

NORCAL Insurance Company

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS, SURGEONS, DENTISTS, AND PODIATRISTS

Important Notice: This application is for claims-made and reported coverage. Please read the entire policy carefully. The application is subject to review and acceptance by The Company and does not bind coverage. Additional information may be requested by The Company.

| |
|------------------|
| Agency name: |
| Agency Location: |
| Producer name: |

REQUESTING ADDITION TO A CURRENT NORCAL POLICY

If accepted, coverage will be extended only while you are acting within the course and scope of your duties for the group and will be subject to the terms, conditions, and limitations of the policy. A copy of the policy will be made available to you upon request.

| | |
|--|---------------|
| Name of Entity/Organization or Physician | Policy Number |
|--|---------------|

APPLICATION CHECKLIST

Please complete the entire application, sign, and date. Indicate not applicable (n/a) where appropriate.

- Answer all questions fully and completely. Alternatively, you may attach a credentialing application or application for another insurer that you have completed within the past 90 days and complete this application beginning with Section VI, Claims Information.
- A copy of the Declarations page and endorsements from your most recent insurance policy. If an extended reporting endorsement (tail) has been purchased, please provide a copy as well.
- Loss runs for the past 10 years, or since the date you began practicing medicine if you began in the last 10 years.
- A copy of your letterhead.
- A copy of your current Curriculum Vitae (CV).
- If you are requesting coverage for a corporation, please include a completed Entity/Organization Application and the Articles of Incorporation.
- If you employ, independently contract with, or otherwise maintain an association with other health care providers (including physicians and/or health care extenders) and desire coverage for them, a separate application is required for each provider.

SECTION I: GENERAL INFORMATION

GENERAL INFORMATION

| | | | | |
|---|---------------|----------------|---|--|
| First Name | Middle Name | Last Name | <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DDS <input type="checkbox"/> DPM | |
| Date of Birth (mm/dd/yyyy) | DEA License # | FEIN License # | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| National Provider Identification (NPI) Number | | | | |
| Authorized Office Representative | Title | Email | Website | |
| Primary Office Phone | Home Phone | Cell Phone | Fax | |
| Primary Office Address | City | State | Zip Code | <input type="checkbox"/> Preferred Mailing |
| Home Address | City | State | Zip Code | <input type="checkbox"/> Preferred Mailing |
| Billing Address | City | State | Zip Code | <input type="checkbox"/> Preferred Mailing |
| Other Address | City | State | Zip Code | <input type="checkbox"/> Preferred Mailing |

MEDICAL LICENSURE

| State | License # | Expiration Date | % of Practice | Status of License |
|-------|-----------|-----------------|---------------|--|
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending |

SECTION II: COVERAGE INFORMATION

COVERAGE DESIRED

Please provide a copy of your current Declarations page from your most recent Insurance Carrier, as well as copies of any extended reported endorsements (tails) that you may have purchased.

Claims-made WITHOUT prior acts of coverage. Under this option, the retroactive date will be the same as the effective date of coverage. Coverage for claims arising from an act or omission that occurred prior to the effective date of this policy will not be provided.

Claims-made WITH prior acts coverage. Under this option, the retroactive date will be the same as the retroactive date on your current policy.

| | | | | |
|--|----------------------------------|--------------|--|------------------|
| Requested Effective Date (mm/dd/yyyy) | Retroactive Date (mm/dd/yyyy) | Limit Amount | Limit Type <input type="checkbox"/> Shared <input type="checkbox"/> Separate | Hours (per week) |
|--|----------------------------------|--------------|--|------------------|

Will you also carry insurance with another company? Yes No If yes, please explain in the Remarks Section.

COVERAGE HISTORY

- List below the professional liability insurance history of this Entity/Organization for the past 10 years, beginning with the most recent. Please include periods covered by a self-insurance program, governmental program, or no coverage. Use the Remarks Section if you need more space.

| Coverage Period (mm/dd/yyyy) | Insurer | Coverage Type | Limit Amount | Premium | Tail Purchased |
|---------------------------------|---------|---|---|---------|---|
| From: To: | | <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Retro: | Amount: <input type="checkbox"/> Shared <input type="checkbox"/> Separate | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| From: To: | | <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Retro: | Amount: <input type="checkbox"/> Shared <input type="checkbox"/> Separate | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| From: To: | | <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made Retro: | Amount: <input type="checkbox"/> Shared <input type="checkbox"/> Separate | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- Does the Entity/Organization provide services covered by another professional liability policy?

Yes No

If yes, please provide proof of coverage and details of those services.

SECTION III: SPECIALTY AND PRACTICE INFORMATION

SPECIALTY INFORMATION

1. Please describe your current medical specialty

| | Medical specialty | % of Practice (must total 100%) | Board Certified? | Board eligible? |
|-------------------|-------------------|------------------------------------|---|---|
| Primary specialty | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sub specialty | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MEDICAL PROCEDURES

2. Please the appropriate box, indicating the extent of surgery you perform:

- No surgery except incisions of boils, cysts, circumcisions (newborns), or other superficial abscesses or suturing minor lacerations
- Minor surgery includes most procedures performed under local anesthesia; assisting in major surgery on your own patients
- Major surgery includes major surgical procedures done under general, spinal, or caudal anesthesia; or assisting in major surgery on other than your own patients.

3. If you assist in surgery, please provide the number of procedures performed annually:
 Assisting in major surgery on own patients: _____ # Per Year
 Assisting in major surgery on patients other than your own: _____ # Per Year

4. Please check the procedures, which you perform, for which you are requesting coverage. Please check any procedure that you have performed in the last 5 years

| | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Abdominoplasty <input type="checkbox"/> Abortion <ul style="list-style-type: none"> Trimester: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> Elective % of Practice _____ <input type="checkbox"/> Therapeutic % of Practice _____ <input type="checkbox"/> Acupuncture or Acupressure <input type="checkbox"/> Addiction Medicine <ul style="list-style-type: none"> <input type="checkbox"/> Suboxone Therapy <input type="checkbox"/> Anesthesia (General/Spinal/Caudal) <input type="checkbox"/> Angiography/Arteriography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arthroscopy | <ul style="list-style-type: none"> <input type="checkbox"/> Pain Management <ul style="list-style-type: none"> <input type="checkbox"/> Implants (incl. Intrathecal Pumps) <input type="checkbox"/> Medication Only <input type="checkbox"/> Nerve Block (Spinal, Paraspinal, Paravertebral, Epidural) <input type="checkbox"/> Nerve Block (Other) <input type="checkbox"/> Radiofrequency Procedures <ul style="list-style-type: none"> <input type="checkbox"/> Spinal Stimulators <input type="checkbox"/> Prenatal Care <ul style="list-style-type: none"> <input type="checkbox"/> Including 1st Trimester only <input type="checkbox"/> Including 1st and 2nd Trimesters <input type="checkbox"/> Prenatal to term, no delivery <input type="checkbox"/> Prenatal to term, incl. delivery |
|---|---|

- Bariatric Surgery
 - Gastric Bands # Per Year: _____
 - Bypass or Staples # Per Year: _____
 - Gastric Sleeve # Per Year: _____
 - Other # Per Year: _____
- Botox # Per Year: _____
- Bronchoscopy
- Cardiac Catheterization
- Chelation Therapy
- Cryosurgery
- D&C
- Dermatology Procedures
 - Chemabrasion/Dermabrasion
 - Chemical Peels
 - Deep
 - Superficial only
 - Hair Transplants
 - Liposuction/Lipoinjection
 - Silicone Injections
 - Skin Flaps/Grafts
- Endoscopic Procedures
 - Sigmoidoscopy only
 - Other than Sigmoidoscopy
 - Laster Therapy
- Fertility/Infertility Treatment
- Fracture Reductions
 - Open
 - Closed
- General Surgery
- Hysterectomy
- Lithotripsy
- Laparoscopy
- Needle Biopsy
 - Type: _____
- Obstetrics
 - Performing Assist only
 - C-Sections # Per Year: _____
 - Vaginal Births # Per Year: _____
 - VBACs # Per Year: _____
- Orthopedics
 - Including Spine
 - No Spine
- Permanent Pacemakers
- Prolotherapy
- Radiology
 - Interventional
 - Radiopaque Dye
- Radiation/X-Ray Therapy
- Renal Dialysis
- Sclerotherapy
- Spinal Surgery
- Thoracic Surgery % of Practice: _____
- Tonsillectomy/Adenoidectomy
- Transgender Surgery
- Trauma Surgery % of Practice: _____
- Tubal Ligations
- Vascular Surgery % of Practice: _____
- Vasectomies
- Wound Care
 - Hyperbaric Medicine
 - Surgical Debridement
- Other Medical/Procedural Techniques not listed above (please describe):

5. Do you perform or provide any of the following services as a part of your practice?
If so, please describe.

| Type | Offered | % of Practice | Description |
|---------------------------|---|---------------|-------------|
| Experimental surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Independent Medical exams | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Weight Control Medication | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

| | | | |
|---------------|---|--|--|
| Telemedicine* | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
|---------------|---|--|--|

*If you are practicing telemedicine, please complete and return the Telemedicine Supplemental Questionnaire

PRACTICE INFORMATION

6. Do you currently practice at any additional locations other than the primary office location listed in Section I: General Information?

Yes No

If yes, please describe:

| Practice Name | Location (City, State, Zip) | Hours (per week) | Specialty (if different than above) | Start date (mm/dd/yyyy) |
|---------------|--------------------------------|---------------------|--|----------------------------|
| | | | | |
| | | | | |
| | | | | |

7. Have you changed medical specialties, hours, or location within the last 5 years?

Yes No

If yes, please explain:

| Location (City, State, Zip) | Hours (per week) | Specialty (if different than the current) | Period (mm/dd/yyyy) | Tail purchased? |
|--------------------------------|---------------------|--|------------------------|---|
| | | | From: To: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | From: To: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | From: To: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

8. Do you currently have Hospital Privileges?

Yes No

If yes, please list all locations below.

| Hospital | Location (City, State, Zip) | Type of Privileges | Current Restrictions? If yes, please comment* |
|----------|--------------------------------|--|---|
| | | <input type="checkbox"/> Staff <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|--|--|--|---|
| | | <input type="checkbox"/> Staff <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Staff <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*Comments:

9. Do you work as an emergency room physician, other than for maintaining hospital privileges?

Yes No

If yes, do you have separate coverage for this exposure?

Yes No

If yes, how many hours per month?: _____

10. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director, or attending physician at any of the following:

- | | | | |
|--|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Sanitarium | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Surgery Center |
| <input type="checkbox"/> Birthing Clinic | <input type="checkbox"/> Clinic | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Blood Bank |
| <input type="checkbox"/> Prepaid Health Plan | <input type="checkbox"/> HIMO | <input type="checkbox"/> Other: _____ | |

If yes, do you have separate coverage for this exposure?

Yes No

Do you practice medicine at the above institution?

Yes No

SECTION IV: EDUCATION AND TRAINING

1. Please describe your medical professional education and training.

Check this box if you have attached a current Curriculum Vitae (CV) and continue with Section V, Entity/Organization Information

| | School/facility | Location | Specialty | Start (mm/dd/yyyy) | Complete (mm/dd/yyyy) |
|----------------|-----------------|----------|-----------|-----------------------|--------------------------|
| Medical School | | | | | |
| Internship | | | | | |
| Residency | | | | | |

| | | | | | |
|----------------|--|--|--|--|--|
| Fellowship | | | | | |
| Other Training | | | | | |

Please explain any gaps in training:

2. Are you a Foreign Medical School Graduate?
 Yes No
 If yes, please provide a copy of your USMLE.
3. Are you certified in:
 ACLS ATLS PALS Other: _____
4. Are you entering private practice for the first time following your residency, training, military services, or an academic position?
 Yes No

SECTION V: ENTITY/ORGANIZATION INFORMATION

ENTITY/ORGANIZATION STRUCTURE

1. Indicate which practice organization applies to you:
 Solo Unincorporated Partner or Partnership Corporate Shareholder
 Government Employee Solo Corporation Employee
 Other: _____
2. Name of Entity/Organization: _____
3. Do you wish for coverage for this Entity/Organization?
 Yes No
 Limit Type: Shared Separate
 If yes, a separate Entity/Organization application is required. Note: Separate limits are not available in all states.
4. Is there any other name under which you practice (i.e. DBA, unincorporated name, trade name)?
 Yes No
 If yes, please provide all names:

| Name | Description |
|------|-------------|
| | |
| | |
| | |

MEDICAL STAFF

5. Do you currently employ, independently contract, or otherwise maintain an association with any other health care providers?

Yes No

If yes, please provide the number of each below. If coverage is desired, a separate application is required for each provider.

Check this box if you have included a current roster in place of completing the table below.

| | # Employed | # Contracted | # Supervise Only | Coverage Desired |
|-------------------------|------------|--------------|------------------|--|
| Physicians and Surgeons | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dentists | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Podiatrist | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fellows | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Residents | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Interns | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CRNAs | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Midwife | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nurse Practitioner | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Optometrist | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Perfusionist | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physician Assistants | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiology Assistants | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Surgical Assistants | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

6. Please provide the coverage information below for all health care providers you employ, contract or otherwise associate with, for which coverage is not desired or attach a copy of their current Declarations page of Certificate of Insurance.

| Name | Specialty | Insurer | License # | Association | Start date |
|------|-----------|---------|-----------|---|------------|
| | | | | <input type="checkbox"/> Employed <input type="checkbox"/> Supervise <input type="checkbox"/> Contracted <input type="checkbox"/> Other: | |
| | | | | <input type="checkbox"/> Employed <input type="checkbox"/> Supervise <input type="checkbox"/> Contracted <input type="checkbox"/> Other: | |
| | | | | <input type="checkbox"/> Employed <input type="checkbox"/> Supervise <input type="checkbox"/> Contracted <input type="checkbox"/> Other: | |

SECTION VI: CLAIMS INFORMATION

1. Within the past 10 years, has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit?

Yes No

If yes, complete the following and a claim/suit/incident supplemental form for each claim, suit, or incident and provide loss runs for the past 10 years, or since the date you began practicing medicine if you began within the past 10 years

| | | |
|-----------------------------------|------------------|-----------|
| Total Number of Claims and Suits: | # Open/Reserved: | # Closed: |
| Total Number of Incidents: | # Open/Reserved: | # Closed: |

2. Have you made any changes to your practice as a result of any claims, suits, or incidents?

Yes No

If yes, please explain:

SECTION VII: ADDITIONAL INFORMATION

For each question below that you answer "yes," please provide a complete explanation in the Remarks Section.

1. Has your medical professional liability insurance ever been declined, non-renewed or cancelled including cancellation for nonpayment of premium? (Not applicable to Missouri applicants)
 Yes No
2. Has your medical professional liability insurance ever been surcharged, reduced, or issued with a deductible or other special terms?
 Yes No
3. Have you ever been charged or convicted of any crimes other than minor traffic violations?
 Yes No
4. Have you ever had your medical license or DEA license revoked, limited, refused, suspended, or denied?
 Yes No
5. Have you ever failed to pass a Board Examination?
 Yes No
6. Have your hospital privileges ever been surrendered, limited, or revoked, whether voluntarily or involuntarily?
 Yes No
7. Have your hospital privileges been expanded or reduced in the last 12 months?
 Yes No
8. Has membership of any Professional Association or Society ever been refused, revoked, or limited in any way?
 Yes No
9. Have you ever had a complaint filed, been censured, or had a private reprimand with a County or State Medical Society?
 Yes No
10. During the past year, have you incurred or become aware of having an illness or physical disability that impairs, or could impair, your ability to practice your medical specialty?
 Yes No
If yes, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.
11. Have you ever been treated for alcoholism, narcotic addiction, or mental impairment?
 Yes No
If yes, please provide the details of the rehabilitation program including dates of treatment.
12. Have you ever been accused of sexual misconduct?
 Yes No
13. Have you ever had any contact of a sexual nature with a patient or former patient?
 Yes No
14. Do you know of any individual who works on your behalf that has a prior history or propensity for sexual misconduct?
 Yes No
15. Have you treated or will you treat celebrities or professional athletes?
 Yes No
16. Have you practiced or will you practice at a prison, correctional facility, or other similar facility, or have you provided or will you provide health care services to prisoners or inmates?
 Yes No

17. Do you enter into arbitration or similar agreements with your patients?

Yes No

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

18. Do you participate in clinical trials?

Yes No

If yes, please complete our clinical trials questionnaire.

19. Do you use any non-FDA-approved devices, drugs, or procedures?

Yes No

REMARKS SECTION

Please provide any additional information/explanations for your application below.

AGREEMENTS AND NOTICES

I understand that, as a condition precedent to approval for coverage, NORCAL Insurance Company, any of its subsidiaries or affiliates, or anyone acting on its or their behalf (collectively, "NORCAL") may perform a detailed inquiry and/or investigation of any applicant's background, training, experience, and qualifications by any legal means and I consent to any such inquiry and/or investigation. In addition, I understand that third-party information, records, or data regarding the applicant's practices, medical procedures, and/or prescribing practices may be used for informational or underwriting purposes. I authorize any individual or entity to which such inquiry and/or investigation is made to provide NORCAL or anyone acting on its behalf with all information within its possession or under its control that pertains to the applicant's background, training, experience, practices, procedures, and qualifications. I release and discharge any such individual or entity, including any such individual or entity's agents and representatives, from any and all liability that might arise out of any such inquiry and/or investigation.

I understand that all information provided by me or on my behalf as part of the application process is considered material and important and will be deemed attached to and made a part of the policy. I also understand that the policy could be void in its entirety or with respect to any Insured if any Insured: (1) attempts to defraud NORCAL or (2) intentionally conceals or misrepresents a material fact concerning such information or the risk insured. In addition, I understand that coverage for any claim; suit; or administrative, disciplinary, regulatory, or other type of proceeding may be unavailable if the circumstances for such claim; suit, or administrative, disciplinary, regulatory, or other type of proceeding were known before the effective date of coverage under any policy of insurance that may be issued by NORCAL. I understand that I must notify NORCAL immediately, in writing, of any changes in the information previously provided by me or on my behalf and that NORCAL may withdraw or modify any outstanding quotation(s) or authorization(s) or agreement(s) to bind insurance.

I understand that this application is subject to review and acceptance by NORCAL and does not bind coverage.

I represent and warrant that the foregoing statements contained in this application and any supplemental information are accurate, true, and complete. I also represent and warrant that I have not withheld any requested information.

I have read the fraud statement, and the state-specific notice(s), if any, applicable to the applicant on the attached State-Specific Notices Supplemental.

| | |
|---------------------|-------------------|
| Applicant Signature | Date (mm/dd/yyyy) |
| Printed Name | Title |

This application is not valid without your complete signature.

CLAIM | SUIT | INCIDENT SUPPLEMENTAL FORM

Attach a detailed narrative, which includes at least the information requested below, or complete this form, for each claim, suit, or incident within the past 10 years. Provide adequate detail to allow proper evaluation. Additional information may be requested.

| | | |
|--|--------------|---|
| Patient Name | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Date of Incident (mm/dd/yyyy) | | Location of Incident |
| Name of insurer | | Date reported to Insurer (mm/dd/yyyy) |
| Type: <input type="checkbox"/> Suit <input type="checkbox"/> Demand for Money <input type="checkbox"/> Incident Only <input type="checkbox"/> Notice of Intent to Sue <input type="checkbox"/> Request for Records <input type="checkbox"/> Other: _____ | | |
| 1. Summary of condition/diagnosis at time if incident: 2. Description of treatment rendered, including dates: 3. Allegations: 4. Other persons and entities involved: 5. Status/Disposition: <input type="checkbox"/> Open Describe current status and defense strategy <input type="checkbox"/> Closed without indemnity payment <input type="checkbox"/> Settled <input type="checkbox"/> Judgement/Verdict for defense <input type="checkbox"/> Judgement/Verdict for defense If closed, date closed (mm/dd/yyyy): _____ Amount reserved for you: _____ Indemnity: \$ _____ Defense: \$ _____ Amount reserved for other defendants : _____ Indemnity: \$ _____ Defense: \$ _____ Amount reserved on your behalf: _____ Indemnity: \$ _____ Defense: \$ _____ Amount paid on behalf of other defendants : _____ Indemnity: \$ _____ Defense: \$ _____ 6. Has there been a change in practice as a result of this claim, suit, or incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: <hr/> I understand this information is part of my Application. | | |
| Signature | Printed Name | Date (mm/dd/yyyy) |