APPLICATION

8-2019

Please type your responses directly on the application, sign and submit via:

e-mail: GroupServices@prms.com

fax: (703) 276-0873

mail: PRMS
Attn: Group Services
1401 Wilson Boulevard, Suite 700
Arlington, VA 22209

Thank you!

Medical Professional Liability Insurance Application – Entity

Applicant Name: ____
Practice Name

Mailing Address: ____

City: ______________________________ **State:** ______________ **Zip:** ______________

Mobile: ______________________________

Website: ______________________________ **Email:** ______________________________

Authorized contact and email: ____

Majority Stakeholder: ____

Please send your articles of incorporation.

Entity type: ❑ Partnership ❑ Corporation ❑ LLC or PLLC ❑ Other: ______________________________

I: Coverage Requested

1. Effective date of coverage: ______________________

2. Limits of liability: ❑ $200,000/$600,000 ❑ $500,000/$1,500,000 ❑ $1,000,000/$3,000,000
❑ $1,300,000/$3,900,000 ❑ Other: ______________________

3. Coverage type: ❑ Occurrence ❑ Claims Made - Retroactive date: __________

If prior coverage was on a claims-made policy, was the Extended Reporting Period Endorsement (tail coverage) purchased?
❑ Yes ❑ No – If no, please explain: ______________________________________

Is the entity or your members requesting prior acts coverage? ❑ Yes ❑ No – If no, please explain: ____________________

4. Practice specialty:
❑ General psychiatry ____% ❑ Child and adolescent psychiatry ____%
❑ Addiction psychiatry ____% ❑ Pain management ____%
❑ Geriatric psychiatry ____% ❑ Forensic psychiatry ____%
❑ Other (please specify): ______________________________ ____%

5. Average number of hours per week requested for this policy: ____________

If 20 hours or less, will your members be performing any activities which will be covered by another professional liability policy? ❑ Yes ❑ No

6. Has any member completed four or more CME hours specific to risk management in the past year? ❑ Yes ❑ No

If your practice is primarily located in New York, were the risk management hours specific to the New York Excess Seminar?
❑ Yes ❑ No

II: Practice Location

1. **Provide location where our coverage is requested:** (if multiple locations, please provide information for each additional practice location on page 6).

Practice Name: ____ **County:** ___________________________

Practice Address: ____ **City:** ________________ **State:** ____ **Zip:** _____

Is the majority of your entity or members' weekly practice time at this location? ❑ Yes ❑ No

Shareholders, partners, employees or independent contractors (members) at this location.

Full name and degree (check if our coverage is requested for the provider)	Specialty	Prescribe (Yes/No)	Total practice hours per week for this policy	Current insurer	Coverage type (occurrence, or claims made with retroactive date)
❑					
❑					
❑					
❑					
❑					
❑					

An Individual application is required for all physicians and prescribing providers to be an insured on this policy.

2. **Indicate percentage of total practice time for each location and be sure to complete the practice location information for each if insurance is requested for this policy:**

❑ Private Office	____%	❑ Home Office	____%	❑ Community Health Center	____%
❑ Detention Facility	____%	❑ Treatment Center	____%	❑ Home Health	____%
❑ Nursing Home	____%	❑ Inpatient Facility	____%	❑ Government Facility	____%
❑ Outpatient Clinic	____%	❑ Residential Facility	____%	❑ Other: _______________	____%

3. **List any practice locations covered by other insurers, employers or self-insured programs:**

Practice Name: ____

III. Additional Information

1. **Has the entity or any member practiced <u>without</u> continuous medical professional liability insurance coverage? If yes, please explain the period of time and reason for the gap in coverage. If your members were insured by an employer, you may answer "No".** ❑ Yes ❑ No

If yes, please explain: ____
____

2. **Has the entity or any member ever had professional liability insurance coverage cancelled, refused renewal, denied or accepted subject to any conditions or restrictions** ❑ Yes ❑ No - If yes, please explain: ___________________________________
____

Note: Missouri applicants do not respond.

3. **Are records created and maintained for each patient, and do your members document informed consent?** ❑ Yes ❑ No

4. **Does any member engage in these practices for which this policy is requested (check all that apply and indicate percentage of practice time for each)?**

❑ **Medication management** ____%
If yes, do your members provide proper monitoring for medication levels, physiological reactions and drug interactions
❑ Yes ❑ No – If no, please explain:
____

If yes, do your members conduct an initial patient clinical evaluation before prescribing medications
❑ Yes ❑ No – If no, please explain on page 6.

❑ **Telepsychiatry** ____%
If yes, are your members licensed in the state where the patient is located
❑ Yes ❑ No

Please indicate the county and state where the majority of your entity and members' telepsychiatry patients are located:

_______________ ______
County State

❑ **Unconventional therapy** ____%
Please explain on page 6.

❑ **Clinical trials or research** ____%

❑ **Collaborative agreement** ____%

❑ **Treatment by email** ____%

5. **If any of the following are answered "Yes", please provide pertinent documents with explanations.**

   a. **Has any lawsuit, claim, incident, investigation or civil proceeding regarding behavioral healthcare practice been brought against your entity, or any current or former member of your group in the past 10 years (or at any time if involving sexual misconduct)? If yes, please explain and provide a claims history report from the insurer(s) of the members over the past 10 years.**
   ❑ Yes ❑ No

   b. **Is any current or former member aware of any occurrences, accidents, conduct, circumstances, complications or unexpected outcomes for psychiatric services provided while a member of the entity that might reasonably be expected to result in a claim, lawsuit, investigation, or civil investigation or proceeding known or which should have been known on the date of this application?**
   ❑ Yes ❑ No

   c. **Has any current or former member had professional licenses, certificates or hospital privileges been declined, subject to an investigation or proceeding for any reason, or have they been voluntarily surrendered or nonrenewed in lieu of disciplinary action in the past 10 years?**
   ❑ Yes ❑ No

   d. **Has any current or former member ever been – or are currently – sexually, romantically, socially or professionally (e.g., a business venture) involved with any current or former patient, or with a key third party of a patient?**
   ❑ Yes ❑ No

   e. **Has any current or former member been convicted of, plead guilty to, or plead no contest to a felony or other criminal proceeding**
   ❑ Yes ❑ No

   f. **Has any current or former member ever experienced any dependency upon or been treated for abuse of alcohol, narcotics or other drugs?**
   ❑ Yes ❑ No

   g. **Has any current or former member ever been diagnosed with any physical or mental condition that impairs or could impair the ability to practice medicine?**
   ❑ Yes ❑ No

   h. **Has any current or former member ever been denied a specialty board certification or re-certification?**
   ❑ Yes ❑ No

If you are a Kansas resident, you must complete the Kansas Health Care Providers Only supplemental application in addition to this application.

Please read the following declarations carefully.
All questionnaires must be signed and dated.

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy with Fair American Insurance and Reinsurance Company.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THE APPLICANT AGREES IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, THAT THIS APPLICATION AND ANY ATTACHMENTS ARE DEEMED ATTACHED TO AND INCORPORATED INTO THE POLICY. BY TYPING MY NAME IN THE FIELD BELOW, I AGREE IT IS EQUIVALENT TO MY SIGNATURE ON THIS DOCUMENT AND I CONSENT TO CONDUCT THE TRANSACTION TO WHICH THIS DOCUMENT IS APPLICABLE BY ELECTRONIC MEANS.

____________________________ ____________________________

Applicant's Signature Date

Further explanation if needed: