Medical Corporation Professional Liability Insurance Renewal Application

ProAssurance
Treated Fairly

ProAssurance Casualty Company/ProAssurance Indemnity Company, Inc.
PO Box 150 • Okemos, MI 48805-0150 • 800-282-6242 • Fax 205-414-2895

Date:_____ Policy #:_____ Expiration Date:_____

Agent/Agency Name:_____ Agent/Agency Phone:_____

Important: Please review, complete, and return this form with **a copy of your current business letterhead**. Please make any changes to the pre-filled information below. Your prompt, accurate reply will avoid delay of your policy's renewal. Thank you.

1. Organization Information

Organization Name:_____

Federal Tax ID:_____-_____ NPI Number: _____

Primary Office Street Address:_____

City:_____ County:_____ State:_____ ZIP:_____

Office Phone:_____ Office Fax:_____ Website:_____

Mailing Address:_____

Preferred Billing Address:_____

Contact Name:_____ Title:_____

Phone:_____ Email:_____

Is the above contact the authorized representative for access to policy information at ProAssurance.com? Yes ☐ No ☐
If no, please provide the name of the policy's authorized representative:_____

A. Type of Corporation:

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership

☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other:_____

B. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:_____

2. Claims Information

A. Since you became insured by a ProAssurance company, has any claim or suit for alleged malpractice been made against you and reported to **a prior insurance carrier or hospital self-insured trust**, or has any claim or suit resulted in payment by you or on your behalf? (Do not include claims reported to a ProAssurance company.) Yes ☐ No ☐
If yes, please explain in space provided at the end of the application.

3. Practice Information

A. Current **insured professionals** designated in the **Coverage Summary**:
Please cross off any professionals no longer with the practice and provide last date of practice in space provided.

[Prefill Names] Last date of practice (if applicable) _____

Name:_____ Policy #:_____ Expiration Date:_____

B. List all healthcare providers **not listed above**. You must provide proof of current professional liability for each physician insured elsewhere.

Name	Specialty	Start Date

C. Current **insured paramedical* employees** designated in the **Coverage Summary**:
Please cross off any employees no longer with the practice and provide last date of practice in space provided.

[Prefill Names]

Last date of practice (if applicable)

_____

D. List all **insured paramedical* employees** not listed above. You must provide proof of current professional liability for each paramedical insured elsewhere.

Name	Specialty	Start Date

**Paramedicals include a person practicing as a psychologist, nurse midwife, nurse anesthetist, nurse practitioner, physician's assistant, surgeon's assistant, perfusionist, optometrist, cytotechnologist, emergency medical technician, anesthesiologist assistant, or any person licensed, certified or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician.*

E. Do physicians/individuals not affiliated with your organization use your facilities and/or equipment? Yes ☐ No ☐

F. Is the organization or any member physician whole or part owner in any medical professional joint venture outside of this practice? Yes ☐ No ☐

If "yes," please explain in space provided at the end of the application.

G. Please give us the name of any **newly formed**, **not previously reported, or dissolved** solo or professional group practice entity (e.g., P.A., P.C., L.L.C., L.L.P., Inc., etc.) related to your practice:_____

_____

Do you desire coverage for this entity?_____ Yes ☐ No ☐

The Organization agrees to notify ProAssurance of any of the following events within thirty (30) days of its occurrence, including but not limited to the following:

A. A change in location of practice.

B. Investigation of Medicare/Medicaid billing procedures.

C. A claim or suit for alleged malpractice has been made against the Organization and reported to **another insurance carrier or hospital self-insured trust,** or any claim or suit resulted in payment by the Organization or on its behalf, since it became an insured of a ProAssurance company.

The Organization acknowledges that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the **Coverage Summary** of the policy.

Failure to notify ProAssurance of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

Florida Fraud Warning – Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Consent to Conditions of Consideration of the Application for Insurance

On behalf of the Organization, I understand that no coverage will be bound until after ProAssurance has reviewed this completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, any advance payment will be promptly returned to the Organization.

On behalf of the Organization, I accept the following conditions during the processing and consideration of this application—regardless of whether or not granted insurance—and for the duration of the insurance which may be issued.

To the fullest extent permitted by law, I, on behalf of the Organization, extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to this application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

The Organization understands that should any incident, injury or death occur to any patient while under our care subsequent to my signing and dating this application, we must notify ProAssurance or its authorized agent or broker in writing of such event.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

Applicant's Representations and Authorization

I, the undersigned, on behalf of the Organization, hereby authorize present and prior professional liability carriers, any and all attorneys who have represented us in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding the Organization, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon our acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

On behalf of the Organization, I understand that third-party information, records or data regarding our practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

On behalf of the Organization, I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

On behalf of the Organization, I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

On behalf of the Organization, I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Title: _____

Note: ProAssurance's Privacy Policy can be found at ProAssurance.com.

Additional Comments

Please attach additional sheets as necessary.

Current Certificate of Insurance Holders:
(Please cross out any Certificate holders no longer applicable and use the additional lines to add other Certificate holders to whom we should mail a Certificate.)

Include Name, Address, and Phone