MEDICAL DIRECTOR'S PROFESSIONAL LIABILITY APPLICATION
(CLAIMS-MADE FORM)

Physician's Personal Information

1. Full Name of Applicant: _____

2. Mailing Address: _____
_____

3. Medical License # and State of Issuance: _____

4. Date of Birth: _____ 5. Place of Birth: _____

6. Medical School & Year of Graduation: _____

7. Medical Specialty:_____ Sub-Specialty: _____

8. Are you American Board Certified? _____ Yes _____ No
If Yes, in what specialty?_____ Year Certified:_____

***PLEASE ATTACH A COPY OF YOUR RESUME OR C.V.**

ENTITY INFORMATION-*provide the following information for every entity for which you provide medical director services and are seeking coverage for those medical director services – Note, entities are not covered by the policy for which you are applying.*

9. Name & Location of Facility Where Medical Director Services are Performed: _____
_____
_____

10. Your relationship to this entity:
_____ owner/partner _____ contractor _____ employee
_____ other. Provide Details: _____

11. When was this facility established? _____

12. Type of Facility-describe in detail medical services provided: _____
_____
_____

13. Does this entity have any beds for overnight occupancy? _____ Yes _____ No
If Yes, how many beds is this facility licensed for? _____

14. What is the total number of outpatient visits and/or tests per year at this facility? _____
_____

15. Is surgery performed at this facility? _____ Yes _____ No
If Yes, how many surgeries per year? _____
***PLEASE ATTACH A LIST OF THE SURGERIES PERFORMED AT THIS FACILITY.**

16. Are obstetrics practiced at this facility? _____ Yes _____ No
If Yes, how many deliveries per year?_____

17. **What is the estimated revenue of the facility for the next 12 months? _____**

18. **Is this facility currently covered by a Medical Malpractice policy? _____ Yes _____ No**
If Yes, who is the medical malpractice insurance carrier? _____
***PLEASE ATTACH A COPY OF THE MEDICAL MALPRACTICE DECLARATIONS PAGE.**

19. **State the approximate division of patients at this facility:**

_____% Alcoholics/Drug Addicts	**_____% Counseling/Family Planning**
_____% Dental/Orthodontic	**_____% General Public**
_____% Hemodialysis	**_____% Holistic Medicine/Acupuncture**
_____% Mentally Retarded	**_____% Obstetrical**
_____% Pediatric	**_____% Psychiatric**
_____% Research or Experimental	**_____% Senile or Aged**
_____% Surgical	**_____% Other: _____**

20. **List the number and type of employees at this facility:**

NUMBER	Type of Profession	NUMBER	Type of Profession
_____	Inhalation Therapists	_____	Nurse Practitioner
_____	Laboratory Technicians	_____	Nurses Registered
_____	Nurse Anesthetists	_____	Opticians
_____	Nurses, Licensed Practical	_____	Optometrists
_____	Perfusionists	_____	Pharmacists
_____	Social Workers	_____	Physicians-minor surgery
_____	Physicians-no surgery	_____	Speech Therapists
_____			

Other:_____

21. **List the number and type of independent contractors who provide professional services at this facility: _____**

22. **Are all physicians, whether employed or contracted, required to carry medical malpractice insurance? _____ Yes _____ No If Yes, at what limits of liability?_____**

23. **Is this facility currently insured under a Commercial General Liability Policy?**
_____ Yes _____ No If Yes, what is the name of the CGL carrier? _____

Medical Director Services Information-NOTE: Policy excludes medical malpractice

24. **How many hours per week are dedicated to medical director services only? _____**

25. **Do you also provide medical services at this facility? _____ Yes _____ No**
If Yes, how many hours per week are dedicated to medical services only? _____
If Yes, please describe, in detail, the medical services you provide: _____
_____
_____

26. **How long have you worked as medical director at this facility?_____**

27. **Please describe your duties as medical director: _____**
_____
_____

Prior Insurance and Claim Information

28. **Do you currently carry Professional Liability Insurance for your medical director services? _____ Yes _____ No If Yes, please complete the following:**

Company	Policy Term	Limits of Liability	Retro Date	Premium

29. **Has any claim ever been made against you solely as respects your duties as a medical director?_____ Yes _____ No If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs.**

30. **Are you aware of any circumstances, solely as respects your duties as a medical director, which may result in a claim against you? _____ Yes _____ No If Yes, please provide details:**

_____

_____

31. **Do you currently carry Medical Malpractice Insurance for your medical services? _____ Yes _____ No If Yes, please complete the following:**

Company	Policy Term	Limits of Liability	Retro Date	Premium

***PLEASE ATTACH A COPY OF YOUR MEDICAL MALPRACTICE DECLARATIONS PAGE**

32. **Has any claim ever been made against you for Medical Malpractice? _____ Yes _____ No If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs.**

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell, nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of this policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

_____ _____

Date **Signature of Applicant**

Please attach copies of the following documents:

- **A minimum of five years of currently valued company loss runs**
- **CV or resume**
- **Proof of medical malpractice coverage for applicant**
- **Proof of medical malpractice coverage for the medical facility**
- **A copy of the contract between applicant and medical facility**

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

Type of Claim (check one): _____ Medical Director Claim _____ Medical Malpractice Claim

1. **Name of applicant/named insured: _____**
   _____
2. **Name of other parties or defendants named in suit: _____**
   _____
   _____
3. **Data of alleged error or occurrence, or contact date: _____**
4. **Data claim was made: _____**
5. **Name of claimant: _____**
6. **Name of Insurance Company handling your claim: _____**
7. **Present status of claim or final disposition: _____**
   _____
   _____
   Circle One: CLOSED OPEN
8. **Defense costs paid to date inclusive of any deductible: _____**
9. **If closed, total loss paid, inclusive of any deductible: _____**
10. **If claim is open or pending, what are the insurers reserves?**
    Defense: _____ Loss: _____
11. **Description of case and events including allegations and assessment of liability: _____**
    _____
    _____
    _____
    _____
    _____
12. **Claimants last settlement demand: _____**

_____ **_____**
Date **Signature**