100 Franklin Corner Road
Lawrenceville, NJ 08648-2104

888-355-5551

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MASSACHUSETTS

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:____/____/____

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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

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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:

_____

_____

_____

_____

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.)

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

☐ $1M/$3M ☐ $2M/$6M

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.

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SECTION 5

Group Professional Liability Insurance History

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

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 MDAdvantage:_____

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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.

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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:_____

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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.

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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._____
_____
_____

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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._____
_____
_____

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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._____
_____
_____

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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.

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SECTION 9

Provider Roster

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

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SECTION 10

Selected Procedures Information

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

_____Abortions – Elective – in hospital or surgi-center
_____% of total practice
_____Abortions – Elective – elsewhere _____% of total practice
_____Abortions - Therapeutic _____% of total practice
_____Bariatric Surgery – Laparoscopic
_____Bariatric Surgery – Non-Laparoscopic
_____Medical Marijuana
_____Pain Management
_____Prison Institution
_____Robotic Surgery_____% of total practice
If robotic surgery is performed, please provide further information:

_____
_____
_____
_____

_____Telemedicine
State where principal practice is located: _____
State(s) where medical service is delivered remotely/electronically:

_____
_____
_____
_____

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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 MDAdvantage 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 MDAdvantage 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 MDAdvantage 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:_____