APPLICATION FOR EXTENDED REPORTING POLICY COVERAGE

Please type or print

Please read this before filling out your application for coverage. You warrant and represent that the following statements are yours and that you know the statements to be true. You know and intend that we will rely on the truth of the information you have provided in deciding to issue a policy to you, and that providing any materially false information in this application is grounds for us to deny you insurance.

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE AND REPORTED COVERAGE WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application in two places where indicated.
- All information requested must be fully and accurately completed.
- If a particular question does not apply, do not leave it blank, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a seven-year experience period if you have been in practice for at least seven years even if the requested retroactive period is less than seven years. This applies to open and closed claims and to any incidents reported to a previous carrier.

APPLICANT CONTACT AND OTHER PROFESSIONAL INFORMATION

First Name:	Years in Practice:
Middle Name:	E-mail:
Last Name:	NPI Number:
Other Names Used (Aliases):	Date of Birth:
Professional Designation/Title:	

CURRENT PRACTICE ADDRESSES

Practice Name:			
Practice Type:	☐ Employed Physician	☐ Independent Contractor	☐ Partnership
	☐ Professional Corporation	☐ Solo Physician	☐ Other:
Website(s):			Phone Number:
1st Location:			
Address 1:			
Address 2:			
City:		State:	Zip Code:
2nd Location:			
Address 1:			
Address 2:			
City:		State:	Zip Code:
3rd Location:			
Address 1:			
Address 2:			
City:		State:	Zip Code:

MAILING ADDRESS

Same as Above: ☐		
Address 1:		
Address 2:		
City:	State:	Zip Code:

PRIOR PRACTICE LOCATIONS

Please provide all former locations where you provided professional services within the retroactive period.

1st Practice Name:		
Address 1:		
Address 2:		
Prior Practice Period:	From:	To:
2nd Practice Name:		
Address 1:		
Address 2:		
Prior Practice Period:	From:	To:
3rd Practice Name:		
Address 1:		
Address 2:		
Prior Practice Period:	From:	To:

CERTIFICATIONS

Are you American Board Certified?						☐ Eligible	☐ Yes	☐ No
Have you ever failed to pass a board certification?							☐ Yes	☐ No
Name of Specialty Board:				Year Certified:		Recertified:		
Name of Subspecialty Board:				Year Certified:		Recertified:		
Name of Subspecialty Board:				Year Certified:		Recertified:		
Are you:	ACLS Certified	☐ Yes	☐ No	ATLS Certified	☐ Yes	☐ No	PALS Certified	☐ Yes	☐ No

EDUCATION AND TRAINING

You may provide a current CV in lieu of completing this section.

Medical School:				
City/State/Country:				
Years Attended:			From:	To:
Are you a foreign Medical School Graduate:				☐ Yes ☐ No
If yes, please provide ECFMG: Certification Number:				
Applicant Specialty:				
Internship:		Years Attended:	From:	To:
City/State/Country:				
Residency:		Years Attended:	From:	To:
City/State/Country:			Specialty:	
Fellowship:		Years Attended:	From:	To:
City/State/Country:			Specialty:	
Additional Training:		Years Attended:	From:	To:
City/State/Country:			Specialty:	

MEDICAL LICENSES		
State:	License No.:	Expiration Date:
State:	License No.:	Expiration Date:
State:	License No.:	Expiration Date:
State:	License No.:	Expiration Date:
State:	License No.:	Expiration Date:

COVERAGE		
Requested Date of Coverage:	Retroactive Date:	
Requested Limit of Liability:	Duration of Reporting: ☐ 3 yrs. ☐ 5 yrs. ☐ Unlimited	
Average number of hours worked per week:		
Average number of patients seen per week:		
Are you retiring from the practice of medicine?		☐ Yes ☐ No
Are you leaving a practice that requires you to purchase Tail Coverage when leaving? *If yes, please provide details for leaving practice attached to this application.*		☐ Yes ☐ No
Are you purchasing Tail Coverage for reasons other than retirement or contractual obligations? *If yes, please provide details attached to this application.*		☐ Yes ☐ No
Briefly describe the reason(s) why you are requesting Tail Coverage. *Please provide details below including where you will be practicing next.*		
Do you participate in any Patient Compensation Fund (PCF)?		☐ Yes ☐ No
If yes, please identify PCFs in which you participate:		
Have you practiced outside of your board specialt(y/ies) during the requested Retroactive Period?		☐ Yes ☐ No
Have you performed any procedure that is outside the practice of your specialty		☐ Yes ☐ No
Limit Structure Requested		
Limits for insured physician only?		☐ Yes ☐ No
Are you requesting coverage for the entity on a shared limits basis?		☐ Yes ☐ No
Does your expiring policy include coverage for any advanced practice professionals?		☐ Yes ☐ No
If yes, are you requesting tail coverage for this exposure as well?		☐ Yes ☐ No
Separate limits may be subject to a policy maximum aggregate limit.		
Does your current policy include a deductible? Each Claim:	Aggregate:	☐ Yes ☐ No
Please answer whether any of the following are applicable to your practice.		
No surgery except incisions of boils, cysts, or other superficial abscesses or suturing or minor lacerations.		☐ Yes ☐ No
Minor Surgery (includes most procedures performed under local anesthesia).		☐ Yes ☐ No
Assisting in major surgery on your own patients.		☐ Yes ☐ No
Assisting in major surgery on patients other than your own.		☐ Yes ☐ No
Major surgery includes all procedures done under general, spinal, caudal anesthesia, tonsillectomy, appendectomy, D&C, cesarean section, abortion, and open reduction of fractures.		
Have there been any significant changes to your practice within the retroactive period? *If yes, please provide details attached to this application.*		☐ Yes ☐ No
Do you prescribe or recommend cards for medicinal marijuana? *If yes, please provide state approved documentation.*		☐ Yes ☐ No
Do you utilize Telemedicine for: *If yes, please complete telemedicine supplement.* ☐ Visits ☐ Consultations ☐ Patient Onboarding		Percentage of Practice %
Do you perform any Aesthetic, Wellness, Preventative, or cash-based services? *If yes, please complete the wellness supplement.*		☐ Yes ☐ No
Do you treat chronic pain? *If yes, please complete pain supplement.*		☐ Yes ☐ No
Do you provide in-home medical services?		☐ Yes ☐ No

APPLICANT HISTORY

Please provide a complete explanation for each question answered "Yes".

Have there been significant changes in your practice during the retroactive period (i.e.,) changes in specialty, deletion, or addition of procedures?	☐ Yes	☐ No
Have your hospital privileges ever been suspended, limited, or revoked whether voluntarily or involuntarily?	☐ Yes	☐ No
Have your hospital privileges been expanded in the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or Specialty Board?	☐ Yes	☐ No
Have you ever had medical professional liability insurance declined, canceled, surcharged, nonrenewed, or issued with a reduction in coverage?	☐ Yes	☐ No
Has membership in any Professional Association or Society ever been refused, revoked, or limited in any way?	☐ Yes	☐ No
Have you ever had a complaint filed or any action taken against your license by a State Licensing Board?	☐ Yes	☐ No
Have you ever been treated for alcoholism, narcotic addiction, or mental impairment?	☐ Yes	☐ No
Have you ever been indicted, charged, or convicted of a felony other than a minor traffic violation?	☐ Yes	☐ No
Do you work as an emergency room physician? *If yes, do you have separate coverage for this exposure?* ☐ *Yes* ☐ *No*	☐ Yes	☐ No
Do you treat celebrities or professional athletes?	☐ Yes	☐ No
Does your practice include the treatment of minors? *If yes, percentage of practice.* %	☐ Yes	☐ No
Does your practice include care at a prison, correctional facility, detention facility, or individuals detained by ICE? *If yes, please note total percentage of your practice here and addresses of the facilities attached to this application.* %	☐ Yes	☐ No
Do you see patients in a Nursing Home, Long Term Care Facility, Rehab Facility or similar? *If yes, please note total percentage of your practice here and addresses of the facilities attached to this application.* %	☐ Yes	☐ No
Do you practice as a Hospitalist? *If yes, please note total percentage here and addresses of the facilities attached to this application.* %	☐ Yes	☐ No
Do you have another practice for which you carry separate coverage or coverage is provided for you? *If yes, please attach a copy of a declarations page or certificate of insurance.*	☐ Yes	☐ No
Do you moonlight (work outside control of employer)? *If yes, please provide details attached to this application.*	☐ Yes	☐ No
Do you perform any cosmetic procedures?	☐ Yes	☐ No
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? *If yes, please list the full name of the entity(ies)/physician(s) with whom you practiced and the period of each such association.*	☐ Yes	☐ No

Name of Entity	Name of Physician	Dates:	
		From:	To:
		From:	To:

INSURANCE HISTORY

Please provide all insurance history for the past 7 years.

Current Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:
Prior Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:
Prior Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:
Prior Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:

CLAIMS HISTORY

Has any claim or suit for alleged malpractice ever been brought against you?		☐ Yes	☐ No
Has any claim or suit for alleged malpractice been brought against you in the last five years?		☐ Yes	☐ No
Are you aware of any circumstances that might reasonably lead to such a claim or suit?		☐ Yes	☐ No
Total number of claims ever filed against you:	Number of open/reserved claims against you:		
Total number of closed claims:	Years of Claims History Provided:		

Please provide any changes you've made to your practice as a result of any claim made against you.

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 Company. 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 Company to complete the insurance. All information in this application is considered material and important. If the Company agrees 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.

RELIANCE ON APPLICATION, FRAUD WARNINGS, AND SIGNATURE

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THIS RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares, warrants and represents, to the extent permitted by applicable law, that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. Should any of the information in this Application be false or inaccurate, this policy may be void *ab initio*, as if the policy had never existed. This insurance shall provide no coverage for any matter that is based upon, arising out of, directly or indirectly resulting from or in any way involving any actual or alleged false or inaccurate information in this Application.

The information contained in and submitted with this Application is on file with the Insurer, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand that:

A. If any portion of the policy to be issued is written on a "Claims Made" basis, then such portion(s) shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Insurer in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and

B. the limit of liability available under the policy to be issued available to pay damages, settlements, or judgments may be reduced, and may be exhausted, by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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.

(RELIANCE ON APPLICATION, FRAUD WARNINGS, AND SIGNATURE continued)

NOTICE TO ARKANSAS, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, VERMONT & 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.

NOTICE TO CALIFORNIA APPLICANTS: For your protection, California law requires the following to appear on this form: any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in 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 KANSAS APPLICANTS: Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. a fraudulent insurance act means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or insurance agent or broker, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for insurance or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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 MAINE, TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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 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.

NOTICE TO OHIO APPLICANTS: Any person who, with the 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 materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that:

A. The misinformation is material to the content of the policy;
B. We relied upon the misinformation; and
C. The information was either:
    1. Material to the risk assumed by us; or
    2. Provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests. Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

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.

ACKNOWLEDGEMENT

This applicant acknowledges that the applicant has read and understood this application, and further 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.