



**PREMIER PHYSICIANS INSURANCE COMPANY, INC.
A Risk Retention Group**

APPLICATION INSTRUCTIONS

**PROFESSIONAL PARTNERSHIPS / CORPORATION APPLICATION
FOR PROFESSIONAL LIABILITY INSURANCE**

ENTITY APPLICATION

In order to hasten your request for coverage and avoid any unnecessary delay, please complete all questions. If a question does not apply to your specialty, mark "None" or "N/A" (Not Applicable). Do not leave any question unanswered! Please use separate paper for any additional comments, explanation or clarification if necessary.

Before submitting your application, please review this checklist to ensure the information below has been included. Missing information could delay the approval of your application.

- Sign, initial and date the application where indicated. The company will not issue quotes for unsigned applications.
- Include a copy of your most recent professional liability declaration page and claims history with retroactive date.
- Complete the "**Remarks**" section for any questions requiring additional details.
- In addition to this application, every physician practicing with the partnership or corporation must complete an individual application for coverage, Physicians and Surgeons Application.**

If you need assistance with the application, please call (866) 371-7742 and ask to speak with a medical liability specialist.

Premier Physicians Insurance Company, Inc., is a Risk Retention Group. Your Risk Retention Group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency funds are not available for your Risk Retention Group. Therefore, these funds will not pay your claims or protect your assets if your Risk Retention Group, the insurer, becomes insolvent and is unable to make payments as promised.

(Continued on next page)



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Your Risk Retention Group's forms include a provision requiring "binding arbitration". Authorized insurers are not allowed to include such a provision.

Your Risk Retention Group's forms require only 30 days notice of non-renewal of coverage. Authorized insurers must give at least 60 days notice, and, in some cases, such as those classes identified as "essential medical specialties", additional notice is required.

**PREMIER PHYSICIANS INSURANCE COMPANY, INC.,
A Risk Retention Group**

**APPLICATION FOR PROFESSIONAL PARTNERSHIP / CORPORATION
FOR PROFESSIONAL LIABILITY INSURANCE
(CLAIMS MADE BASIS)**

APPLICANT INSTRUCTIONS:

1. Indicate your requested effective date of coverage: _____ / _____ / _____
2. Please type or print.
3. Answer all questions. If the answer requires detail, please attach a separate sheet.
4. Application must be signed and dated by owner, partner or officer.
5. Please complete application at least **45 DAYS** before the proposed effective date.
6. Please carefully read the statements at the end of this application.

I. GENERAL INFORMATION

CHECK ONE: The Applicant Entity is a Partnership Corporation (More Than One Shareholder)

1. Exact Name of Professional Partnership/Corporation: _____

Name if a "dba" is Used: _____

2. Primary Office: _____
STREET ADDRESS CITY STATE ZIP
 Leased / Rented Owned Approximate Square Footage _____

3. Business Phone: (_____) _____ **Business Fax:** (_____) _____

4. E-Mail Address/Website: _____ **5. Employer IRS #:** _____

6. Secondary Office Address: _____
STREET ADDRESS CITY STATE ZIP
 Leased / Rented Owned Approximate Square Footage _____

7. Name of President / Senior Partner: _____

8. Name of Business Manager / Administrator: _____

II. ENTITY INFORMATION

1. Does the partnership/corporation currently have a separate professional liability insurance policy? YES NO

2. List all previous professional liability carriers for the last 5 years, beginning with your current carrier first. If none state "None".

INSURANCE CARRIER	Limits of Liability Ie. \$1M / \$3M	PREMIUM	POLICY PERIOD	
			FROM	TO
	/		/	/
	/		/	/
	/		/	/
	/		/	/
	/		/	/

II. ENTITY INFORMATION (Continued)

3. Date partnership / corporation was formed: _____ / _____ / _____

4. Does the partnership / corporation have a current effective Certificate of Registration as a professional partnership / Corporation under the Business and Professional Code of the applicable jurisdiction? YES NO

5. List the names of all partners (partnership) or shareholders (corporation) and all physicians who are salaried employees of the entity:

NAME	PROFESSIONAL LIABILITY INSURANCE COMPANY	POLICY NUMBER	SOCIAL SECURITY #	OWNER
			- -	Yes / No
			- -	Yes / No
			- -	Yes / No
			- -	Yes / No
			- -	Yes / No
			- -	Yes / No

(IF ADDITIONAL SPACE NEEDED, PLEASE USE "REMARKS" SECTION, PAGE 5)

6. List the names of all physicians who provide services to the entity as independent contractors.

NAME	PROFESSIONAL TITLE / DUTIES	PROFESSIONAL LIABILITY INSURANCE COMPANY

(IF ADDITIONAL SPACE NEEDED, PLEASE USE "REMARKS" SECTION, PAGE 5)

7. If the entity is a corporation, list the following:

a. Names of all Directors

_____	_____
_____	_____
_____	_____
_____	_____

b. Names of Officers

President _____ Secretary _____

Vice President _____ Treasurer _____

Other _____

II. ENTITY INFORMATION (Continued)

8. Healthcare Professionals:

The Company may charge an additional premium for Physician Assistants and Nurse Practitioners and may charge an additional premium as a condition to cover all other healthcare professionals. In addition, the Company may decline to approve a licensed healthcare professional. The approval or declination action will be in accordance with the Company's then current rules, rates and rating plans.

a. List healthcare professionals who provide services at any of the entity's facilities or offices as salaried employees of the partnership / corporation.

NAME	PROFESSIONAL TITLE / DUTIES

b. List healthcare professionals who provide services at any of the entity's facilities or offices as independent contractors of the partnership / corporation.

NAME	PROFESSIONAL TITLE / DUTIES	PROFESSIONAL LIABILITY INSURANCE COMPANY

c. List the number of the following types of individuals who provide services in the entity's office:

HEALTHCARE PROFESSIONAL	NUMBER	HEALTHCARE PROFESSIONAL	NUMBER
Administrative Personnel		Physician Assistant	
Medical Assistant		Technician (Dialysis, Lab, Pathological)	
Nurse (Registered or Licensed Vocational)		Technician (X-Ray, Radium)	
Licensed Nurse – Anesthetist		Other: _____	
Nurse Practitioner		Other: _____	

Attach a copy of the Physician Assistant's license and the Nurse Practitioner's license to this application.

Each licensed Nurse Anesthetist, Physician Assistant and Nurse Practitioner who is an employee of the partnership / Corporation must complete an individual application for Professional Liability Coverage. (Physicians & Surgeons Application)

III. MISCELLANEOUS INFORMATION

1. **Does the partnership / corporation maintain an outpatient surgical facility?** Yes No
(If YES, does the partnership / corporation currently have a separate professional liability policy
For the surgical facility?) Yes No
Name of Carrier _____ Policy # _____
2. **Has any insurance company cancelled, declined coverage, modified (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any similar partnership / corporation insurance?** Yes No
(If YES, describe, giving company name and policy number in Remarks Section, Page 5)
3. **Has the partnership / Corporation ever been investigated by the State Board of Medical Examiners and/or the State Licensing Authority, Narcotics Bureau, State Board of Dental Examiners, or other governmental agency?** Yes No
(If YES, describe in Remarks Section, Page 5, and forward a copy of any formal accusation or decision)
4. **Has a claim or suit for any alleged malpractice and / or business liability ever been made Or brought against the partnership / corporation in the past ten (10) years?** Yes No
(If YES, complete a Claim Information Sheet for each, Page 6)
5. **Does the partnership / corporation manufacture, sell or distribute any drug, pharmaceutical or medical device or other product to persons other than its patients or patients of its physician members?** Yes No
(If YES, describe the product or activities of the partnership / corporation in connection with the product in the Remarks Section, Page 5)
6. **Does the partnership / corporation own any other corporation or is the partnership / corporation under common ownership or the control of any subsidiary corporation?** Yes No
(If YES, describe ownership and activities of the partnership/corporation in Remarks Section, Page 5)
7. **Is the partnership / corporation a party to any joint venture agreement or any other contract under which professional or business activities are or will be conducted in conjunction with any other person or partnership / corporation?** Yes No
(If YES, describe agreement and activities in Remarks Section, Page 5)
8. **Does any facility of the partnership / corporation conduct treatment, storage or disposal of hazardous waste on-site or in a manner which requires a permit under either federal or state hazardous waster control laws?** Yes No
(If YES, describe activities in Remarks Section, Page 5)
9. **Has any facility of the partnership / corporation ever been alleged to be in non-compliance with the substantive or procedural requirements of either federal or state hazardous waste control laws?** Yes No
(If YES, describe each such allegation and its resolution in Remarks Section, Page 5)
10. **Has the partnership / corporation been named as a defendant in any administrative or judicial proceeding in which it is alleged that the company is liable for response costs incurred or natural resource damages arising from the actual or threatened release of hazardous substances?** Yes No
(If YES, describe each such proceeding and the allegations made against the partnership/corporation in Remarks Section, Page 5)
11. **Please attach a copy of the partnership / corporation's letterhead.**

V. CLAIMS INFORMATION

PLEASE COPY THIS PAGE FOR ALL ADDITIONAL CLAIMS YOU ARE REPORTING TO PREMIER PHYSICIANS INSURANCE COMPANY

NOTE: This **Claims Information Form** pertains to lawsuits, claims or demands for arbitration or incidents which could lead to claims. A claims form must be completed for each lawsuit, claim, demand for arbitration or incident. Sufficient information must be provided to evaluate the medical aspects of the case specifically relating to the physician's involvement.

1. Patient's Name: _____ **2. Age:** _____ **3. Sex (M/F)** _____

4. Your relationship to patient (i.e. Attending Physician, Primary Surgeon, Assistant Surgeon)

5. Date of Incident: ____/____/____ **6. Location:** _____

7. Insurance Carrier: _____ **8. Other Defendants:** _____

9. Present Status: OPEN CLOSED ____/____/____
DATE

INCIDENT ONLY 90-DAY NOTICE SUIT FILED SUIT SERVED ARBITRATION

Method of Closing: DISMISSED DEFENSE VERDICT

SETTLED AMOUNT PAID ON YOUR BEHALF: \$ _____ TOTAL SETTLEMENT \$ _____

JUDGEMENT AMOUNT PAID ON YOUR BEHALF: \$ _____ TOTAL SETTLEMENT \$ _____

The following questions should be answered in explicit clinical detail to allow proper evaluation by the PPIC Underwriting Department. Attach additional sheets as required.

10. Patient's allegations or circumstances brought to your attention: _____

11. Condition and diagnosis at time of incident: _____

12. Dates and description of treatment rendered: _____

13. Conditions of patient subsequent to treatment (and dates of follow-up treatment): _____

I understand information submitted herein becomes part of the PPIC's Named Insured's records and part of the Professional Partnership / Corporation Application as submitted.

_____/_____/_____
DATE

APPLICANT NAME (PLEASE PRINT)

SIGNATURE

VI. APPLICANT RETROACTIVE COVERAGE

The following questions refer to your application for retroactive coverage (ie. "Prior Acts" or "Nose Coverage") with Premier Physicians Insurance Company.

If you are approved for retroactive coverage, you will receive a certificate of coverage with a specified retroactive coverage date. Thereafter and subject to the terms, conditions and exclusions of the PPIC policy, you will be entitled to claims defense and claims payment services described in your policy with PPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences subsequent to the retroactive date indicated in your certificate of insurance with PPIC.

Retroactive coverage is only available from PPIC to those physicians who have maintained continuous and uninterrupted "Claims Made" medical professional liability coverage up to the commencement date of their coverage with PPIC.

2. Are you, your employees or associates aware of any threats or complaints that could lead to legal action against you or your medical practice? Yes No

If Yes, please indicate the number of threats or complaints and describe below. (Use separate paper if necessary)

3. Have you ever been the subject of a deposition or subpoena as a result of medical service provided by you on behalf of a patient? (other than as an expert witness, but including consultative services) Yes No

OBLIGATION OF DISCLOSURE

Nevada law requires you to disclose to Premier Physicians Insurance Company (PPIC) any information known to you that would influence PPIC's decision to approve your application for coverage, including the information you provide in this claims section. You also have an obligation to inform PPIC of any information that becomes known to you between the date of your signature below and the effective date of coverage with PPIC that could alter your previous response to the claims information requested herein. You are advised to notify PPIC of any additional information not previously disclosed in your application for coverage.

Yes

I request retroactive coverage from PPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences in Nevada and subsequent to my retroactive coverage date with PPIC.

I represent and warrant that I will maintain my current professional liability coverage up to the commencement date of my membership with PPIC. I make this representation with the understanding that should any future investigation reveal that I did not maintain continuous claims made professional liability coverage, PPIC may deny all claims defense and claims payment services for any claim arising out of professional services that I rendered to patients during the retroactive coverage period.

I also make this representation with the understanding that my failure to meet my obligation of disclosure may result in the termination of my policy with PPIC and the loss of all claims defense and claims payment services.

Requested Retroactive Date: _____
Mo/Day/Year

NO, I decline retroactive coverage

This application for Retroactive Coverage is deemed part of your Application for Membership in PPIC and is incorporated by this reference into the PPIC policy.

I declare under penalty of perjury that the foregoing is true and correct. Executed this _____ of _____, 200____
Day Month Year

In _____, _____ by _____
City State Signature

