

NEW JERSEY

# Group Application for Professional Liability Insurance

This is an application for medical professional liability insurance on a group policy and not a binder. No coverage exists until authorized in writing by MDAdvantage. Certain responses may require your further explanation.

Requested Effective Date: \_\_\_/\_\_\_/\_\_\_



SECTION 1

**Group Demographic Information**

Practice Name: \_\_\_\_\_

Practice Manager Name: \_\_\_\_\_

Practice Manager Email Address: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

Office Phone: \_\_\_\_\_

Office Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Website: \_\_\_\_\_

Mailing Address: (If different from Office)

Billing Address: (If different from Office)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Preferred address for mail (If not chosen, default is office address):

Office  Mailing  Other (specify) \_\_\_\_\_

SECTION 2

**Group Practice Locations**

List all satellite office locations

Name of Location	Address	State	ZIP

SECTION 3

### Other Exposures

Does any physician or prospective insured wholly or partially own or directly or indirectly operate or serve as an executive or administrative officer, medical director or department head for any hospital, nursing home, non-hospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization?

If yes, provide its name and describe the relationship(s) to the physician or prospective insured:

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SECTION 4

### Type of Coverage

**Policy Type:**

- Claims-Made (Coverage does not include extended reporting period (tail) coverage.)
- Occurrence (Extended reporting period (tail) coverage is not applicable with this coverage.)
- Permanent Protection (Claims-made coverage that includes extended reporting period (tail) coverage.)

**Limits of Liability requested (each medical incident/aggregate):**

- \$1M/\$3M     \$2M/\$4M     \$3M/\$5M     \$5M/\$7M

**Deductibles**

- Yes, the Group would like information on a deductible option.
- No, the Group does not choose a deductible option.

**Corporation/Business Entity /Partnership**

The Group would like coverage for a corporation/business entity/partnership.  Yes  No  
If yes, please complete an application for Corporation/Business Entity/Partnership.

**Coverage for this exposure will not take effect unless underwritten and approved by MDAdvantage.**

SECTION 5

**Group Professional Liability Insurance History**

	Current Year	1 <sup>st</sup> Year Prior	2 <sup>nd</sup> Year Prior	3 <sup>rd</sup> Year Prior	4 <sup>th</sup> Year Prior
<b>Insurance Company</b>					
<b>Limits of Insurance</b>					
<b>Type of Policy (claims-made/modified claims-made/occurrence)</b>					
<b>Policy Period</b>					
<b>Retroactive Date</b>					

If the Group’s previous policy was claims-made, did the Group obtain extended reporting period (“tail”) coverage?  Yes  No      If yes, please enclose a copy.

Has any physician practiced without professional liability insurance?  Yes  No  
If yes, please attach a complete explanation, including dates.

Has the Group’s or any physician’s professional liability insurance ever been canceled or non-renewed (other than at their request) or has their policy premium ever been surcharged or has any application for professional liability insurance ever been declined?  Yes  No  
If yes, please attach a complete explanation.

**Note: If physicians practice as general surgeons, obstetricians/gynecologists or orthopedic surgeons, the Selected Procedures information on page 11 must also be completed.**

SECTION 6

**Current Group**

**Group Organization:**

PA    LLC    LLP    Corporation    Joint Venture

Name of Employer/Legal Entity: \_\_\_\_\_

Number of physicians, dentists or podiatrists in your group: \_\_\_\_\_

Number insured by or applying to MDA Advantage: \_\_\_\_\_

## SECTION 7

### Underwriting Information

#### Other Positions

Do any physicians hold any positions outside of the Group's principal medical or surgical practice (e.g., moonlighting in an ER, serving part-time at a clinic or nursing home, working for an HMO or other managed care or insurance company, serving as a Medical Director, etc.)?  Yes  No If yes, please describe below. Include for whom they provide these services.

#### Other Procedures

Do any physicians perform any procedures, techniques or treatment modalities that are outside the specialties the physicians are currently practicing, as stated on page 10 under the Provider Roster?  Yes  No If yes, please describe below.

#### Other Practices

Are any physicians collaborating physicians with a qualified nursing professional?  Yes  No If yes, please describe the extent of this practice, including the number of nurses involved, and if the nurses are working within the Group's practice location. Attach copies of the Joint Protocols that the Group has in place with these individuals.

#### Other Coverage

Do any physicians have positions for which no coverage is required, or for which the Group is insured with another carrier?  Yes  No If yes, include activity, entity and location to be excluded and indicate hours worked at this position only.

#### Office Systems

Does your Group utilize an electronic medical record system?  Yes  No

Does your Group utilize an electronic prescription writer?  Yes  No

**Please use the space below to give details for any question to which you answered "yes" above. Attach additional sheets as needed.**

SECTION 7

**Underwriting Information continued...**

**Number of Employees\***

**\*If this application is approved, the limits of insurance will be shared by the insured provider applying for this insurance and the following allied healthcare employees when a claim is made against both of them. If separate limits of insurance are desired for any employee, an application for Allied Health Care Employees Professional Liability Insurance must be submitted and approved by MDAdvantage.**

Nurse practitioners \_\_\_\_\_ Nurse anesthetists \_\_\_\_\_ Nurses \_\_\_\_\_  
Medical assistants \_\_\_\_\_ Lab technicians \_\_\_\_\_ Perfusionists \_\_\_\_\_  
Physical/occupational therapists \_\_\_\_\_ Other medical employees \_\_\_\_\_  
Non-medical staff \_\_\_\_\_

**NOTE: If coverage is desired for any employed Physician Assistant or Nurse Midwife, an application for Allied Health Care Employees Professional Liability Insurance must be submitted for each such employee. There will be no coverage for any Physician Assistant or Nurse Midwife without a completed, returned and approved application.**

Physician Assistants \_\_\_\_\_ Nurse Midwives \_\_\_\_\_

Has any employee of the applicant ever been named in a claim or suit arising from professional services or from managed care services?  Yes  No

Has any employee of the applicant ever had any action taken against his or her license by any licensing board or regulatory authority or ever been the subject of any disciplinary proceeding by any hospital or employer?  Yes  No

If you answered "yes" to either of the above questions, please provide complete details: \_\_\_\_\_

\_\_\_\_\_

**Group Practice Profile**

Specialty the Group will be practicing while insured by MDAdvantage: \_\_\_\_\_

Primary practice focus: \_\_\_\_\_

Average number of practice hours per week: \_\_\_\_\_

## SECTION 8 Claim History

**Note: This application will not be approved unless the Group provides complete claim information.**

In the past 10 years, has any claim or suit been made against any physician in the Group arising from the practice of medicine or surgery?  Yes  No

If yes, please indicate the number of claims or suits: \_\_\_\_\_

Besides any claim or suit made, has any healthcare provider or practice administrator in the Group received any requests for patient records from an attorney?  Yes  No

Has anyone in the Group reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any of the Group's previous insurers?  Yes  No

Are there any medical incidents, adverse outcomes, or other circumstances known to anyone in the Group that might give rise to a claim in the future or has anyone in the Group received a request for patient records from an attorney for which a claim has not been made?  Yes  No

If you answered "yes" to any of the above questions, please provide details on the following page.

SECTION 8

**Claim History continued...**

Claim    Incident   Name of Patient: \_\_\_\_\_  
Name of Insured Physician/Paramed/Entity: \_\_\_\_\_  
Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_   Name of Carrier: \_\_\_\_\_  
Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_   Has a suit been filed?  Yes  No  
Current Status: \_\_\_\_\_   Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Amount paid on Group's behalf: \$\_\_\_\_\_   Amount paid on behalf of all defendants: \$\_\_\_\_\_  
Is this an incident reported to an insurer even though a claim has not been made?  
 Yes  No  
Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes  No  
What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_  
\_\_\_\_\_  
Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claim    Incident   Name of Patient: \_\_\_\_\_  
Name of Insured Physician/Paramed/Entity: \_\_\_\_\_  
Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_   Name of Carrier: \_\_\_\_\_  
Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_   Has a suit been filed?  Yes  No  
Current Status: \_\_\_\_\_   Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Amount paid on Group's behalf: \$\_\_\_\_\_   Amount paid on behalf of all defendants: \$\_\_\_\_\_  
Is this an incident reported to an insurer even though a claim has not been made?  
 Yes  No  
Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes  No  
What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_  
\_\_\_\_\_  
Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



SECTION 8

**Claim History continued...**

Claim    Incident   Name of Patient: \_\_\_\_\_

Name of Insured Physician/Paramed/Entity: \_\_\_\_\_

Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_   Name of Carrier: \_\_\_\_\_

Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_   Has a suit been filed?  Yes  No

Current Status: \_\_\_\_\_   Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Amount paid on Group's behalf:\$ \_\_\_\_\_   Amount paid on behalf of all defendants:\$ \_\_\_\_\_

Is this an incident reported to an insurer even though a claim has not been made?

Yes    No

Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes  No

What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_

Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_

Claim    Incident   Name of Patient: \_\_\_\_\_

Name of Insured Physician/Paramed/Entity: \_\_\_\_\_

Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_   Name of Carrier: \_\_\_\_\_

Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_   Has a suit been filed?  Yes  No

Current Status: \_\_\_\_\_   Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Amount paid on Group's behalf:\$ \_\_\_\_\_   Amount paid on behalf of all defendants:\$ \_\_\_\_\_

Is this an incident reported to an insurer even though a claim has not been made?

Yes    No

Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes  No

What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_

Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_

SECTION 8

**Claim History continued...**

Claim    Incident   Name of Patient: \_\_\_\_\_  
Name of Insured Physician/Paramed/Entity: \_\_\_\_\_  
Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_   Name of Carrier: \_\_\_\_\_  
Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_   Has a suit been filed?  Yes  No  
Current Status: \_\_\_\_\_   Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Amount paid on Group's behalf:\$ \_\_\_\_\_   Amount paid on behalf of all defendants:\$ \_\_\_\_\_  
Is this an incident reported to an insurer even though a claim has not been made?  
 Yes    No  
Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes    No  
What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_  
\_\_\_\_\_  
Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claim    Incident   Name of Patient: \_\_\_\_\_  
Name of Insured Physician/Paramed/Entity: \_\_\_\_\_  
Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_   Name of Carrier: \_\_\_\_\_  
Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_   Has a suit been filed?  Yes  No  
Current Status: \_\_\_\_\_   Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Amount paid on Group's behalf:\$ \_\_\_\_\_   Amount paid on behalf of all defendants:\$ \_\_\_\_\_  
Is this an incident reported to an insurer even though a claim has not been made?  
 Yes    No  
Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes    No  
What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_  
\_\_\_\_\_  
Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SECTION 8

**Claim History continued...**

Claim     Incident    Name of Patient: \_\_\_\_\_  
 Name of Insured Physician/Paramed/Entity: \_\_\_\_\_  
 Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_    Name of Carrier: \_\_\_\_\_  
 Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_    Has a suit been filed?  Yes  No  
 Current Status: \_\_\_\_\_    Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Amount paid on Group's behalf: \$ \_\_\_\_\_    Amount paid on behalf of all defendants: \$ \_\_\_\_\_  
 Is this an incident reported to an insurer even though a claim has not been made?  
 Yes     No  
 Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes  No  
 What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_  
 \_\_\_\_\_  
 Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Claim     Incident    Name of Patient: \_\_\_\_\_  
 Name of Insured Physician/Paramed/Entity: \_\_\_\_\_  
 Date of Medical Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_    Name of Carrier: \_\_\_\_\_  
 Date Reported to Carrier: \_\_\_\_/\_\_\_\_/\_\_\_\_    Has a suit been filed?  Yes  No  
 Current Status: \_\_\_\_\_    Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Amount paid on Group's behalf: \$ \_\_\_\_\_    Amount paid on behalf of all defendants: \$ \_\_\_\_\_  
 Is this an incident reported to an insurer even though a claim has not been made?  
 Yes     No  
 Are these circumstances that may result in a claim but have not previously been reported to the Group's insurer?  Yes  No  
 What medical or surgical treatment led to the alleged injury to the patient? \_\_\_\_\_  
 \_\_\_\_\_  
 Describe the alleged injury or problem that led to the claim made against the Group. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please use multiple copies of this form if your Group has had more than eight claims.**

**Note: The Group may be requested to provide information such as office records, operative reports, discharge summaries, X-rays, etc. No application may be approved without complete and accurate claim information.**

SECTION 9  
**Provider Roster**

Provider Name	Date of Birth	Specialty	Practice Hours	1 <sup>st</sup> Date of Private Practice	Retroactive Date (Claims-made)

SECTION 10

**Selected Procedures Information**

Please check any of the following procedures that you will perform.  
Percentages and counts are understood to be approximate.

<p><input type="checkbox"/> Abortions – Elective – in hospital or surgi-center     <input type="checkbox"/> % of total practice</p> <p><input type="checkbox"/> Abortions – Elective – elsewhere <input type="checkbox"/> % of total practice</p> <p><input type="checkbox"/> Abortions - Therapeutic <input type="checkbox"/> % of total practice</p> <p><input type="checkbox"/> Bariatric Surgery – Laparoscopic</p> <p><input type="checkbox"/> Bariatric Surgery – Non-Laparoscopic</p> <p><input type="checkbox"/> Medical Marijuana</p> <p><input type="checkbox"/> Pain Management</p> <p><input type="checkbox"/> Prison Institution</p> <p><input type="checkbox"/> Robotic Surgery <input type="checkbox"/> % of total practice</p> <p>    If robotic surgery is performed, please provide further information:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Telemedicine</p> <p>State where principal practice is located: _____</p> <p>State(s) where medical service is delivered remotely/electronically:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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**Certification, Authorization and Signature**

I certify that the information in this application is true and correct and I authorize the release and exchange of any information regarding my medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which any applicant is or has been a member and MDAvantage Insurance Company of New Jersey.

I further agree to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

Notice: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Applicant's Name: \_\_\_\_\_ Applicant's Title: \_\_\_\_\_

**Assignment of Any Return Premium**

This section should be completed if the premium for this insurance is paid by someone other than the Applicant. If the premium for this insurance has been paid and the policy is later canceled or otherwise changed, any refund of premium that results from such cancellation or change should be assigned to:

Name of Payor: \_\_\_\_\_  
(employer or other person or entity to whom any refund check should be made payable)

The Payor agrees to pay any premium for the professional liability insurance policy applied for and any renewal or replacement of it. The Applicant for this insurance assigns any and all rights to receive any refund of premium in excess of that earned by MDAvantage Insurance Company of New Jersey for this insurance to the Payor named above. The Applicant appoints Payor or Payor's successors or assigns as Applicant's Attorney-in-Fact with full authority to cancel or amend the insurance policy applied for and to execute or receive any document, instrument, payment or notice of any kind relating to the insurance policy, except with respect to giving or withholding consent to settle a claim or suit as may be provided in the insurance policy applied for.

No other interest in the insurance applied for may be assigned by any party without the written consent of MDAvantage Insurance Company of New Jersey.

This assignment will remain in effect unless both Payor and Applicant agree in writing to its termination.

Applicant's Signature (Group's Authorized Representative): \_\_\_\_\_  
Applicant's Name: \_\_\_\_\_ Applicant's Title: \_\_\_\_\_