COPIC®

Better Medicine • Better Lives

Group Medical Practice Application

Medical Professional Liability Policy - Claims Made and Reported

Along with this completed application, please submit the following information:

1) Current policy /declarations pages and applicable endorsements, if any
2) Supplemental details and documents as required
3) 10-year loss history

COPIC®

A Risk Retention Group

NOTICE

If this policy is issued by COPIC, a Risk Retention Group, it may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.

COPIC/ COPIC RRG

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

Group Medical Practice Application
Medical Professional Liability Policy

Entity Information

1. Name of Legal Entity: _____
2. Name of any dba or trade names: _____
3. Type of Group: ☐Corporation ☐Partnership ☐Other_____
4. Tax ID Number: _____
5. Primary Office Phone_____ Website: _____
6. Primary Office Physical Location: _____
7. Primary Office Mailing Address: _____
8. Billing Address: _____
9. Other Office Locations:

_____

_____

Contacts

10. Practice Administrator/ Business Manager: _____ Phone Number: _____

    Title: _____ Email: _____
11. Policy Billing Contact: _____ Phone Number: _____

    Title: _____ Email: _____
12. Primary Risk Manager: _____ Phone Number: _____

    Title: _____ Email: _____
13. Secondary Risk Manager: _____ Phone Number: _____

    Title: _____ Email: _____
14. Agency Name: _____ Phone Number: _____

    Email: _____
15. Producer Name: _____ Phone Number: _____

    Email: _____

Coverage/ Limits

16. Requested Effective Date: _____ 12:01 a.m., Standard Time of the office location.

17. Requested Limits $ _____ / $ _____ Retroactive Date: _____
Per Medical Incident Annual Aggregate

18. Do you want a deductible? ..... ☐Yes ☐No
If Yes, what amount? $_____ ☐ Indemnity Only or ☐ Indemnity and Expense

19. Would you like a quote for excess limits? ..... ☐Yes ☐No
If Yes, for what amount? $_____

20. Do you want increased cyber liability and/or covered proceeding limits? ..... ☐Yes ☐No
If Yes, a supplemental application will be required.

Patient Compensation Funds

21. If approved for COPIC coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under a patient compensation fund? ..... ☐Yes ☐No ☐N/A

22. Have you been a qualified health care provider under the Fund at all times subsequent to the retroactive date requested above and as shown on the insurance declarations page(s) attached to the application? ..... ☐Yes ☐No ☐N/A
"N/A" means that you do not practice within a Fund state and, therefore, this question is not applicable.

Practice Details

23. Please describe your medical practice operations:
_____
_____

24. Do you have Governmental Immunity? ..... ☐Yes ☐No

25. Are there any additional wholly owned corporations to be covered (LLC, PC, PLLC, etc.)? ..... ☐Yes ☐No
If Yes, please list entities in need of coverage here. If necessary, attach additional details:
_____

26. Do any of these entities require separate limits of liability? ..... ☐Yes ☐No

27. Including any telemedicine activities, do you have operations outside of your primary state? ..... ☐Yes ☐No
If Yes, please explain: _____

28. Do any of your physicians act in the capacity of a Medical Director for another facility for which this coverage should extend?..... ☐Yes ☐No
If so, please provide name of facility for which they are Medical Director and describe their duties:
_____

29. Does your practice conduct peer review activities or do you have a professional review committee? ..... ☐Yes ☐No
If so, have you registered, if necessary, and follow all required protocols under any professional review statute? ..... ☐Yes ☐No

30. Do you follow all state and national guidelines regarding prescribing practices? ..... ☐Yes ☐No

Physicians/Surgeons and Non - Physician Employees

31. What is the total number of physicians/surgeons? _____

32. Do you require coverage for your physicians as part of this application? ..... ☐Yes ☐No

*If you desire coverage for **physicians/surgeons**, please complete the provider roster document. Additional questions or materials may be requested.*

If you answer "yes" to the column regarding any adverse actions on the provider roster document, please complete the supplemental claims page and provide supporting details for each provider.

33. What is the total number of each of the following that requires coverage?

	# to be insured		**# to be insured**		**# to be insured**
Advanced Practice Nurses	_____	Embryologists	_____	Psychologists	_____
Anesthesiologist Assistants	_____	Nurse Midwives	_____	Psychotherapists	_____
Aestheticians	_____	Nurse Practitioners	_____	Optometrists	_____
*CRNA/Nurse Anesthetists	_____	Pharmacists	_____	Surgical Assistants	_____
Cytotechnologists	_____	Physician Assistants	_____		

The COPIC policy provides no individual coverage to any employee or independent contractor in any of these classifications working in your office unless he/she is specifically named on the Declarations Page. Please include their information in the provider individual data document. Please contact your underwriter if you have any questions.

***Nebraska Applicants Only:** Nurse Anesthetists are required to complete a special application form; please contact your agent or the COPIC Underwriting Department for the appropriate application form.

Other/ Experience

34. Has the Applicant or any other associated entity or persons ever lost a license, been denied a license or been disciplined (probations, sanctions, fines, etc.) by any governmental licensing agency, by any accrediting review body, or by any state or federal agency?..... ☐Yes ☐No

If Yes, please explain:

_____

_____

35. Has any insurer ever canceled, declined to issue, refused to renew, or issued coverage to the Applicant, or for those to whom coverage would apply, with any restrictions or exclusions? ..... ☐Yes ☐No

If yes, please provide additional details:

_____

_____

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. Provider/Entity name: _____

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 you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ☐Yes ☐No

9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ 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 your favor

☐ Summary judgment in your favor

☐ Court outcome in favor of plaintiff:
   Amount of Loss payment:
   $_____

☐ Awaiting mediation

☐ Awaiting court action:
   Reserve Amount:
   $_____

10. To your knowledge, was any settlement paid by another party (provider or entity) involved? ..... ☐Yes ☐No

    If "yes," amount was $_____

Signature: _____ **Date**: _____

Provider/Authorized Representative

Name (Printed): _____

Warranty Statement

COPIC®
Better Medicine • Better Lives

COPIC®
A Risk Retention Group

The Applicant understands and agrees that all information contained in the application(s) and supplemental information submitted to COPIC[1] in connection with the insurance being applied for will be relied upon by COPIC underwriters in issuing the policy and are the basis for the proposed insurance. Such application(s) and information submitted to COPIC shall be deemed attached to, and made a part of, this Warranty Statement.

The Applicant also understands and agrees that the policy, for which this Warranty and application are made subject to its terms and conditions, does not apply to claims or potential claims the Applicant is aware of, or should be aware of after reasonable inquiry, prior to the effective date of coverage. All claims or potential claims should be reported to the Applicant's carrier prior to the effective date of the new policy.

The Applicant warrants, after reasonable inquiry, that it is not aware of any dispute, error, omission, act or circumstance that is, or could reasonably be expected to become, a claim under the policy of which the application(s) and supplemental information are submitted to COPIC, including, but not limited to, an attorney's request for records, patient/family dissatisfaction, or unanticipated death/paralysis/disability.

☐ Check this box if the Applicant warrants that the above statements are true.

I. By signing below, the Applicant warrants that the foregoing is true and complete and acknowledges that the insurer is relying on the accuracy of this statement in acceptance of the risk. This does not bind the company to offer insurance.

II. The Applicant acknowledges and agrees that this warranty statement shall be the basis of the proposed insurance and shall be considered incorporated into and constituting part of the proposed insurance.

III. The Applicant agrees that if the information supplied on this warranty statement changes between the date of the warranty statement and the inception date of the insurance, the Applicant will immediately notify the insurer of such a change, and the insurer may modify or deny coverage.

Print Name: _____ **Title**: _____

Signed: _____ **Date**: _____

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

[1] The reference to COPIC may be to either COPIC Insurance Company or COPIC, A Risk Retention Group. Each of those companies are members of the COPIC family of companies. The specific COPIC company to which this Warranty applies is the company from which you are seeking coverages.

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

The applicant understand that this is an application for insurance and not an insurance binder.

The applicant hereby declares and warrants that all answers and statements herein given are true and complete to the best of their knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. The applicant understands that these answers and statements are material and as such will be relied upon in the determination by the company to grant liability insurance as requested. If there is a misstatement or failure to disclose any pertinent information, the application for coverage may be declined. If the application is approved and it includes any misstatement or failure to disclose pertinent information, COPIC/COPIC RRG has the right to cancel the insurance. COPIC/COPIC RRG also has the right to decline coverage for a specific claim if COPIC/COPIC RRG would have declined to issue insurance or limited coverage if the misstatement or omission did not occur.

Further, as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC/COPIC RRG and/or its assigns may conduct a peer review investigation of the practice or individuals insured. As part of such peer review investigation, consent is provided to the release of any prior Practice Assessments and to periodic chart and medical record reviews conducted as COPIC/COPIC RRG may request or direct. We agree to abide by any recommendations arising from that review.

By submitting this application, authorization is given to 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/COPIC RRG or its assigns. The applicant approves the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC/COPIC RRG policy, consent is provided to COPIC/COPIC RRG to release of the following information about insureds under this policy, which may change from time to time, 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/COPIC RRG, its employees and agents, from any and all liability therefore. This release applies to the following information: insured(s) name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, 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.

Signature of Authorized Representative: _____ Date _____

Name (Printed): _____

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.

INSURANCE FRAUD WARNINGS

ALABAMA

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 restitution fines or confinement in prison, or any combination thereof. Ala. Code 1975 § 27-12A-20

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for 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. A.C.A. § 23-66-503

COLORADO

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 in formation 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. C.R.S. § 10-1-128 (6)(a)

DISTRICT OF COLUMBIA

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. DC ST § 22-3225.09

FLORIDA

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. West's F.S.A. § 817.234

KENTUCKY

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. KRS § 304.47-030

LOUISIANA

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. LSA-R.S. 40:1424

MAINE

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. 24-A M.R.S.A. § 2186(3)

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. MD INSURANCE § 27-805(b)(1)

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. NJ ST 17:33A-6(c)

NEW MEXICO

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 subject to civil fines and criminal penalties. NM ST § 59A-16C-8

NEW YORK

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. N.Y. Ins. Law § 403

OHIO

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. OH ST § 3999.21

OKLAHOMA

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. OK ST T. 36 § 3613.1

RHODE ISLAND

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. Gen Laws 1956, § 27-54.1-3

TENNESSEE

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. T. C. A. § 56-53-111(b)(1)(A)

VIRGINIA

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. VA Code Ann. § 52-40. B

WASHINGTON

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. RCWA 48.135.080

WEST VIRGINIA

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. W. Va. Code, § 33-41-3(a)

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

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.