Preferred Physicians Medical
Risk Retention Group
A Mutual Insurance Company

ANESTHESIOLOGY GROUP CORPORATE APPLICATION PROFESSIONAL LIABILITY INSURANCE

Claims-Made Policy

NOTICE

This application is provided by a risk retention group. A risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for a risk retention group.

IMPORTANT

- This group application applies only to corporations with more than one shareholder or to formal partnerships.
- It needs to be completed only once, at the time the group first seeks coverage with Preferred Physicians Medical.
- Please complete the application in its entirety. We are unable to offer coverage based upon an incomplete application.
- Please print or type your answers.
- You may explain any special needs not specifically addressed in this application in the Remarks section on page 6, or you may attach a separate sheet.
- An authorized representative's signature and the signature of the Chairman, President or CEO is required on page 6.
- This application may be required even if the group does not intend to purchase separate coverage for the corporate entity or partnership itself.
- If the group structure includes more than one multi-shareholder corporation or partnership, and separate coverage is desired for more than one entity, a separate group application must be completed for each.

NOTE: If you have any questions about this application please call us. We will be happy to assist you. You may fax this application for review. If you fax an application, please mail the original with the original authorized signature on page 6 for final approval.

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PART 1: GROUP PRACTICE INFORMATION

1. LEGAL NAME OF ENTITY:

2. LEGAL DESCRIPTION OF ENTITY: ☐ CORPORATION ☐ ASSOCIATION ☐ PARTNERSHIP ☐ OTHER TAX ID #: _____

3. a. WHEN DID THE ENTITY FIRST COME INTO EXISTENCE: _____ (YEAR) b. LEGAL DOCUMENTS FILED IN: _____ (COUNTY / STATE)

HAS ANY MEMBER OF THE GROUP EVER PRACTICED UNDER ANOTHER ENTITY THAT MAY NEED COVERAGE? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DETAILS UNDER THE REMARKS SECTIONS, PAGE 6

c. WHO IS THE REGISTERED AGENT (NAME): _____

4. BUSINESS ADDRESS

_____ (STREET)

_____ (CITY) (STATE) (ZIP)

_____ (PHONE) (FAX) (WEBSITE)

COMPLETE ITEM 5 ONLY IF POLICY DOCUMENTS AND CORRESPONDENCE OR PREMIUM INVOICES SHOULD BE MAILED TO A LOCATION OTHER THAN THE BUSINESS ADDRESS (ITEM 4 ABOVE).

5. MAILING ADDRESS FOR:

☐ DOCUMENTS / CORRESPONDENCE _____

☐ PREMIUM INVOICES _____

6. WHOM MAY WE CONTACT REGARDING INSURANCE MATTERS?
PLEASE INDICATE (a) AN ADMINISTRATIVE STAFF CONTACT AND (b) A PHYSICIAN MEMBER OF THE GROUP.

a. STAFF

_____ (NAME) _____ (TITLE)

_____ (PHONE) (FAX) (EMAIL)

b. PHYSICIAN

_____ (NAME) _____ (TITLE)

7. a. DOES THE ENTITY EMPLOY OR DO GROUP MEMBERS SUPERVISE ANY OF THE FOLLOWING HEALTHCARE EXTENDERS? ☐ YES ☐ NO

	# EMPLOYED	# FACILITY EMPLOYS	# INDEPENDENT CONTRACTORS	NORMAL SUPERVISION RATIO
CRNAS				
PHYSICIAN ASSISTANTS / ANESTHESIA ASSISTANTS				
NURSE PRACTITIONERS				
STUDENT NURSE ANESTHETISTS				
OTHER: _____ (PLEASE SPECIFY)				

b. CHECK ALL APPLICABLE ITEMS REGARDING THE ABOVE PERSONNEL:

☐ GROUP MEMBERS NEVER MEDICALLY DIRECT OR SUPERVISE CRNAS, PAS OR AAS

☐ GROUP MEMBERS MEDICALLY DIRECT OR SUPERVISE CRNAS, PAS OR AAS BUT NOT WHILE DOING CASES

☐ A GROUP MEMBER MAY MEDICALLY DIRECT OR SUPERVISE CRNAS, PAS OR AAS WHILE DOING CASES

☐ CRNAS DO CASES WITHOUT SUPERVISION BY AN ANESTHESIOLOGIST

c. PLEASE ESTIMATE THE ANNUAL NUMBER OF CASES DONE OR MEDICALLY DIRECTED BY THE GROUP _____

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8. DO THE HEALTHCARE EXTENDERS YOU EMPLOY OR THE HOSPITAL EMPLOYS PROVIDE ANESTHESIA CARE TO PATIENTS NOT SEEN PREOPERATIVELY BY ANESTHESIOLOGISTS? ☐ YES ☐ NO

9. PRACTICE INFORMATION: (EXPLAIN ALL YES ANSWERS IN REMARKS, PAGE 6.)

a. DOES THE GROUP PRACTICE AT ANY LOCATION THAT DOES NOT MEET THE ASA STANDARDS FOR BASIC ANESTHETIC MONITORING? ☐ YES ☐ NO

b. DOES THE GROUP PRACTICE AT ANY LOCATION THAT DOES NOT MEET THE ASA STANDARDS FOR POSTANESTHESIA CARE? ☐ YES ☐ NO

c. DOES THE GROUP PRACTICE AT ANY LOCATION WHERE THE JOINT COMMISSION *UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE, WRONG PERON SURGERY* IS NOT FOLLOWED? ☐ YES ☐ NO

d. DOES THE GROUP PRACTICE AT ANY LOCATION WHERE AN ANESTHESIA-SPECIFIC INFORMED CONSENT IS NOT USED? ☐ YES ☐ NO

e. DO GROUP MEMBERS PLACE REGIONAL BLOCKS WHILE THEIR PATIENT IS UNDER GENERAL ANESTHESIA? ☐ YES ☐ NO

f. DO GROUP MEMBERS PARTICIPATE IN VBAC PROCEDURES? ☐ YES ☐ NO

g. DOES THE GROUP PRACTICE AT ANY LOCATION WHERE THERE IS NO PROTOCOL IN PLACE TO PREVENT INTRAOPERATIVE FIRES? ☐ YES ☐ NO

10. LIST ALL PHYSICIANS PRACTICING WITH THE ENTITY AND INDICATE THEIR RELATIONSHIPS. USE ATTACHMENTS, IF NECESSARY. IN ADDITION, PLEASE ATTACH A COPY OF THE GROUP'S LETTERHEAD.

NAME	SHAREHOLDER/ PARTNER	OFFICER OF CORP	EMPLOYEE	OTHER	START DATE MM / DD / YYYY
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

11. LIST ALL PRACTICE LOCATIONS THE ENTITY WILL HAVE WHEN THIS COVERAGE BEGINS. ATTACH ADDITIONAL SHEET FOR OTHER LOCATIONS. (*PREFERRED PHYSICIANS MEDICAL WILL SEND CERTIFICATES OF INSURANCE TO EACH FACILITY LISTED, UNLESS YOU DIRECT OTHERWISE.*)

FACILITY NAME
MAILING ADDRESS
CITY / COUNTY / STATE / ZIP

DON'T SEND CERTIFICATE ☐

☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER

☐

☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER

☐

☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER

☐

☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER

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12. LIST THE PHYSICIANS WHO HAVE PREVIOUSLY PRACTICED WITH THE ENTITY AND HAVE LEFT WITHIN THE PAST FIVE (5) YEARS. ALSO, INDICATE WHETHER THAT INDIVIDUAL CURRENTLY HAS A CLAIM OR INCIDENT PENDING.

NAME	TITLE	TAIL COVERAGE SECURED		PRACTICED WITH ENTITY		CLAIMS OR INCIDENTS
		INDIVIDUAL	*ENTITY*	*FROM* MM / DD / YYYY	*TO* MM / DD / YYYY	
		☐	☐			☐
		☐	☐			☐
		☐	☐			☐
		☐	☐			☐
		☐	☐			☐

13. WILL THE ENTITY EMPLOY OR CONTRACT FOR THE SERVICES OF ANY MEDICAL PROFESSIONALS WHO WILL NOT BE INSURED BY PREFERRED PHYSICIANS MEDICAL? IF YES, LIST IN REMARKS, PAGE 6. ☐ YES ☐ NO

14. IS THERE A WRITTEN CONTRACT BETWEEN YOUR ENTITY AND THE PRACTICE FACILITIES? ☐ YES ☐ NO

a. WHAT ARE THE INSURANCE REQUIREMENTS FOR ANESTHESIOLOGY? _____

b. WHAT ARE THE INSURANCE REQUIREMENTS AT THE FACILITIES FOR SURGEONS? _____

PART 2: SPECIAL CIRCUMSTANCES / CLAIM INFORMATION

15. SPECIAL CIRCUMSTANCES (EXPLAIN ALL YES ANSWERS IN REMARKS, PAGE 6.)

a. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY EVER BEEN INVESTIGATED, DISCIPLINED, SUSPENDED, RESTRICTED, REVOKED, DENIED RENEWAL OR HAS ANY OTHER ACTION BEEN TAKEN AGAINST THEIR NARCOTICS LICENSE OR THEIR LICENSE TO PRACTICE MEDICINE OR NURSING IN ANY STATE WHETHER VOLUNTARILY AGREED TO OR NOT? ☐ YES ☐ NO

b. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY HAD RESTRICTIONS PLACED ON THEIR PRIVILEGES OR RESTRICTIONS PLACED ON THE TYPE OF CASES ASSIGNED TO THEM BY A HOSPITAL, OTHER HEALTHCARE FACILITY, OR PRACTICE ENTITY, OR HAVE THEY EVER BEEN INVESTIGATED FOR PATIENT CARE OR SAFETY REASONS AND FOUND NOT TO HAVE MET THE STANDARD OF CARE? ☐ YES ☐ NO

c. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY VOLUNTARILY AGREED TO LIMITATIONS ON THEIR PRIVILEGES OR LIMITATIONS ON THE TYPE OF CASES ASSIGNED TO THEM BY A HOSPITAL, OTHER HEALTHCARE FACILITY, OR PRACTICE ENTITY? ☐ YES ☐ NO

d. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY EVER BEEN DISCIPLINED BY OR HAD MEMBERSHIP OR PARTICIPATION RESTRICTED BY ANY MEDICAL SOCIETY OR HEALTH INSURANCE PLAN OR ORGANIZATION INCLUDING MEDICARE AND MEDICAID PROGRAMS? ☐ YES ☐ NO

e. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR OR HAVE THEY EVER BEEN NAMED AS A DEFENDANT IN A CRIMINAL OR CIVIL TORT CASE OTHER THAN A MEDICAL MALPRACTICE CASE? ☐ YES ☐ NO

f. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY EVER HAD; OR EVER BEEN INVESTIGATED FOR; OR HAVE EVER RECEIVED TREATMENT FOR AN ALCOHOL OR SUBSTANCE ABUSE PROBLEM OR BEEN CONVICTED OF AN ALCOHOL AND/OR DRUG RELATED OFFENSE? ☐ YES ☐ NO

g. HAS ANY PHYSICIAN, CRNA OR OTHER HEALTHCARE EXTENDER EMPLOYED/CONTRACTED BY ENTITY EVER HAD ANY PERSONAL HEALTH PROBLEMS WHICH MIGHT AFFECT THEIR PRACTICE OF MEDICINE OR NURSING; OR HAVE EVER BEEN UNDER PSYCHIATRIC CARE OR TREATED FOR MENTAL ILLNESS? ☐ YES ☐ NO

h. DOES THE ENTITY ADVERTISE TO THE PUBLIC BY RADIO OR TELEVISION BROADCAST, INTERNET, NEWSPAPER, YELLOW PAGES OR DIRECT MAIL? (PLEASE ENCLOSE COPIES OF ANY ADVERTISING MATERIALS USED TO PROMOTE THE PRACTICE.) ☐ YES ☐ NO

i. ARE ENTITY MEMBERS ENGAGED IN ANY MEDICAL MOONLIGHTING ACTIVITY? ☐ YES ☐ NO

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16. CLAIM INFORMATION: (EXPLAIN ALL YES ANSWERS BELOW, OR ATTACH A NARRATIVE DESCRIPTION.)

a. HAS THE ENTITY EVER BEEN NOTIFIED EITHER DIRECTLY OR INDIRECTLY OF, OR ARE YOU AWARE OF THE ENTITY'S INVOLVEMENT IN A MALPRACTICE CLAIM OR SUIT? ☐ YES ☐ NO

b. ARE YOU AWARE OF ANY INCIDENTS, CIRCUMSTANCES, ADVERSE EVENTS OR SENTINEL EVENT WHICH MIGHT GIVE RISE TO A CLAIM OR SUIT AGAINST THE ENTITY? ☐ YES ☐ NO

c. ARE YOU AWARE OF ANY CLAIM OR SUIT, INCIDENTS, CIRCUMSTANCES, ADVERSE EVENTS OR SENTINEL EVENT INVOLVING THE ENTITY THAT HAS NOT YET BEEN REPORTED TO ITS CURRENT INSURER, OR WHICH HAS NOT BEEN ACCEPTED FOR COVERAGE BY ITS CURRENT INSURER? ☐ YES ☐ NO

THIS SECTION MUST BE COMPLETED IF QUESTION 16 A, B OR C WAS ANSWERED "YES"

DATE OF INCIDENT (MM / DD / YYYY)	ALLEGATION / INCIDENT DESCRIPTION: (PLEASE INDICATE CURRENT STATUS AND ANY PAYMENTS MADE ON YOUR BEHALF.)	REPORTED TO INSURER
_____	_____	☐ YES ☐ NO
_____	_____	☐ YES ☐ NO

PART 3: COVERAGE INFORMATION

17. DOES THE ENTITY WISH TO PURCHASE SEPARATE ENTITY COVERAGE? ☐ YES ☐ NO

IF YES, WHAT IS THE DESIRED EFFECTIVE DATE OF COVERAGE? _____

LIMITS OF LIABILITY (CHECK ONE):

- ☐ $1,000,000 EACH CLAIM / $3,000,000 AGGREGATE PER YEAR
- ☐ $500,000 EACH CLAIM / $1,500,000 AGGREGATE PER YEAR
- ☐ $250,000 EACH CLAIM / $750,000 AGGREGATE PER YEAR
- ☐ $200,000 EACH CLAIM / $600,000 AGGREGATE PER YEAR
- ☐ OTHER: _____ EACH CLAIM / _____ AGGREGATE PER YEAR

18. DOES THE ENTITY CURRENTLY HAVE A PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE POLICY? ☐ YES ☐ NO

IF YES, PLEASE ATTACH A PHOTOCOPY OF THE DECLARATIONS PAGE OF THE ENTITY'S CURRENT POLICY SHOWING THE POLICY LIMITS AND THE "RETROACTIVE DATE" OR "PRIOR ACTS DATE." IF YOU ARE UNABLE TO ATTACH A COPY OF THE ENTITY'S POLICY DECLARATIONS WITH THIS APPLICATION, PLEASE COMPLETE THE CURRENT POLICY INFORMATION ITEMS BELOW SO WE MAY PREPARE A PREMIUM QUOTATION.

PLEASE FORWARD A COPY OF THE CURRENT POLICY DECLARATION PAGE AS SOON AS POSSIBLE.

a. INFORMATION CONCERNING THE ENTITY'S CURRENT POLICY AND COVERAGE. (SHOW PAST THREE (3) YEARS)

POLICY DATES		INSURER	FORM OF COVERAGE		LIMITS OF LIABILITY	
FROM	*TO*		*OCCURRENCE*	*CLAIMS-MADE*	*EACH CLAIM*	*AGGREGATE*
_____ MM / YYYY	_____ MM / YYYY	_____	☐	☐	_____ /	_____
_____ MM / YYYY	_____ MM / YYYY	_____	☐	☐	_____ /	_____

b. IF THE ENTITY'S CURRENT PROFESSIONAL LIABILITY INSURANCE COVERAGE IS ON A CLAIMS-MADE FORM, DOES THE ENTITY WISH TO PURCHASE COVERAGE FOR PRIOR ACTS FROM PREFERRED PHYSICIANS MEDICAL (IN LIEU OF PURCHASING EXTENDED REPORTING PERIOD COVERAGE, COMMONLY REFERRED TO AS A "TAIL," FROM ITS CURRENT INSURER)? ☐ YES ☐ NO

c. IF 18(b) IS YES, WHAT IS THE "PRIOR ACTS" OR "RETROACTIVE" DATE ON THE ENTITY'S CURRENT POLICY? _____ MM / DD / YYYY

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REMARKS (ATTACH ADDITIONAL PAGES, IF NECESSARY)

PART 4: AGREEMENT AND RELEASE

THIS RELEASE MUST BE SIGNED

APPLICATION AGREEMENT AND RELEASE AUTHORIZATION

1. On behalf of the entity, I have been authorized to complete this application for insurance.
2. I understand that this is an application for insurance and not an insurance binder.
3. I have accurately and truthfully completed the application on behalf of the entity and have not withheld any information which is reasonably likely to influence the judgment of the Company in considering this application. I agree to notify Preferred Physicians Medical of any change in the information provided. I understand that any misrepresentation or concealment of information may void all coverage extended by Preferred Physicians Medical.
4. For the purpose of evaluating this application, I authorize Preferred Physicians Medical to obtain information about this entity from past or present insurance providers or consultants, health care facilities, other health care providers or other individuals with information. I further authorize Preferred Physicians Medical to obtain information regarding civil litigation or criminal prosecution. I agree to release from liability and hold harmless Preferred Physicians Medical and any individual or organization providing information pursuant to this release.
5. If I have applied for Prior Acts Coverage on behalf of the entity, I have accurately and truthfully reported in the application any adverse outcomes, circumstances or events that could give rise to a claim, and I understand that coverage for same will not be provided unless specifically accepted by Preferred Physicians Medical. I further understand that the limits of liability provided under the prior acts coverage may be no greater than coverage carried by the entity under prior insurance policies.
6. I understand that Preferred Physicians Medical is a mutual insurance company and each applicant who becomes a policyholder becomes a member of the mutual. Each member of the mutual is required to provide an irrevocable proxy authorizing the proxyholder to exercise certain voting rights related to corporate governance. This proxy will be executed along with your policy documents.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	SIGNATURE OF CHAIRMAN, PRESIDENT OR CEO
TITLE	TITLE
DATE	DATE