Multispecialty
Indicate three (3) largest (patient volume) departments by specialty.
(1) _____approximate percentage to total volume_____%
(2) _____approximate percentage to total volume_____%
(3) _____approximate percentage to total volume_____%

VIII. Medical Staff

Do you employ/contract/supervise any of the following personnel? Indicate the number of the following advanced practice healthcare providers utilized by you or your group? ☐ Employ ☐ Contract ☐ Supervise ☐ N/A

Please indicate the number of staff below.

Physicians	Employees	Independent Contractors		Employees	Independent Contractors
Physicians			Occupational Therapist		
Interns			Orthodontist		
Residents			Physician's Assistant		
Fellows			Speech Therapist		
Psychologist			Other (please explain)		
Audiologist			Occupational Therapist		
CRNA			Laboratory Technician		
Nurse Practitioner			Optician		
Laboratory Technician			Podiatrist		
Optician			Social Worker		
Optometrist			Pharmacist		

Are you requesting the above to be covered by ALTOR National? ☐ Y ☐ N
If yes, should the advanced practice professionals be covered on a shared or separate limit of liability? ☐ Shared ☐ Separate

Do any of the advanced practice professional staff have his/her own coverage? ☐ Y ☐ N
If yes, please provide the declarations page or certificate of insurance to verify coverage.

VIII. Medical Staff (continued)

Do you have any restricted licensed physicians on staff: ☐ Y ☐ N If yes, please explain.

Do you have any physicians on staff who do not maintain staff privileges at a hospital? ☐ Y ☐ N If yes, please explain.

Please describe the peer review process for medical staff.

Does the facility require Certificates of Insurance for all staff physicians? ☐ Y ☐ N
If yes, please provide limits $_____(per claim)$_____(aggregate)

Do you have qualified physician(s) or other personnel trained in emergency medical care in the center during all hours of operation?
☐ Y ☐ N Please describe:

IX. Practice Operations

DOCUMENTATION

A. Do you maintain adequate medical records for each patient? ☐ Y ☐ N Please explain.
B. How often are the medical records reviewed?
C. What arrangements are made for transmitting medical records to other requesting physicians?

D. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule?
☐ Y ☐ N
E. Has the applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ Y ☐ N
F. Provide the name and title of the applicant's Privacy Officer:
G. Do you secure a fully completed medical record from each new patient? ☐ Y ☐ N
H. Do you secure a signed Informed Consent Document from each patient? ☐ Y ☐ N

SERVICES

I. Does the applicant provide medical services for other than fee for service? ☐ Y ☐ N
J. If yes, provide details of arrangements, including a copy of the contract(s)
K. What is the patient mix: _____% fee for service _____% prepaid
L. Percent of prepaid patients referred to outside physicians: _____%
M. Indicate the percentage of elective surgery _____% non-elective surgery _____%
N. Do you prescribe drugs for weight reduction of patients ☐ Y ☐ N
O. Number of annual X-ray exposures: _____diagnosis; _____ treatment.
P. Do you maintain any beds for overnight occupancy? ☐ Y ☐ N If yes, how many:_____
If yes, minors: ☐ Y ☐ N
If yes, psychiatric: ☐ Y ☐ N

IX. Practice Operations (continued)

Q. Indicate which of the following equipment you have at the facility.

- ☐ Laboratory with the capabilities of (CBC, UA electrolytes, blood sugar, arterial blood gasses, pregnancy test, BUN, and or creatinine?
- ☐ X-ray with on-premises processing
- ☐ EKG (12 lead)
- ☐ Monitor/Defibrillator
- ☐ Crash cart with full cardiac life support capabilities and necessary IV fluids
- ☐ Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage
- ☐ Oxygen
- ☐ Suction
- ☐ Pneumatic anti-shock trousers
- ☐ Dedicated telephone lines to the closest appropriate hospital emergency department and/or communication with EMS

R. Hours of operation

	OPEN	CLOSE
Sunday:	_____	_____
Monday:	_____	_____
Tuesday:	_____	_____
Wednesday:	_____	_____
Thursday:	_____	_____
Friday:	_____	_____
Saturday:	_____	_____

S. Do you have qualified physician(s) or other personnel trained in emergency medical care in the center during all hours of operation?

☐ Y ☐ N Please describe: _____

_____

_____

X. Patient Visits

Type of Visit	Number of Visits Last 12 months	Number of Visits Next 12 months
Clinic	_____	_____
Laboratory	_____	_____
Emergency	_____	_____
Urgent Care	_____	_____
TOTAL NO. OF VISITS	_____	_____

XI. Practice Profile Questions – If needed, please attach information on a separate sheet of paper.

A. Has the applicant's professional liability insurance ever been cancelled for non-payment of premium? *(Not Applicable to Missouri Applicants.)* ☐ Y ☐ N

If yes, please describe. _____

B. Has the applicant's professional liability insurance ever been declined, canceled, non-renewed or issued on special terms? *(Not Applicable for Missouri Applicants.)* ☐ Y ☐ N

If yes, please describe. _____

C. Does the applicant, through its medical staff, treat or intend to treat any patient by means of unconventional therapy which may be considered human experimentation, or conceivably be subject to regulatory approval? ☐ Y ☐ N

If yes, please identify the physicians involved and provide details. _____

D. Does the applicant contract with any government facility including prisons or correctional facilities? ☐ Y ☐ N

If yes, please identify the government agency, facility type and the relationship._____

E. Does the applicant ever enter into arbitration or similar agreements with your patients? ☐ Y ☐ N

If yes, please attach a copy of the agreement(s). _____

XI. Practice Profile Questions (continued) – *If needed, please attach information on a separate sheet of paper.*

F. Does the applicant own a subsidiary(ies)? ☐ Y ☐ N
If yes, disclose that subsidiary here and indicate its type of organization._____

G. Has the applicant or any of its employees ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Y ☐ N
If yes, please identify the physicians involved and provide details. _____

H. Has the applicant or any of its employees ever been indicted for, or convicted of any act committed in violation of any law or ordinance, other that traffic offenses, or had hospital privileges or medical licenses revoked, suspended, restricted, placed on probation, or voluntarily surrendered? ☐ Y ☐ N
If yes, please identify the physicians involved and provide details. _____

I. Has the applicant or any of its employees ever filed for bankruptcy? ☐ Y ☐ N
If yes, please identify the physicians involved and provide details. _____

J. Has any of the applicant's employees ever been treated or recommended for treatment for alcoholism, drug addiction, or sex addiction? ☐ Y ☐ N
If yes, please identify the physicians involved and provide details. _____

K. Has the applicant ever been suspended by any government health program (e.g. Medicare or Medicaid)? ☐ Y ☐ N
If yes, please provide details below._____

L. Has any Physician, patient, or insurance plan ever filed a complaint against the group with any medical association, society or foundation, consumer protection agency, chamber of commerce, or better business bureau? ☐ Y ☐ N
If yes, please provide details._____

M. Does the applicant maintain current certificates of insurance on file for all doctors and advanced practice professionals employed, contracted, or privileged at its facility(ies)? ☐ Y ☐ N

N. Does all biomedical equipment receive scheduled preventative maintenance annually by a qualified technician? ☐ Y ☐ N
If yes, is your biomedical equipment checked by your employees on a routine basis? ☐ Y ☐ N
If yes, are these check logs maintained in your practice? ☐ Y ☐ N

O. Is the entity certified or accredited by any of the following? ☐ AAAHC ☐ ARC ☐ CAP ☐ JCAHO ☐ Other (include a copy of the most recent survey, certification, or accreditation).

P. Does the applicant have an Ambulatory Surgery Center? ☐ Y ☐ N
If yes, is the facility accredited? ☐ Y ☐ N
ASC Accreditation: ☐ JCAHO ☐ AAAHC ☐ Other _____
Does your recovery room provide for a dedicated nurse? ☐ Y ☐ N
What is the time in minutes to the nearest fully-equipped hospital? _____

Q. Do any of the applicant's employees have any other medical director responsibilities? ☐ Y ☐ N
If yes, please identify the physicians involved and provide details. _____

R. Does the applicant perform activities covered by another professional liability policy? ☐ Y ☐ N
If yes, please provide proof of coverage, including name and address of entity. _____

S. Is the applicant a member of a national organization? ☐ MGMA ☐ AGPA ☐Other_____

T. Has the applicant, its medical staff, or other employees ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency, or have its licenses to practice or its narcotics license ever been denied, revoked, suspended, or limited in any way? ☐ Y ☐ N
If yes, please provide copies of complaint and disposition documents._____

U. Did you practice with other physicians in an employer-employee relationship, implied or formal partnership, professional association or Medical Corporation during the period for which you are requesting prior acts coverage? ☐ Y ☐ N
If yes, please list the full name of the entity(ies)/physician(s) with whom you practiced and the period of each such association.

Name of Entity	Name of Physician	Dates: From - To

XI. Practice Profile Questions (continued) – *If needed, please attach information on a separate sheet of paper.*

V. Please identify all Physicians and/or Advanced Practice Professionals who will be insured under the applicant's professional liability insurance program including the following information:
Name, Specialty, Date of Birth, Medical Board License, State, #Hrs/wk, Retroactive Date, Termination Date (if applicable)

XII. Risk Management

A. Do you have a credentialing process in place to verify the education, licensure and other qualifications of all medical staff employees and independent contractors? ☐ Y ☐ N

B. Do you practice within the Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008 – published by the Center for Disease Control and Prevention (CDC)? ☐ Y ☐ N

C. Do you have a quality assessment /improvement plan or risk management plan in place? ☐ Y ☐ N
If yes, who directs these activities and what is their specialty? _____

D. Do you require medical staff to participate in ongoing CE? Please describe._____

XIII. Claims

A. Has any claim or suit been brought against you and/or any of your employees? ☐ Y ☐ N

B. Are you aware of any circumstances which may result in a malpractice claim or suit being made against you or any of your employees that has not been reported to your current carrier? ☐ Y ☐ N If yes, please explain _____

_____

_____

_____

C. Please provide 10 years of currently valued loss runs.

Warranty*

These warranties* are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by ALTOR National as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the insurer. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

* Some state laws permit the statements on the application to be only representations. If the policy will be issued in one of these states, your statements will be representations and not warranties.

Acknowledged and Agreed:

_____

Applicant Signature Date

Signing this application does not bind the insurer to complete the insurance. All information in this application is considered material and important. If the insurer agree to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

Fraud Warnings:

Notice to Alabama Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who 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.

Notice to Alaska Applicants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Applicants: 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.

Notice to California Applicants: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: 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.

Notice to District of Columbia Applicants: 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.

Notice to Florida Applicants: 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.

Notice to Kentucky Applicants: 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.

Notice to Louisiana Applicants: 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.

Notice to Maine Applicants: 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.

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

Notice to Minnesota Applicants: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

Notice to New Mexico Applicants: 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.

Notice to New York Applicants: 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.

Fraud Warnings continued:

Notice to Ohio Applicants: 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.

Notice to Oklahoma Applicants: 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.

Notice to Oregon Applicants: 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 may be guilty of a crime and may be subject to fines and confinement in prison. In addition, if an insured or applicant misstates, misrepresents, omits or conceals information, and we rely on such misstatement, misrepresentation, omission or concealment and it is proven to be material to the policy or fraudulent, we may take action, including denying coverage for a claim or other covered event or rescinding, cancelling, or nonrenewing the policy or coverage.

Notice to Pennsylvania Applicants: 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 subjects such person to criminal and civil penalties.

Notice to Rhode Island Applicants: 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.

Notice to Tennessee Applicants: 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.

Notice to Virginia Applicants: 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.

Notice to Washington Applicants: 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.

Notice to West Virginia Applicants: 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.

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

_____

Signature **Date**

_____

Printed Name **Title**

This application is not valid without your complete signature, date, printed name, and title above.

Altor National
SUPPLEMENT TO APPLICATION
CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ ☐ Male ☐ Female

2. Date of Incident _____ Location of Incident _____
Insurance Carrier _____ Date Reported to Insurer _____

☐ Suit ☐ Demand for Money ☐ Incident Only
☐ Notice of Intent to Sue ☐ Request for Records ☐ Other _____

3. Summary of condition/diagnosis at time of incident

_____
_____
_____
_____
_____

4. Description of treatment rendered, including dates.

_____
_____
_____
_____
_____

5. Allegation

_____
_____
_____
_____
_____

6. Other physicians or entities involved

_____
_____

7. Status/Disposition of Claim:
- ☐ Closed without indemnity payment
- ☐ Settled
- ☐ Judgment/Verdict
  - ☐ For the defense
  - ☐ For the plaintiff

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendant(s)	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

☐ Open—please provide current status and defense strategy: _____

8. Has there been a change in practice as a result of this claim(s)? ☐Yes ☐No
If yes, what has been the change? _____
_____
_____

I understand this information is part of my Application.

Please print your name _____

Signature _____ Date _____