



Entity Professional Liability Insurance Application

PLEASE TYPE OR PRINT IN BLACK INK, AND ANSWER ALL QUESTIONS IN DETAIL. **COVERAGE WILL NOT BE CONSIDERED UNTIL APPLICATION IS FULLY COMPLETED AND SIGNED.**

This form must be completed for each and every separate joint venture, partnership, and/or corporation. Please attach copies of Articles of Incorporation, Partnership Agreements, etc. Please attach a listing of all organizations and a description of how they interact.

PLEASE ATTACH THE FOLLOWING:
COPY OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY DECLARATIONS PAGE.
COMPLETED ROSTER FOR ALL EMPLOYED PHYSICIANS, CONTRACTED, PARTNERS, OR OTHERWISE.
COMPLETE LIST OF BOARD OF DIRECTORS/SHAREHOLDERS

I. ORGANIZATION INFORMATION

A. ENTITY NAME: ADMINISTRATOR: FEDERAL TAX I.D. NUMBER:

Administrator Email: _____

PLEASE LIST OTHER NAMES UNDER WHICH THIS ENTITY MAY DO BUSINESS:

B. LOCATIONS AND ADDRESSES (ATTACH OTHER SHEETS IF NECESSARY):

(1)	Street Address	Suite	City	State	Zip
	County	Telephone	Fax	Website (if applicable)	
(2)	Street Address	Suite	City	State	Zip
	County	Telephone	Fax	Website (if applicable)	
(3)	Street Address	Suite	City	State	Zip
	County	Telephone	Fax	Website (if applicable)	

Which of the above is considered your primary location? # _____

Which of the above is your preferred mailing address? Address # _____ If none of the above, please list below:

Street Address Suite City State Zip

C. TYPE OF ORGANIZATION: _____

D. TYPE OF LEGAL ENTITY:

<input type="checkbox"/> Solo incorporated	<input type="checkbox"/> Professional Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Not-for-profit
<input type="checkbox"/> Multi-shareholder corporation	<input type="checkbox"/> Governmental	<input type="checkbox"/> Joint venture	
<input type="checkbox"/> Other: _____			

E. PLEASE COMPLETE ATTACHED ROSTERS (pages 7 & 8).

II. MEDICAL INFORMATION

A. WHAT TYPES OF PATIENT CARE ARE PROVIDED?

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcohol / drug abuse treatment | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Burn care |
| <input type="checkbox"/> Cardiac intensive care | <input type="checkbox"/> Cardiovascular surgery | <input type="checkbox"/> Trauma care |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Community-based healthcare center | <input type="checkbox"/> Cosmetic procedures |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Dental care | <input type="checkbox"/> Oral surgery |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Endocrinology |
| <input type="checkbox"/> Experimental drugs | <input type="checkbox"/> Experimental surgery | <input type="checkbox"/> Home health care |
| <input type="checkbox"/> In vitro fertilization | <input type="checkbox"/> Pathology | <input type="checkbox"/> Nuclear medicine |
| <input type="checkbox"/> Nursing home | <input type="checkbox"/> Obstetrics/gynecology | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Orthopedic surgery | <input type="checkbox"/> Organ / tissue transplant | <input type="checkbox"/> Outpatient surgery |
| <input type="checkbox"/> Pain management | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Plastic surgery | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Rehabilitation/chronic disease clinic | <input type="checkbox"/> Sports medicine |
| <input type="checkbox"/> University / teaching | <input type="checkbox"/> Walk-in emergency / urgent care center | <input type="checkbox"/> Weight reduction surgery |
| <input type="checkbox"/> Other: _____ | | |

III. GENERAL INFORMATION

Please provide a written attachment explaining any "yes" answers to questions B through F.

- A. Does your collection agency have authority to file a collection suit at their discretion without your prior approval? Yes No
- B. Has/is your organization or any of its employees ever been, or are they currently being, disciplined or under review by any committee, group or board? Yes No
- C. Are any of your organizations or their employees now, or have they ever been, under review or disciplined by any organization, including hospital committees, state boards, or any other medically related group? Yes No
- D. Have you or any of your employees ever been, or are you currently being, investigated, charged with or convicted of a felony? Yes No
- E. Are there any pending actions, proceedings or investigations related to the practice of medicine by you or any of your employees? Yes No
- F. Have you ever been advised that your medical professional liability insurance would be declined, non-renewed, or accepted on special terms? Yes No
- G. Do you maintain current certificates of insurance on file for all doctors and allied health care providers employed, contracted, or privileged by your organization?** Yes No
- H. Do you provide outpatient surgical services? Yes No
 If yes, please answer the following:
 1) Is the facility accredited? Yes No By whom? JCAHO AAAHC
 2) What is the time in minutes to the nearest fully equipped hospital? _____
 3) Who provides anesthesia? _____
- I. Do you provide walk-in clinic services? Yes No
 If yes, please answer the following:
 1) Are your services available 24 hours a day? Yes No
 2) What is the average number of physician extenders supervised by a physician at a time? _____
 3) Do any physician extenders have authorization to write prescriptions? Yes No
- J. Do you provide diagnostic imaging or x-ray services? Yes No
 If yes, please answer the following:
 1) Do you provide any radiation therapy? Yes No
 2) Who interprets the results of the tests performed? _____

Name/Specialty _____	Contracted or Employed? _____
Name/Specialty _____	Contracted or Employed? _____

- 3) Do your physicians refer all x-rays to be over-read? Yes No
- 4) Does your facility interpret results of tests performed at facilities other than those requesting insurance through this application? Yes No

K. Please include the annual numbers for the following:

Office visits _____	Clinic visits _____
Surgeries _____	Revenues _____
Deliveries _____	

IV. LOSS INFORMATION

LIST ALL CLAIM(S) INFORMATION REPORTED FROM JANUARY 1, 2003 TO THE PRESENT

- All claims listed on your Application must have been reported to your prior insurer(s).
- All claims not listed on your Application must have been reported to your prior insurer(s).
- A claim, potential claim, incident, or lawsuit reported to a previous insurer is not covered by APIE. Furthermore, under no circumstances or event will any coverage apply to any claim, potential claim, incident, or lawsuit which is known or which may arise out of any incident which is known by any named insured, physician extender, or ancillary personnel as of the effective date of this Policy. It is your responsibility to report all claims, potential claims, incidents or lawsuits, which are known or which may arise out of an incident which is known, to your previous insurer(s).

DO YOU HAVE KNOWLEDGE OF ANY CLAIMS OR POTENTIAL CLAIMS ARISING FROM THE RENDERING OF, OR FAILURE TO RENDER PROFESSIONAL SERVICES INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION, OR ANY FORMER OR PRESENT EMPLOYEE OF THIS CORPORATION, PARTNERSHIP, OR PROFESSIONAL ASSOCIATION? Yes No

IF YES, HOW MANY? _____ HAVE THESE BEEN REPORTED TO YOUR INSURER? Yes No

CLAIMS LISTED AS PART OF THIS APPLICATION ARE NOT CONSIDERED CLAIMS REPORTED TO US.

PLEASE NOTE THAT A COMPLETE CLAIM/ SUIT ADDENDUM FOR EACH INCIDENT NOTED ABOVE MUST BE ATTACHED FOR THE APPLICATION TO BE PROCESSED. YOU MAY INSTEAD ATTACH A LOSS RUN, BUT IT MUST INCLUDE ALL INFORMATION OUTLINED ON THE CLAIM/SUIT ADDENDUM.

V. COVERAGE INFORMATION

PLEASE LIST ALL PROFESSIONAL LIABILITY CARRIERS, BEGINNING WITH YOUR CURRENT CARRIER AND CONTINUING BACK TO YOUR FIRST PRACTICE DATE. ATTACH ADDITIONAL PAGES IF NECESSARY. PLEASE ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR CURRENT POLICY AND ANY ENDORSEMENTS GRANTING EXTENDED REPORTING (TAIL) COVERAGE.

Circle One:

Professional liability carrier / policy number	Limits of liability	Policy dates / Retroactive date	<u>Occurrence / Claims Made</u>
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Professional liability carrier / policy number	Limits of liability	Policy dates / Retroactive date	<u>Occurrence / Claims Made</u>
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Professional liability carrier / policy number	Limits of liability	Policy dates / Retroactive date	<u>Occurrence / Claims Made</u>
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Have you previously applied for or have you ever had coverage with us in the past? Yes No

I request that my professional liability coverage be effective at 12:01 a.m. on ____/____/____.
(The "Policy Effective Date")

(Each loss limit/ aggregate limit)

- | | | |
|----------------------|-----------------|---------------------|
| 1. Please check ONE: | 100,000/300,000 | 500,000/1,000,000 |
| | 200,000/600,000 | 500,000/1,500,000 |
| | 300,000/900,000 | 1,000,000/3,000,000 |

2. If current carrier coverage is a claims-made policy, PLEASE SELECT ONE OF THE FOLLOWING:

I **AM** applying for prior acts coverage. I request a retroactive date of ____/____/____
OR

An extended reporting endorsement (tail coverage) has been or will be purchased from my current carrier. In this situation, the retroactive date will be the policy effective date above. **Please provide a copy of the extended reporting endorsement.**

3. If current carrier coverage is an occurrence policy:

An extended reporting endorsement has not and will not be purchased, and I am **NOT** applying for prior acts coverage.

Please note: Prior Acts coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

I represent, warrant, agree and understand that coverage provided will be for claims reported after the policy effective date. The medical incident must also have occurred after the policy retroactive date. I will have no right to report claims, suits or medical incidents that occurred prior to the policy retroactive date, and you will have no obligation to indemnify or defend me for any medical incident occurring prior to such date. I represent and warrant that I have no knowledge of any medical incidents, claims or suits arising from the rendering of, or failure to render, professional services by me or by any person for whose acts or omissions I am legally responsible, except as noted in the Claims Information section. I understand that "medical incident" shall mean an act or omission arising out of your rendering or failing to render professional services from which a claim might arise. I also represent that any medical incident, claim or suit noted herein has been reported to my current or prior insurance carrier. All applications for prior acts coverage must be approved by Underwriting Management.

VI. PURCHASING GROUP INTENT TO JOIN

THE UNDERSIGNED INDIVIDUAL HEREBY CONSENTS TO JOIN A PURCHASING GROUP FORMED UNDER THE PROVISION OF THE LIABILITY RISK RETENTION ACT OF 1986. ONE OF THE PURPOSES OF THIS GROUP IS TO PURCHASE INSURANCE ON A GROUP BASIS. THE CURRENT INSURANCE POLICIES ISSUED FOR THIS GROUP ARE UNDERWRITTEN BY AMERICAN PHYSICIANS INSURANCE EXCHANGE (APIE).

VII. SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with the company, APIE. All statements are my own representations and are true, to the best of my knowledge. I have not knowingly withheld any information that is calculated to influence the judgment of the Company in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance on the truth of my representations. I understand that no insurance will be afforded unless and until this application is approved by the company and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by the company. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, and individuals. I expressly release and discharge the aforesaid entities, their agents, employees and/ or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as the evaluation of information so received from whatever source.

I understand that, if I am insured by the company, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with the company and any party furnishing information pursuant to this authorization is entitled to rely on the representation of the company that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to the company.

Signature

Print Full Name

Date

PLEASE COMPLETE ENTIRE APPLICATION

INCOMPLETE APPLICATIONS WILL BE RETURNED

The following supplemental subscriber agreement and membership fee form must be completed.

NOTE: Signature of this form does not bind the Applicant, the Exchange, or the Company and no insurance coverage will be considered to be in effect until the applicant has received a confirmation in writing, duly executed by the company.

VIII. SUBSCRIBER'S AGREEMENT AND POWER OF ATTORNEY

The undersigned, hereafter known as the Subscriber, agrees with other subscribers at an exchange to be known as the AMERICAN PHYSICIANS INSURANCE EXCHANGE (API or the "Exchange"), located at Austin, Texas, to exchange private contracts of indemnity. To that end, I hereby appoint APMC INSURANCE SERVICES, INC., located at Austin, Texas, with full powers of substitution and revocation, and with authority to act as my Attorney-in-Fact, in my name, place and stead, to represent me in the following matters:

1. To exchange with other subscribers at API insurance coverages as now or hereafter authorized by the Board of Directors; to subscribe and deliver all proper contracts of insurance; to negotiate and contract for the cession and retrocession of reinsurance as deemed prudent by the Attorney-in-Fact; to take any action in furtherance of the exchange of such contracts of insurance; to do and perform every other thing that I could do in respect to such contracts so exchanged, including the appearance and defense in my name in actions and proceedings; and to manage and conduct the business, affairs and property of the Exchange under the supervision of the Board of Directors. It is expressly understood that I will incur no financial obligation in respect of this reciprocal insurance exchange company except insurance premiums necessary for me to be a member and subscriber in the said company, and such premiums shall become payable only upon policies applied for or issued to and accepted by me through the Exchange.

2. To take on my behalf all actions in respect to operating API that are expressly committed to the Attorney-in-Fact by the By-Laws of the Exchange. I adopt as part of this agreement the By-Laws of the Exchange now or hereafter effective, expressly including the provision of said By-Laws that provides for election at each annual meeting of the subscribers of a Board of Directors of not less than four nor more than fifteen subscribers or executive officers of corporations that are subscribers.

3. The powers hereby vested in my said attorney shall be exercised only in accord with the decisions of the Board of Directors of the Exchange, provided that the said attorney may deputize such person or persons as may be appointed therefore by the Board of Directors to authenticate the policy contracts applied for or those that I may hereafter apply for, and all papers pertaining thereto. It is understood that the subscribers reserve unto themselves the right to govern the Exchange according to the decision of a majority of subscribers present in person or by proxy at any meeting. The intent and purpose of this instrument is to clothe the Attorney-in-Fact with the power necessary to enable me, through the Attorney-in-Fact, to exchange insurance contracts with other subscribers, provided, however, the Attorney-in-Fact shall have no power to make me jointly liable with any other subscriber. There shall be no joint or partnership liability, capital or stock. The Attorney-in-Fact shall not bind me for the obligation of any other subscriber, but for myself alone.

4. I agree that this Power of Attorney shall have application to all insurance applied for by me, whether before or after such insurance is issued, cancelled or expired, including such modifications or changes in any of my insurance as may be made at my request, and the representation made by me in connection with each policy shall have the same force and effect as if contained in this instrument, and that I will cooperate with the Exchange in the defense of any claim made under the aforesaid insurance.

5. I agree further that this Power of Attorney shall be and become effective on the date hereof and shall remain in force and effect for the next year and so long thereafter as I have a contract of insurance with the Exchange. After I have become insured through the Exchange, this Agreement and Power may be cancelled prospectively only in accordance with the cancellation provision of insurance contracts issued pursuant hereto. This Agreement is strictly limited to the use and purpose herein expressed and to no other purpose.

SIGNATURE

DATE



Claim/Suit Information Addendum
Complete ONE Claim/Suit Information Addendum for EACH incident, claim or suit.
PLEASE PRINT ALL INFORMATION.

Doctor's Name _____

1. Name, age, and sex of patient/claimant _____

2. Date(s) of treatment and/or surgery which led to the allegations against you (month/year) _____

3. Nature of the allegations in the claim or suit, or description of medical incident _____

4. Specify incident or claim report date(s) _____

5. Specify if a suit was ever filed: Yes No If yes, provide (month/year) _____

6. Name of the other doctor(s) and hospital(s), if any, involved in claim or suit _____

7. Disposition or current status of incident, claim or suit

Incident only.

OPEN CLAIM-Indicate case value established by insurance company, if known \$ _____

CLOSED CLAIM-Was payment made? Yes No If yes, when ____/____/____

If no, was claim or suit withdrawn? Yes No

If payment was made, indicate amount of settlement \$ _____ award \$ _____

Amount paid on your behalf: \$ _____

8. Name of insurance company defending you _____

Policy Number _____

9. Narrative description of the medical facts. (Must include, but is not limited to, the type of treatment and/or surgery; and your involvement, i.e., consultant, assistant in surgery, E.R. physician, primary surgeon, resident, etc.)
