Fair American Insurance and Reinsurance Company
(A Stock Insurance Company)
One Liberty Plaza, 165 Broadway
New York, NY 10006

Medical Professional Liability Insurance Application – Entity

Please complete the application and submit via email to GroupServices@prms.com or via fax (703) 276-9530. You may provide any additional details or explanations in the Additional Notes section. **Please include your articles of incorporation with your submission.**

Practice Name: _____

Entity Type: ❑ Partnership ❑ Corporation ❑ LLC or PLLC ❑ Other:_____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Website:** _____

Primary/Authorized Contact Information

First Name: _____ **Last Name:** _____ **Degree:** _____

Email: _____**Mobile Phone:** _____ **Office Phone:** _____

I. Coverage Requested

1. Effective date: _____

2. Limits of liability: ❑ $500,000/$1,500,000 ❑ $1,000,000/$3,000,000 ❑ Other: _____

3. Coverage type: ❑ Occurrence ❑ Claims Made – Entity Retroactive Date: _____

If the entity's prior coverage was on a claims-made policy, was the tail/retroactive coverage purchased?

❑ Yes ❑ No – If no, please explain: _____

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

_____

4. MARYLAND APPLICANTS ONLY: Deductible Option: ❑ NONE ❑ $25,000 ❑ $50,000 ❑ $100,000

5. Has any physician provider 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 Specialty

1. Please indicate your practice specialty. If more than one specialty, please estimate the percentage of time of each:

❑ General Psychiatry _____% ❑ Child and Adolescent Psychiatry _____% ❑ Addiction Psychiatry _____%
❑ Geriatric Psychiatry _____% ❑ Forensic Psychiatry _____% ❑ Pain Management _____%
❑ Other (please specify): _____ _____%

III. Practice Locations

1. **Please provide the location where our coverage is requested and is the location of the majority of your entity or providers' weekly practice time is spent:**

A. Practice Name: _____

Practice County: _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

❑ **Check if same as mailing address above**

Practice Type:
❑ Private Practice ❑ Detention/Correctional Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

Additional practice location(s) <u>where our coverage is requested</u>:

B. Practice Name: _____

Practice County: _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Practice Type:
❑ Private Practice ❑ Detention/Correctional Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

C. Practice Name: _____

Practice County: _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Practice Type:
❑ Private Practice ❑ Detention/Correctional Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

D. Practice Name: _____

Practice County: _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Practice Type:
❑ Private Practice ❑ Detention/Correctional Facility
❑ Group Home ❑ Home Practice
❑ Hospital ❑ Other:_____

For additional locations, please use the notes page(s).

IV. Physician/Provider Rosters

1. **Complete the following for <u>all physicians</u> in your group. For additional physicians, please use the notes page(s).** An individual application may be required for any physicians upon request.

Physician Full Name	Degree	Current Insurance (if applicable) If claims-made, provide copy of certificate of insurance.	PRMS Coverage Requested?	Practice Hours per Week for this Policy	License # /State(s)	Primary Practice State	Select all that apply:
____________	____	____________ Current Insurer ❑ Occurrence ❑ Claims Made ____________ Retroactive Date	❑ Yes ❑ No	______		______	❑ Completed residency/fellowship within the past five years. Completion Date: ___________ ❑ Current member of a psychiatric-specific association. List association: ___________________________ ❑ Completed a child and adolescent fellowship % of practice seeing child & adolescent patients: _____ ❑ Discharged from military within the past five years. Discharge Date: ___________
____________	____	____________ Current Insurer ❑ Occurrence ❑ Claims Made ____________ Retroactive Date	❑ Yes ❑ No	______		______	❑ Completed residency/fellowship within the past five years. Completion Date: ___________ ❑ Current member of a psychiatric-specific association. List association: ___________________________ ❑ Completed a child and adolescent fellowship % of practice seeing child & adolescent patients: _____ ❑ Discharged from military within the past five years. Discharge Date: ___________
____________	____	____________ Current Insurer ❑ Occurrence ❑ Claims Made ____________ Retroactive Date	❑ Yes ❑ No	______		______	❑ Completed residency/fellowship within the past five years. Completion Date: ___________ ❑ Current member of a psychiatric-specific association. List association: ___________________________ ❑ Completed a child and adolescent fellowship % of practice seeing child & adolescent patients: _____ ❑ Discharged from military within the past five years. Discharge Date: ___________
____________	____	____________ Current Insurer ❑ Occurrence ❑ Claims Made ____________ Retroactive Date	❑ Yes ❑ No	______		______	❑ Completed residency/fellowship within the past five years. Completion Date: ___________ ❑ Current member of a psychiatric-specific association. List association: ___________________________ ❑ Completed a child and adolescent fellowship % of practice seeing child & adolescent patients: _____ ❑ Discharged from military within the past five years. Discharge Date: ___________

For additional physicians, please use the notes page(s).

2. **Complete the following for <u>all non-physician providers</u> in your group. For additional providers, please use the notes page(s).** An individual application may be required for any prescribing providers upon request.

Full Name	Degree	**Current Insurance** (if applicable) **If claims-made, please provide copy of certificate of insurance (COI).**	Coverage requested through PRMS?	Practice Hours per Week for this Policy	Prescriber	License #/State(s)	Primary Practice State
______	______	______ Current Insurer ❑ Occurrence ❑ Claims Made ______ Retroactive Date	❑ Yes ❑ No	______	❑ Yes ❑ No		______
______	______	______ Current Insurer ❑ Occurrence ❑ Claims Made ______ Retroactive Date	❑ Yes ❑ No	______	❑ Yes ❑ No		______
______	______	______ Current Insurer ❑ Occurrence ❑ Claims Made ______ Retroactive Date	❑ Yes ❑ No	______	❑ Yes ❑ No		______
______	______	______ Current Insurer ❑ Occurrence ❑ Claims Made ______ Retroactive Date	❑ Yes ❑ No	______	❑ Yes ❑ No		______
______	______	______ Current Insurer ❑ Occurrence ❑ Claims Made ______ Retroactive Date	❑ Yes ❑ No	______	❑ Yes ❑ No		______
______	______	______ Current Insurer ❑ Occurrence ❑ Claims Made ______ Retroactive Date	❑ Yes ❑ No	______	❑ Yes ❑ No		______

V: Practice Profile

If you answer "Yes" to 1., 2., 3. or 4., please provide an explanation in the additional notes section.

1. **Has the entity or any provider practiced without continuous medical professional liability insurance coverage?** *If you were insured by an employer, you may answer NO.* ❑ Yes ❑ No
2. **Has the entity or any provider ever had professional liability insurance coverage cancelled, refused renewal, denied, or accepted subject to any conditions or restrictions?** *Missouri applicants: please do not answer.* ❑ Yes ❑ No
3. **Do any of your providers engage in unconventional therapy?** *(e.g., psychiatric treatment not considered to be mainstream)* ❑ Yes ❑ No
4. **Do any of your providers engage in clinical trials or research?** ❑ Yes ❑ No
5. **Are records created and maintained for each patient, and is informed consent documented?** ❑ Yes ❑ No
6. **Does any provider engage in medication management?** ❑ Yes ❑ No
   If yes:
   - **Do they provide proper monitoring for medication levels, physiological reactions and drug interactions?**
     ❑ Yes ❑ No, please explain: _____
   - **Do they conduct an initial patient clinical evaluation before prescribing medications?**
     ❑ Yes ❑ No, please explain: _____
7. **Does the entity have any ownership interest in a hospital, nursing home, sanitarium, clinic, laboratory, any facility providing bed and board, and/or any other business enterprise?** *No coverage is provided for ownership or administrative activities related to the above.* ❑ Yes ❑ No
8. **Is the entity in the business of managing or providing staffing to a hospital, nursing home, sanitarium, clinic, laboratory, any facility providing bed and board, and/or any other business enterprise?** *No coverage is provided for management/administrative activities related to the above.* ❑ Yes ❑ No
9. **Do any of your providers engage in telepsychiatry?** ❑ Yes ❑ No
   If yes, please complete the following:

   What percentage of the total practice is dedicated to telepsychiatry? _____%

   In which state(s) are your patients located when they are receiving telepsychiatry services?
   - Majority of telepsychiatry practice: State:_____ County:_____
   - Other states, if any:_____

❑ **Please check to confirm you have reviewed and agree to the following regarding your telepsychiatry practice:**
- We comply with the applicable laws and regulations by the state(s) and, if prescribing controlled substances, federal government as well as the relevant agencies or exceptions. This includes, but is not limited to, prescribing requirements and an in-person examination.
- Services are considered rendered in the patient's state, not the entity's location.
- The patient location is confirmed at the start of every session.
- We are using HIPAA-compliant equipment. If the equipment vendor stores any patient information, we have a Business Associate Agreement from the vendor unless there is an exception.
- Informed consent includes the use of telepsychiatry.
- Patients can decline treatment via telepsychiatry.
- We have contingency plans for emergencies and technical failures.

VI. Additional Information

For the following questions, please answer with regards to your Professional Corporation, Partnership, Sole Practitioner, or Fictitious Name Entity OR any of your employee/independent contractor professionals, partners and/or shareholders. If your response is "Yes" to any of the questions below, please explain in the additional notes section and provide a claims history report from the insurer(s) over the past 10 years.

1. Has any lawsuit, claim, investigation, or civil proceeding regarding your practice been brought against your entity, or any incoming, current, or former provider of your group in the past 10 years (or at any time if involving sexual misconduct)? **If your response is yes, please explain in the additional notes section and provide a claims history report from your insurer(s) over the past 10 years.** ❑ Yes ❑ No
2. Are any incoming, current, or former providers aware of any occurrences, accidents, conduct, circumstances, complications, or unexpected outcomes for professional services that might reasonably be expected to result in a claim, lawsuit, investigation, or civil investigation or proceeding known to you on the date of this application? ❑ Yes ❑ No
3. Has any incoming, current, or former provider had professional licenses, certificates or hospital privileges or applications for these 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
4. Has any incoming, current, or former provider 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? (Key third parties include, but are not limited to, spouses, partners, parents, siblings, children, guardians, surrogates, proxies and the like.) ❑ Yes ❑ No
5. Has any incoming, current, or former provider been convicted of, plead guilty to, or plead no contest to a felony? Or, within the past 10 years, been convicted of, plead guilty to, or plead no contest to any other criminal proceeding? ❑ Yes ❑ No
6. Has any incoming, current, or former provider experienced any dependency upon or been treated for abuse of alcohol, narcotics, or other drugs within the past 10 years? ❑ Yes ❑ No
7. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice? ❑ Yes ❑ No

VII: Cybersecurity

1. **In your practice, who is responsible for information security and compliance operations?**
   ❑ Self ❑ IT Department/Office Manager/Another Designated Individual ❑ N/A, paper files are used

2. **How many people in your practice, in addition to yourself, have access to patient/medical records and financial records?**
   _____

3. **Do the providers of your practice, engage in regular training regarding security issues and procedures, anti-fraud and cyber phishing?** ❑ Yes ❑ No ❑ Unsure/I don't know ❑ N/A, there is no electronic communication or use in the practice

4. **Where is your data stored? (Please check all that apply)**
   ❑ On the premises – desktop, non-mobile, computers
   ❑ On a laptop or other device that can be carried off premise
   ❑ In the cloud / data center / internet
   ❑ I do not use a computer in my practice.
   ❑ N/A, paper files are used

5. **Please check the methods in which your data is being secured and managed:**
   - ❑ Data is encrypted
   - ❑ Emails are encrypted
   - ❑ Data is regularly backed up in the cloud/secondary backup computer system
   - ❑ None of the above
   - ❑ I don't know
   - ❑ N/A, paper files are used

6. **Please check the methods in which your computer system is being secured:**
   - ❑ Wireless network is secure
   - ❑ Data is protected by an active and up-to-date firewall
   - ❑ Computers have up-to-date anti-malware/anti-virus software installed
   - ❑ Operating system and software updates are automatically or regularly installed
   - ❑ None of the above
   - ❑ I don't know
   - ❑ N/A, paper files are used

7. **Are the security policies of third-party service providers that may have access to personally identifiable information (such as EMR providers, third party billing, etc.) reviewed to ensure practice data is safeguarded appropriately?**
   ❑ Yes ❑ No ❑ Unsure/I don't know ❑ N/A, paper files are used

All Applicants: 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, in writing, notify the company of such changes, and the company reserves the right to withdraw or modify any outstanding quotations.

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 this Application are hereby incorporated by reference into this Application and made a part hereof.

GENERAL 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, LOUISIANA, RHODE ISLAND, 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 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 a denial of insurance benefits.

NOTICE TO ALABAMA APPLICANTS
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO CALIFORNIA APPLICANTS
For your protection, California law requires the following to appear on this form: any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 agencies.

NOTICE TO DELAWARE APPLICANTS
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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 (22-3225.09).

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 of the third degree.

NOTICE TO HAWAII APPLICANTS
For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

NOTICE TO IDAHO APPLICANTS
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE TO KANSAS APPLICANTS
A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 HAMPSHIRE APPLICANTS
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO 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 civil fines and criminal 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.

NOTICE TO OREGON APPLICANTS
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may be subject the 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 VERMONT APPLICANTS
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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 Personal Signature Date

Additional Notes, Explanations, and Information:

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