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EXPOSURE BASIS

Is the adding of additional specialties contemplated during the coming year: Yes No

If "YES," please describe _____

Provide the following information for the past five years:

Fiscal Year	Total # of Locum Hours
19__	
19__	
19__	
19__	
19__	

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PROFESSIONAL LIABILITY INSURANCE COVERAGE

Current Professional Liability Insurance:

Present Insurance Carrier: _____

Coverage Type: Occurrence Claims Made

IF CLAIMS MADE, ATTACH COPY OF POLICY.

Present Premium: _____

Present Limits of Liability: \$ _____ / \$ _____

Policy Expiration Date: _____ / _____ / _____

Previous Professional Liability Insurance - past five years:

Policy Year	Insurance Carrier	Policy Limits	Policy Type	SIR/Deductible Amount
19__			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19__			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19__			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19__			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19__			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	

Has any company refused coverage, cancelled, or refused to renew any insurance?

Yes No If Yes, please explain: _____

List all claims for the group and all medical professionals for the last five years. Use a separate sheet if necessary, or attach a copy of the loss report.

Physician's Name	Institution	Allegation	Type of Injury	Date of Treatment	Status (Event, Claims, Suit)	Amounts Paid to Date	Amounts Reserved to Date	Name of Insurance Carrier
	City/State			Date of Claim				
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

MEDICAL INDEPENDENT CONTRACTORS/EMPLOYEES

MEDICAL SPECIALTY	Number Full Time	Number Part Time
Anesthesiology		
Family Practice		
Emergency Medicine		
Internal Medicine		
Pathology		
Pediatrics		
Psychiatry		
Radiology		
Other		

SURGICAL SPECIALTY	Number Full Time	Number Part Time
General		
Neurosurgery		
OB/GYN		
Oral Surgery		
Ophthalmology		
Orthopedics		
Plastic		
Urology		
Vascular/Thoracic		

Are references listed by new applicants checked in writing? Yes No

Are diplomas, licenses and other credentials for applicants verified prior to employment? Yes No

Is the initial employment for a specified probationary period? Yes No If 'Yes,' what is the probationary period? _____

Does the organization have a formal physician peer-review process? Yes No

Are any non-physician professionals (employees/independent contractors) associated with your organization? Yes No If 'Yes,' please describe: _____

Have any of your physicians been involved in an impaired physician program for substance abuse or mental or nervous disorder? Yes No If 'Yes,' please attach details.

Have any of your physicians had a license suspended or revoked, or hospital privileges suspended or revoked? Yes No If 'Yes,' please attach details.

**CURRENT PHYSICIAN
ROSTER**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____
31. _____

PRIOR ACTS SUPPLEMENTARY INFORMATION

Name of Group (Insured): _____

Requested Policy Term: _____

PRIOR ACTS COVERAGE IS PROVIDED FOR ALL PHYSICIANS ONLY FOR WORK PERFORMED ON BEHALF OF THE ABOVE NAMED GROUP SUBSEQUENT TO THE RETROACTIVE DATE SHOWN, AND DOES NOT INCLUDE ANY MOONLIGHTING OR WORK PERFORMED OUTSIDE OF THE GROUP CONTRACT. IF COVERAGE FOR WORK OUTSIDE OF THE GROUP CONTRACT IS NEEDED, PLEASE COMPLETE THE FOLLOWING.

Is Prior Acts coverage requested for individual specific physicians for work performed outside of the group? If so, please provide the following:

PHYSICIAN'S NAME	RETROACTIVE DATE	LIMITS DURING RETROACTIVE PERIOD	SPECIALTY	LOCATION

CONDITIONS OF APPLICATION

By applying for Medical Malpractice Insurance from National Fire & Marine Insurance Company, I hereby:

- consent to the inspection by National Fire & Marine Insurance Company, or their agents of all documents that may be material to an evaluation of the group's qualifications and competence.
- release from liability National Fire & Marine Insurance Company, their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications.
- release from liability any and all individuals and organizations who provide information to National Fire & Marine Insurance Company in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

	X
Date	Applicant's Signature

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, or attempt to defraud or lie to us about any matter contained in this application.