TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
(hereafter, the "Underwriter")
A wholly owned subsidiary of The Doctors Company
Servicing Address: 1888 Century Park East, Suite 850
Los Angeles, CA 90067

Locum Tenens Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Verify that all requested explanations and documents are attached, including current declarations page and policy.

- Please complete this form electronically or type/print clearly and answer all questions.
- Upon approval, coverage for the Locum Tenens will be provided based on the specialty indicated on the Declarations and subject to the terms of the Policy and Endorsements.
- Limits of Coverage will be shared with the Named Insured.

ACCOUNT INFORMATION

1.	Applicant Name			
	Other Names Used			
	Gender	☐ Male ☐ Female		
	Degree / Title			
	Birth Date (MM/DD/YYYY)			
	Federal DEA #			
	National Practitioner ID #			
2.	Home Address	Street:		
		City:	State:	Zip:
		County:		
		Phone:	Fax:	
		Email:		
3.	Principal Office Address	Street:		
		City:	State:	Zip:
		County:		
		Phone:	Fax:	
		Email:		
		Website:		
4.	Other Office Address	Street:		
		City:	State:	Zip:
		County:		
		Phone:	Fax:	
		Email:		
		Website:		

5. Name of healthcare provider you are covering for:

6. Requested dates of coverage:

FINANCIAL AND EXPOSURE DETAILS

7. List all states where the Applicant is licensed:

State: _____ License # _____
State: _____ License # _____
State: _____ License # _____

8. Medical Specialty: _____ % of practice: _____
Sub-Specialty: _____ % of practice: _____

9. Are you American Board Certified in your Specialty? ☐Yes ☐No
Name of Specialty Board(s): _____
Date of Certification: ___/___/___

10. Are you American Board Certified in your Sub-Specialty? ☐Yes ☐No
Name of Specialty Board(s): _____
Date of Certification: ___/___/___

11. If you are a foreign medical graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ☐Yes ☐No

12. Have you ever failed any Board Certification testing? ☐Yes ☐No
If "Yes," please explain:

13. **Attestation**
If the answer to any of the following is "Yes," please give full details (including dates) on a separate sheet of paper:

a. Have you ever been or are you currently being investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency? (If "Yes," provide copies of all accusations, decisions, consent orders, etc.) ☐Yes ☐No

b. Has or is your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ☐Yes ☐No

c. Have you ever had privileges at any hospital or other institution denied, reduced, revoked, restricted or suspended? ☐Yes ☐No

d. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics or any other substance abuse, sexual addiction, anger management issues, or any mental or emotional disorder? ☐Yes ☐No

e. Have you ever been arrested, indicted, pled guilty to, or been convicted of any crime other than minor traffic violations? ☐Yes ☐No

f. Has your membership in any professional society or association ever been refused, censured, suspended or revoked? ☐Yes ☐No

g. Do you currently have or have you ever had a chronic physical or mental defect or have you been diagnosed with or treated for any medical or mental conditions or impairments that might affect your ability to practice medicine? ☐Yes ☐No

h. Are you currently or have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform your professional duties? ☐Yes ☐No

i. Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? ☐Yes ☐No

j. Have you ever been suspended by any governmental or non-governmental health program (e.g. Medicare, Medicaid, HMO, PPO and/or any managed care program)? ☐Yes ☐No

k. Have you been accused of any acts of sexual molestation or misconduct? ☐Yes ☐No

14. **Training**

Medical Degree from (school): _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Internship: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Type of Residency: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Fellowship Training Type: _____

Hospital: _____ Dates: _____ to _____

City: _____ State: _____ Country: _____

Additional Medical Specialty training:

Location	Type	Dates

15. List all facilities (i.e. hospitals, surgicenters, etc.) where you are currently on staff and show percentage of work in each facility:

Facility Name	City	State	Type of Privileges	% of Work

16. List all locations where you have practiced in the last 10 years (include time period, group name and address).

Group Name	Street/City/State	During Years

CURRENT AND REQUESTED COVERAGE

Please attach a copy of your most recent declarations page and policy.

17. MISSOURI RESIDENTS - DO NOT ANSWER.

Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? ☐Yes ☐No

If "Yes," please provide details:

18. Requested Effective Date of Coverage: _____

19. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

Carrier	Limits	Policy Period MM/DD/YYYY – MM/DD/YYYY	Claims Made or Occurrence	Retroactive Date (if applicable)	Premium

20. Does your current policy provide coverage for you while you work as a Locum Tenens? ☐Yes ☐No

CLAIMS INFORMATION

21.	In the past, has the Applicant or any entity or individual proposed for coverage under this insurance, received or been involved in any claim, suit or medical incident that may fall within the scope of the proposed insurance? If "Yes," please complete a **Claims Information Form** for each claim, suit or medical incident. **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, SUIT OR MEDICAL INCIDENT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 21 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No
22.	Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? If "Yes," please complete a **Claims Information Form** for each fact, circumstance, situation, transaction, event, act, error or omission. **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 22 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No

CLAIMS INFORMATION FORM

(Please make additional copies if needed)

1. Name of Patient: 2. Age: 3. Gender: ☐M ☐F

4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon):

5. Date of Incident: 6. Date Reported to Carrier: 7. Location:

8. Insurance Carrier(s):

9. Other Defendant(s):

10. Plantiff's Counsel:

11. Defendant's Counsel:

12. Status: ☐ Incident Only ☐ Suit ☐ Closed If Closed, Date Closed:
Amount Paid: ☐ Settlement ☐ Judgement

13. Allegation(s) (as stated by patient/plantiff):

14. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? ☐Yes ☐No

15. Condition and diagnosis at time of treatment:

16. Dates and description of treatment rendered:

17. Condition of patient subsequent to treatment (include DATES & FOLLOW UP TREATMENT):

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: X _____ Date: _____

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND 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.

ARKANSAS, MINNESOTA AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS 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 civil fines and criminal penalties.

MAINE, 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 may include imprisonment, fines or a denial of insurance benefits.

MISSOURI APPLICANTS: Any person commits a "fraudulent insurance act" if such person knowingly 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 oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

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.

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.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITITES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____ City: _____ State: _____ Zip: _____
Email Address	
Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____ City: _____ State: _____ Zip: _____

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.