TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Physician Group Professional Liability Insurance 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 REPORTED 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. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

ACCOUNT INFORMATION

1.	Applicant Name	
2.	Mailing Address	Street:
		City: State: Zip:
		County: Website Address:
3.	Business Contact	Name/Title:
		Email Address:
		Telephone Number:
4.	Risk Management Contact	Name/Title:
		Email Address:
		Telephone Number:
5.	Applicant's Legal Structure	☐Corporation ☐Partnership ☐Joint Venture ☐LLC ☐Other: _____
6.	Tax Status	☐For Profit – Private ☐For Profit – Publicly Traded ☐Not for Profit ☐Governmental
7.	Type of Risk	☐Single Specialty ☐Multi-Specialty ☐Staffing Locum Tenens ☐Other (describe): _____

In California: Insurance City Solutions, License Number: 0L85833

8. Number of years in operation: _____ Number of years under current ownership: _____

9. List all states where the Applicant is operating and providing services:

10. Is the Applicant currently enrolled in a patient compensation fund? ☐Yes ☐No
If "Yes," please provide details:

11. Does the Applicant have any operations outside of the United States of America? ☐Yes ☐No
If "Yes," please provide details:

12. Is the Applicant owned, controlled or managed by another entity? ☐Yes ☐No
If "Yes," please explain:

13. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:

a. Merge, acquire or consolidate with another entity? ☐Yes ☐No

b. Sell or divest another entity or facility? ☐Yes ☐No

c. Discontinue any operations or services? ☐Yes ☐No

d. Enter into any new business activities or services (including adding new physicians or facilities)? ☐Yes ☐No

If "Yes," describe the essential terms of each such transaction:

14. List all subsidiaries, including description of operations, relationship to the Applicant, ownership, and retroactive date:

Name & Address	Description of Operations	Relationship	Ownership %	Retroactive Date

(**NOTE:** Coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

15. Does the Applicant own, operate or manage any business or facilities other than the operations described in this Application? ☐Yes ☐No

If "Yes," provide details, including name of entity and the Applicant's ownership interest/management role.

CURRENT AND REQUESTED COVERAGE

16. Requested policy period: _____

17. Retroactive date: _____

18. Physician limits requested:

State:	_____	Each claim:	_____	Aggregate:	_____
State:	_____	Each claim:	_____	Aggregate:	_____
State:	_____	Each claim:	_____	Aggregate:	_____

19. Entity limits requested: State: _____ Each claim: _____ Aggregate: _____

20. Limit structure requested:

☐ Separate limits for each insured physician and separate limits for each insured entity
☐ Separate limits for each insured physician and shared limits for all insured entities
☐ Shared limits for all insured physicians and all insured entities

NOTE: In all cases, all non-physician insureds share in the applicable insured entity limits.

Separate limits may be subject to a policy maximum aggregate limit.

21. Deductible / SIR requested: ☐ None ☐ Deductible ☐ SIR
Each Claim: _____ Aggregate: _____

22. Provide the following information for professional liability insurance issued to the Applicant for the current policy year and the previous 6 years:

Insurance Carrier	Policy Period MM/DD/YY-MM/DD/YY	Limits	Deductible/SIR	Retroactive Date	Premium

23. **MISSOURI RESIDENTS – DO NOT ANSWER THIS QUESTION.**
Has any professional liability insurer ever cancelled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewals) for the Applicant? ☐ Yes ☐ No

If "Yes," please provide details:

FINANCIAL AND EXPOSURE DETAILS

24. Schedule of physicians for whom the Applicant is requesting coverage:

(Please attach an additional sheet if necessary.)

Name	Specialty	Retroactive Date	Surgery Level (No Surgery/Minor Surgery/Major Surgery)	Status (Employed or Contracted)

NOTE: Coverage for any contracted physician is not automatically included. The policy, if issued, will determine coverage.

25. Are contracted physicians required to maintain professional liability coverage? ☐Yes ☐No

If "Yes," what is the required minimum limit? _____

26. If the Applicant is a teleradiology operation, indicate the annual number of reads:

State	General Radiology	Mammography	CT Scan	Ultrasound	MRI	Nuclear

27. Provide the number of annual patient encounters/visits:

State/Location	# of Annual Encounters/ Visits Projected Next Year	# of Annual Encounters/ Visits Current Year	# of Annual Encounters/ Visits Previous Years

Allied Health Care Providers

28. Provide the number of health care professionals described below who are employed by or work under the control of the Applicant:

_____ Certified Nurse Midwives
_____ Certified Registered Nurse Anesthetists
_____ Dentists
_____ Laboratory Technicians
_____ Licensed Practical Nurses
_____ Nurse Practitioners
_____ Oral Surgeons
_____ Pharmacists
_____ Physical Therapists
_____ Other (describe):
_____ Physician Assistants
_____ Psychologists
_____ Registered Nurses
_____ Surgical Assistants

29. Schedule of departed physicians for whom the Applicant is requesting coverage:
(Please attach an additional sheet if necessary.)

Name	Specialty	Retroactive Date	Termination Date	Surgery Level (No Surgery/ Minor Surgery/ Major Surgery)

PRACTICE INFORMATION

30. Does the Applicant concentrate in any particular specialty(ies) of medicine? ☐Yes ☐No

If "Yes," identify the specialty(ies):

31. What percentage of the Applicant's physicians are board certified or board eligible in their specialty?

Board Certified: _____% Board Eligible: _____%

32. Does the Applicant use locum tenens physicians? ☐Yes ☐No

33. Does the Applicant own, operate or control any specialized medically related unit including, but not limited to, a pharmacy, laboratory, physical therapy center or surgery center? ☐Yes ☐No

If "Yes," please explain:

34. Are any of the following services performed by the Applicant?

a. Experimental Surgery ☐Yes ☐No
b. Weight Reduction Surgery ☐Yes ☐No
c. Cosmetic Surgery ☐Yes ☐No
d. Correctional Medicine ☐Yes ☐No
e. Medical Spa ☐Yes ☐No
f. Services outside specialty ☐Yes ☐No

If "Yes" to any of the above, please explain:

35. Does the Applicant have any Medical Director responsibilities? ☐Yes ☐No

If "Yes," please explain:

36. Within the past 5 years have the Applicant's practice characteristics changed (services, procedures performed, etc.)? ☐Yes ☐No

If "Yes," please explain:

OPERATIONS AND ADMINISTRATION

37. Has the Applicant or any individual or entity proposed for coverage under this insurance:

a. Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐Yes ☐No
b. Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐Yes ☐No
c. Been treated for any alcohol, narcotics or substance abuse? ☐Yes ☐No
d. Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐Yes ☐No
e. Had hospital privileges reduced, suspended or revoked? ☐Yes ☐No
f. Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐Yes ☐No

If "Yes," to any of the above, please explain:

38.	Are all physicians' and allied health care professionals' privileges reviewed at least once every 2 years? If "No," please explain:	☐Yes ☐No
39.	Are all foreign medical graduates certified by the Educational Council for Foreign Medical Graduates If "No," please explain:	☐Yes ☐No
40.	Does the Applicant have a formal risk management plan? If "No," please explain:	☐Yes ☐No
41.	Does the Applicant have a formal quality assurance committee? If "No," please explain:	☐Yes ☐No
42.	Does the Applicant have a credentialing committee? If "No," please explain:	☐Yes ☐No
43.	Who does the credentialing? ☐ Outside credentialing entity ☐ Rely on contracted hospital ☐ Self ☐ Other (describe): _____	
44.	How often does the Applicant re-credential its physicians? _____	
45.	Does the Applicant use electronic medical records?	☐Yes ☐No
46.	Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services for the Applicant's operations:	
	a. Verification of educational background	☐Yes ☐No
	b. Verification of previous employers/employment history	☐Yes ☐No
	c. Verification of personal references	☐Yes ☐No
	d. Verification of hospital privileges for physicians and dentists If "Yes," how often does the Applicant update its list of specific privileges? _____	
	e. Verification of any pending license suspensions or revocations, or any pending disciplinary actions by other facilities	☐Yes ☐No
	f. Criminal background checks: ☐ County ☐ State ☐ Federal ☐ None	
	g. Require information on any professional liability or work related claims that have previously been made against any individual	☐Yes ☐No
	h. Require information on any allegations of sexual abuse or molestation previously made against any individual	☐Yes ☐No
	i. Drug/alcohol testing	☐Yes ☐No

CLAIMS HISTORY

47.	During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed): **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 47 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No
48.	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 provide details: **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 48 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No

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 ENTITIES 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.