Application for PRACTICE SHIELD™

BILLING ERRORS AND OMISSIONS • ADMINISTRATIVE DISCIPLINARY PROCEEDING • BREACH OF SECURITY

NOTICE: The Insurer agrees to use all information provided in this application solely in connection with the proposed insurance. The insurance for which you are applying is claims-made and reported coverage. Only claims first made and reported to Underwriters per policy conditions on or after the effective date but before the end of the policy period, or any applicable extended reporting period, will be covered.

1. APPLICANT INFORMATION

1. Name of Applicant: _____
2. Business Address: _____

   City: _____ State: _____ Zip: _____
3. Type of Entity: _____ (Professional Corp., LLC, Company, Partnership, etc.)

   Medical Group ☐ Individual Physician ☐

2. GENERAL INFORMATION

4. Requested Effective Date: _____ Any previous coverage?: **Yes** ☐ **No** ☐ (if YES, provide Declarations Page)
5. Requested Coverage:
   Physician E&O Limit: **$100,000** ☐ **$250,000** ☐ **$500,000** ☐ **$1,000,000** ☐
   Medical Group Aggregate Limit: **$1,000,000** ☐ **$3,000,000** ☐ **$5,000,000** ☐
   Administrative Disciplinary Proceedings Limits: **NONE** ☐ **$50,000** ☐ **$100,000** ☐
   Breach of Security Limits: **NONE** ☐ **$25,000** ☐
6. How many physicians are on staff or in your group (if applicable): _____ Full Time _____ Part Time
7. Specialties of practice (if applicable): _____
8. Medical malpractice carrier(s) (if applicable): _____

   Physician Minimum limits of liability (if applicable): _____
9. Do you have a compliance program in place? **Yes** ☐ **No** ☐
10. Does your practice manage billing through one central responsible party? **Yes** ☐ **No** ☐
11. Does your practice utilize a third party for billing or administrative services? **Yes** ☐ **No** ☐
12. Do you use an outside compliance consultant? **Yes** ☐ **No** ☐ Name: _____
13. Total Annual Billings: Previous 12 months: $_____

    Projected 12 months: $_____

3. EXPERIENCE

Has the applicant:

14. Been investigated or sanctioned by any local, state or federal government agency regarding the delivery of health care services or reimbursement? **Yes** ☐ **No** ☐

Has the applicant:

15. Been investigated or sanctioned by any commercial payor regarding the delivery of health care services or reimbursement? **Yes** ☐ **No** ☐
16. Been investigated or sanctioned by a state medical licensing board? **Yes** ☐ **No** ☐
17. Refunded more than 10% of annual billings to public and/or private payors? (If YES, provide details for each of the last 3 years) **Yes** ☐ **No** ☐
18. Lost any medical practice privileges? **Yes** ☐ **No** ☐
19. Provided notice of a claim or circumstance to any professional liability carrier in the past year? (If YES, provide details for each) **Yes** ☐ **No** ☐

Is the applicant:

20. Aware of any specific claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed coverage? **Yes** ☐ **No** ☐
21. Involved in any on-going litigation arising out of your billing practices? **Yes** ☐ **No** ☐

Please explain any "YES" response in section 3. Experience: _____

_____

_____

_____

4. WARRANTIES AND REPRESENTATIONS

IF A MATERIAL CHANGE OCCURS TO ANY OF THE ANSWERS PROVIDED ABOVE PRIOR TO THE INCEPTION OF ANY INSURANCE, THE APPLICANT MUST NOTIFY THE INSURER, AND AT THE SOLE DISCRETION OF THE INSURER, ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN.

THE APPLICANT WARRANTS AND REPRESENTS THAT, TO THE BEST OF HIS OR HER KNOWLEDGE, THE STATEMENTS HEREIN ARE TRUE AND THAT REASONABLE EFFORTS HAVE BEEN MADE TO OBTAIN SUFFICIENT INFORMATION TO FACILITATE THE PROPER AND ACCURATE COMPLETION OF THIS APPLICATION. THE PARTICULARS AND STATEMENTS CONTAINED IN THIS APPLICATION AND ANY OTHER INFORMATION SUBMITTED ARE THE BASIS FOR THE PROPOSED INSURANCE AND WILL BE CONSIDERED AS INCORPORATED INTO AND CONSTITUTING PART OF THE PROPOSED POLICY, UNLESS OTHERWISE STATED.

THE UNDERSIGNED AGREES THAT IN THE EVENT THIS APPLICATION CONTAINS MISREPRESENTATIONS OR FAILS TO STATE FACTS MATERIALLY AFFECTING THE RISK ASSUMED BY THE INSURER, ANY INSURANCE ISSUED SHALL BE VOID IN ITS ENTIRETY.

THE UNDERWRITERS ARE HEREBY AUTHORIZED TO MAKE AN INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT MAY DEEM NECESSARY.

IF SIGNING ON BEHALF OF A GROUP, THE UNDERSIGNED WARRANTS THAT THEY ARE DULY AUTHORIZED TO EXECUTE THIS APPLICATION, MAKE WARRANTIES AND PROVIDE REPRESENATIONS FOR THE GROUP OR ENTITY.

_____ _____

APPLICANT SIGNATURE DATE

_____

PRINT NAME and TITLE

Submitted by:

Agent Name: _____

Agency Name: _____