Copic Application for Medical Professional Liability Insurance

Physician Application

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

With your completed application, we require the following information:

- Current declarations page which provides a retroactive date and indicates limits of liability for which you are requesting coverage.
- Written confirmation of the purchase of or your intent to purchase a reporting endorsement ("tail coverage") from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
- Please check the following specialties that apply. Note: An additional application will be provided.

☐ Anesthesiology/Pain Management
☐ Bariatric Surgery
☐ Cardiology
☐ Dermatology
☐ Hand Surgery
☐ Family Physician performing Obstetrics
☐ Ophthalmology
☐ Orthopedics
☐ Physical Medicine & Rehabilitation
☐ Radiology
☐ Surgery (General, Thoracic & Vascular)

- If you are requesting coverage for your employed Advanced Practice Provider, a separate application is required.
- Current business letterhead and advertisements (including website material).
- Curriculum Vitae (C.V.)
- A loss run report. To obtain this information, please call your prior carrier(s) and request a currently-valued loss run for the past ten (10) years

Additional information may be requested.

APPLICANT DATA

1. First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____Title: _____

2. Date of Birth: _____/_____/_____ **3.** National Provider Identifier (NPI): _____

4. Personal/Confidential Email Address (Required for Online Access): _____

5. Legal Residency:

Physical Street/Home Address: _____

City: _____ State: _____ ZIP: _____ Cell Phone Number: _____

Rural Mailing Address/PO Box (if applicable): _____

City: _____ State: _____ ZIP: _____ Home Phone Number: _____

6. Primary Practice Location:

Address: _____

City: _____ State: _____ ZIP: _____ Office Phone Number: _____

Website Address: _____ Primary Contact Name: _____

Primary Contact Email Address: _____ Primary Contact Phone Number: _____

7. Office/Practice Mailing Address (if different from primary practice location)

PO Box: _____ City: _____ County: _____ State: _____ ZIP: _____

8. Billing Address (if different from practice location)

Firm Name: _____

Address: _____

City: _____ County: _____ State: _____ ZIP: _____ Phone Number: _____

9. Preferred Mailing Address (Confidential)

Choose one: ☐ Office ☐ Office PO Box ☐ Residence ☐ Residence PO Box ☐ Billing Address

Preferred Mailing Address for Policy-Related Documents

Choose one: ☐ Office ☐ Office PO Box ☐ Residence ☐ Residence PO Box ☐ Billing Address

COVERAGE REQUESTED

10. Requested Effective Date: _____/_____/_____ Retroactive Date: _____/_____/_____

11. Limits of Liability Per Incident: $_____ Per Aggregate: $_____ (For example, $1M/$3M)

12. Type of Coverage Desired:

☐ Claims-made coverage with prior acts coverage (If this option is chosen, move to the next question.)

☐ Claims-made coverage without prior acts coverage (If this option is chosen, please complete the following:)

If Claims-made coverage without prior acts coverage was selected as the desired coverage option and the most recent prior coverage was issued on a claims-made basis, please indicate one of the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.

☐ An extended reporting endorsement (tail coverage) has not and will not be purchased. I will not purchase tail coverage (extended reporting endorsement) from my current insurer where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying with Copic Insurance Company, if offered, will not provide prior acts coverage.

Initial here to confirm your understanding: _____

13. Practicing as: ☐ Individual ☐ Joining Group ☐ Forming Group ☐ Joining Hospital ☐ Slot ☐ Locum Tenens

Name of Group or Employer: _____

Other: _____

14. Practice Ownership Information

(a) List each professional corporation, association, partnership, or other health-care-related entity in which you have any ownership and need coverage under this policy.

Name of Entity: _____ Your % of Ownership: _____%
Name of Entity: _____ Your % of Ownership: _____%
Name of Entity: _____ Your % of Ownership: _____%

(b) Please provide the name of all other partners or shareholders with an ownership stake in any of the entities listed in response to question 12(a).

Name of Partner/Shareholder: _____ Name of Associated Entity: _____ Insured with COPIC? ☐ Yes ☐ No
Name of Partner/Shareholder: _____ Name of Associated Entity: _____ Insured with COPIC? ☐ Yes ☐ No
Name of Partner/Shareholder: _____ Name of Associated Entity: _____ Insured with COPIC? ☐ Yes ☐ No

(c) Do any of the above entities need to be added as an additional insured under your policy? ..... ☐ Yes ☐ No

If yes, which entities: _____

PROFESSIONAL LIABILITY INSURANCE HISTORY

15. Policy Information

Name of Company: _____ Policy Limits: $_____ / $_____
Period of Coverage: (MM/YY) to (MM/YY) Retroactive Date: (MM/YY) to (MM/YY) ☐ Claims-Made ☐ Occurrence
Name of Company: _____ Policy Limits: $_____ / $_____
Period of Coverage: (MM/YY) to (MM/YY) Retroactive Date: (MM/YY) to (MM/YY) ☐ Claims-Made ☐ Occurrence
Name of Company: _____ Policy Limits: $_____ / $_____
Period of Coverage: (MM/YY) to (MM/YY) Retroactive Date: (MM/YY) to (MM/YY) ☐ Claims-Made ☐ Occurrence

16. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate, required that you accept a deductible, or issued coverage with any restrictions or exclusions? ..... ☐ Yes ☐ No

(Missouri applicants do not answer this question.)

17. Have you ever practiced without professional liability insurance? ..... ☐ Yes ☐ No

LICENSES/CERTIFICATION

18. List all states in which you have ever been licensed to practice medicine, the license number for that state, the date the license was issued, and the number of hours you will work in each state as of the requested effective date of coverage.

State: _____ License #: _____ Date Issued: _____ # Hours/Week: _____
State: _____ License #: _____ Date Issued: _____ # Hours/Week: _____
State: _____ License #: _____ Date Issued: _____ # Hours/Week: _____

19. Are you ABMS or AOA Board Certified? ..... ☐ Yes ☐ No

If "No," have you ever failed any licensing or Board Certification Examinations? ..... ☐ Yes ☐ No

If “No”, are you eligible by a member board of the ABMS or AOA? ..... ☐ Yes ☐ No

20. Have you ever been denied a medical license or certification by a specialty board? ..... ☐ Yes ☐ No

21. If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ..... ☐ Yes ☐ No ☐ N/A

PRACTICE HISTORY/TRAINING/EDUCATION

22. You must provide a current C.V. If you have any gaps in practice over 90 days, an explanation must be included.

PRACTICE CHARACTERISTICS

23. What is your specialty? _____

Percentage of your practice devoted to your specialty: _____ %

24. What is your subspecialty? _____

Percentage of your practice devoted to your subspecialty: _____ %

25. Average number of hours worked per week

When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds. ☐ 1-15 ☐ 16-20 ☐ 21-25 ☐ ≥26

26. After your effective date, will you maintain professional liability coverage with another carrier for activities or exposures not covered by Copic? ..... ☐ Yes ☐ No

If "Yes," please explain: _____

27. After the Requested Effective Date, do you plan to practice/consult outside your principal state of practice including any telemedicine services in the next 12 months? ..... ☐ Yes ☐ No

If "Yes," do you or will you maintain professional liability insurance for this exposure? ..... ☐ Yes ☐ No

Please describe the nature of your out-of-state practice and indicate the number of hours per week devoted to it:

_____

28. Are you employed or contracted as a medical director for an agency, business, or organization outside of your trained specialty? ..... ☐ Yes ☐ No

29. Do you practice "concierge medicine" or Direct Patient Care? ..... ☐ Yes ☐ No

If "No," please skip to question #30.

If "Yes," what percentage of your practice is based on this model? _____ %

Do patient's pay a monthly or annual fee? ..... ☐ Yes ☐ No

Do you accept commercial insurance? ..... ☐ Yes ☐ No

What is your current total patient count? _____

30. Do you work in an urgent care? ..... ☐ Yes ☐ No

If "Yes," percentage of practice: _____ %

If "Yes," do you hold a current ATLS and ACLS certification? ..... ☐ Yes ☐ No

31. Do you provide services at a correctional facility? ..... ☐ Yes ☐ No

32. Do you provide medical services to professional athletes/sports teams or celebrities? ..... ☐ Yes ☐ No

33. Please describe your practice: ☐ Hospitalist ☐ Intensivist/Critical Care Specialist ☐ N/A

If you answered "N/A" to question #33, please skip the next question and proceed to question #35.

34. Please indicate the percentage of your total practice devoted to in-patient care of hospitalized patients: _____ %

35. Do you practice in an Emergency Department (ED)? ..... ☐ Yes ☐ No

For the purpose of this question, answer "No" if you only provide backup/consult call or work in the ED only for the purpose of maintaining privileges.

36. Have there been any changes in your specialty, classification, or practice activity within the past ten years? ..... ☐ Yes ☐ No

If yes, please explain: _____

37. Do you utilize any patient-facing artificial intelligence technologies, such as chatbots or similar tools in your practice? ☐ Yes ☐ No

If "Yes", do you confirm/review the information being provided to the patient? ..... ☐ Yes ☐ No

PROCEDURES PERFORMED

38. Do you perform or supervise anyone who performs aesthetic or cosmetic procedures? ..... ☐ Yes ☐ No

If "Yes", and you are not a plastic surgeon or dermatologist, please provide an Elective Aesthetic & Cosmetic Procedures Supplemental Application.

39. Do you perform sclerotherapy (the injection of sclerosing agents) into the vertebral column? ..... ☐ Yes ☐ No

40. Do you perform bariatric surgery? ..... ☐ Yes ☐ No

41. Do you participate in non-IRB clinical trials? ..... ☐ Yes ☐ No

42. Do you offer/provide any non-FDA approved devices, drugs, or procedures?..... ☐ Yes ☐ No

43. Do or will any of your employees practice at a location geographically separate from you? ..... ☐ Yes ☐ No

If "Yes," please provide details on an additional sheet. Please include in your explanation the distance of these employees' separate practice locations from your practice location and a summary of these employees' duties and responsibilities while practicing there. In addition, please explain how these employees are supervised consistent with their duties and the frequency of and methods by which that supervision occurs.

44. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? ..... ☐ Yes ☐ No

45. Do you perform surgery or obstetrical procedures at a location more than 50 miles or one hour from your office location(s)? ..... ☐ Yes ☐ No

46. Do you perform surgery or obstetrical procedures in a surgical suite more than 50 miles or one hour from a hospital? .. ☐ Yes ☐ No

47. Do you perform procedures or use equipment not used by a majority of physicians in your specialty or perform "invasive" procedures for which you were not resident trained or for which you do not hold hospital privileges? ..... ☐ Yes ☐ No

If applicable, please list all such procedures: _____

48. Do you maintain hospital privileges? ..... ☐ Yes ☐ No

49. Do you perform or assist in surgery? ..... ☐ Yes ☐ No

50. Do you perform office-based surgeries or procedures which require sedation?..... ☐ Yes ☐ No

51. Do you provide gender-affirming care/services? ..... ☐ Yes ☐ No

If "yes", do you offer/provide gender-affirming surgical services to minors?..... ☐ Yes ☐ No

52. Do you perform cervical epidural injections (CEI)? ..... ☐ Yes ☐ No

53. Do you provide "house call" services to patients other than hospice or palliative care patients? ..... ☐ Yes ☐ No

If "Yes," what percentage of your total practice is devoted to "house calls" for non-hospice or non-palliative-care patients? _____ %

FAMILY PRACTICE PHYSICIANS ONLY

54. Do you perform:

a. Prenatal care beyond the first trimester? ..... ☐ Yes ☐ No

b. Second-trimester abortions? ..... ☐ Yes ☐ No

c. Obstetrical procedures? ..... ☐ Yes ☐ No

d. VBAC's (Vaginal Birth After Cesarean)? ..... ☐ Yes ☐ No

FAMILY PRACTICE WITH OB & OB/GYN PHYSICIANS ONLY

55. a. Do you provide obstetric ultrasound services that produce images or videos intended solely for non-medical purposes without a corresponding medical report?..... ☐ Yes ☐ No

b. Do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)? ..... ☐ Yes ☐ No

c. Do you perform elective home delivery? ..... ☐ Yes ☐ No

d. Do you perform water births? ..... ☐ Yes ☐ No

e. Do you supervise or employ nurse midwives who manage the active labor and any subsequent delivery for vaginal birth after caesarean (VBAC)? ..... ☐ Yes ☐ No

f. If yes, is a physician physically on premises and immediately available for the entire course of care? ..... ☐ Yes ☐ No

Average number of deliveries performed per year: _____ Average number of C-sections performed per year:_____

OTHER PERSONNEL TO BE COVERED

56. a. Will you/your entity employ or contract with any allied health practitioners who will work at any of your office locations? ..... ☐ Yes ☐ No

If "Yes," please provide the census information requested below. If you are practicing as part of a group practice, one person may complete this section if the information applies to all physicians in the group.

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

b. Will you/your entity employ or contract with Podiatrists? ..... ☐ Yes ☐ No

***Nebraska and Wisconsin Applicants Only:** Nurse Anesthetists are required to complete a special application form; please contact Copic Underwriting Department, or your agent for the appropriate application form.
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 contact your underwriter or agent for more information.

IF YOU PRACTICE IN A STATE WITH A PATIENT COMPENSATION FUND

57. 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

58. 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.)

Note Examples of states with patient compensation funds include Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, and Wisconsin. It is advisable to investigate specific regulations in each state where you practice to determine whether participation in the fund is voluntary.

OTHER INFORMATION

ALL 'YES' ANSWERS REQUIRE AN EXPLANATION. PLEASE ATTACH ADDITIONAL SHEETS, IF NECESSARY

59. Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? (Include any disciplinary actions by the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity. Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations which are currently pending.) ..... ☐ Yes ☐ No

60. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ..... ☐ Yes ☐ No

61. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? ..... ☐ Yes ☐ No

62. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? (Note: You must answer "Yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned, or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.) ..... ☐ Yes ☐ No

63. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, healthcare facility, or any other healthcare entity? ..... ☐ Yes ☐ No

64. With in the past 5 years incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e. serious neurologic illness or injury, uncontrolled seizure disorder, mental health diagnoses, sexual addiction, alcohol, opioid, or other substance use disorder, serious physical illness or injury, etc.) ..... ☐ Yes ☐ No

If "Yes", state the condition(s) and date(s), and identify your treating physician(s) below. A statement from your physician attesting to your fitness to practice your specialty is required to be submitted with this application.

Description of condition: _____

Date(s) of treatment(s): From _____/_____ To: _____/_____ ☐ Currently in treatment

Name of treating physician(s): _____

65. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended, or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action? ..... ☐ Yes ☐ No

66. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing board, Board of Medical Examiners, health plan, managed care organization, or other medical review committee? ..... ☐ Yes ☐ No

67. Are you personally registered as a patient or recipient on any state's medical marijuana registry, or are you personally a frequent or habitual user of marijuana? ..... ☐ Yes ☐ No

68. Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee, or an employee of a hospital or surgery center; or have you been accused by a patient or been investigated by any state regulatory authority for boundary violations of a sexual nature? ..... ☐ Yes ☐ No

69. Have you ever been reported to the National Practitioners Data Bank? ..... ☐ Yes ☐ No

CERTIFICATES OF INSURANCE

70. Please record below all organizations you would like listed as a certificate holder on your policy (e.g., hospitals, health plans, HMOs, IPAs, etc.)

Name: _____

Address (including city, state, and zip code): _____

Name: _____

Address (including city, state, and zip code): _____

Name: _____

Address (including city, state, and zip code): _____

CLAIMS INFORMATION

Important information regarding questions 71 and 72 (including sub-questions):

1. The word "claim" as used in questions 71 and 72 below refers to:

a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or

b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.

2. If you answer "Yes" to question 71 and 72 (including sub-questions), please complete the attached Supplementary Claims Information Form.

71. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? ..... ☐ Yes ☐ No

72. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome? ..... ☐ Yes ☐ No

b. A letter from an attorney regarding your medical treatment of a patient? ..... ☐ Yes ☐ No

c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ..... ☐ Yes ☐ No

d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ..... ☐ Yes ☐ No

e. Any other circumstances that might reasonably lead to a claim or suit? ..... ☐ Yes ☐ No

73. If "yes", to any of the above, have they been reported to your current or prior professional liability insurance carrier? ..... ☐ Yes ☐ No ☐ N/A

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. Patient's Initials: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____
_____
_____

6. What is the present condition of the patient? _____
_____
_____

7. 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

8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed but dropped by claimant		
☐ Summary judgment in your favor	☐ Court outcome in favor of plaintiff:	☐ Awaiting court action:
	Amount of Loss payment: $_____	Reserve Amount: $_____
☐ Suit settled out of court		

a. Date claim paid:_____
b. Amount paid: $_____
c. Did you want to settle this claim? ☐ Yes ☐ No

9. To your knowledge, was any settlement paid by another party involved(i.e., your P.A., P.C., partners, employees, etc.)? .....☐ Yes ☐ No
If "yes," amount was $_____

Signature: _____ **Date**: _____

Name (Printed): _____

Re: Notice to Health Care Providers to be provided with Policy or Certificate of Insurance.

With this letter, we are furnishing for each covered provider a copy of the policy or a certificate of coverage specifying the coverage provided. For physicians, the coverage provided under this certificate is not limited to a specific practice location, to services performed for a specific employer or in any other way, as long as the claim arises out of a medical incident that:

a. Is covered by this policy and an exclusion does not apply,
b. Occurs within the coverage territory (the state of Wisconsin unless enlarged by endorsement),
c. Occurs on or after the retroactive date of your coverage,
d. Is first reported during the policy term or extended reporting period; and .
e. Does not involve a prior known act.

For all other covered providers, the coverage is further limited to medical service provided while acting within the course and scope of your duties for [the First Named Insured]..

It is the responsibility of the individual provider to ensure that he or she has health care liability insurance coverage meeting the requirements of ch. 655, Stats., in effect for all of his or her practice in this state, unless the provider is exempt from the requirements of that chapter.

We will notify each covered provider individually when the policy is cancelled, nonrenewed or otherwise terminated, or amended to affect the coverage provisions.

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! As a condition of being insured, I understand and agree to the requirement to submit to a health and skills assessment by a physician of Copic's choice. This assessment may be required at Copic's discretion.

I hereby declare and represent that all answers and statements in this application are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and, as such, will be relied upon by Copic to determine whether to issue my liability insurance, to determine the amount of limits available, or to specifically exclude a risk. If I or any other person making application or providing information on my behalf misstate(s) or fail(s) to disclose any material information, my application may be declined. If my application is approved and it includes any material misstatement or it fails to disclose material information, Copic has the right to rescind my insurance. Copic also has the right to decline coverage for a specific claim if Copic would have declined to issue insurance or would have limited my coverage if I had not made the material misstatement or omission.

I authorize any state board of medical examiners or medical board, or any licensure, hospital board or committee, hospital records department, insurance company, professional society or association, 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 or its assigns. This authorization applies regardless of whether I am currently affiliated with the above persons or entities, or have been in the past. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with Copic policy, I hereby consent to Copic's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to medical boards and boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: my 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. To the fullest extent permitted by law, I hereby release all providers of such information, including Copic, its employees and agents, from any and all liability therefore.

Physician signature _____ Date _____

Please PRINT your name _____

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

The following Insurance Fraud Warnings are required to be provided with all applications.

CALIFORNIA

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 state prison.

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.

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.

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 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.

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.

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.

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.

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.

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.

MARYLAND

Any person who knowingly and 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.

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.

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.

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.

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.

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.

OREGON

Any person who knowingly provides false, incomplete, or misleading material information to an insurance company with the intent to knowingly defraud may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA

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.

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.

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.

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.

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.

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.

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.