MIEC

6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

Community Clinic
Application for Claims-Made Professional Liability Insurance

Check one of the following:

☐ New Application
☐ Renewal Application (Existing MIEC Policyholder)

Policy Number:_____

- Answer all questions. Indicate N/A if not applicable
- Have Officer/Director sign and date pages 10 and 11

IMPORTANT NOTICE

You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

FACILITY INFORMATION / REQUESTED COVERAGE / LIMITS — ANSWER 1-3

1. FACILITY INFORMATION

_____
Name of Facility/Entity

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ _____ _____
Telephone Number Fax Number Website Address

_____ _____
Administrator Medical Director

_____ _____
Contact Person (if other than Administrator) Contact Person's E-mail

Structure:

☐ Non-profit ☐ Non-investor owned

☐ Federally funded ☐ State funded ☐ Other (specify)_____

2. REQUESTED COVERAGE EFFECTIVE DATE

_____
Date (mm/dd/yyyy)

I request that this insurance commence at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

FACILITY INFORMATION / REQUESTED COVERAGE / LIMITS, cont'd. ANSWER 1-3

3. REQUESTED LIABILITY LIMITS

Check one. Limit Per Claim / Annual Aggregate

NOTE: Higher annual aggregates are available. Contact MIEC.

☐ $500,000 / $1,500,000 ☐ $2,000,000 / $4,000,000 ☐ $4,000,000 / $6,000,000

☐ $1,000,000 / $3,000,000 ☐ $3,000,000 / $5,000,000 ☐ $5,000,000 / $7,000,000

Coverage and actual effective date are subject to the approval of MIEC's Underwriting Department

LOCATION(S) / HOURS / VISITS ANSWER 4-10

4. LOCATION(S)

Clinic locations. List full street address including number, street name, city and state. If you desire premises liability coverage for any of these locations, check appropriate boxes "yes" or "no."

Yes	No	Location	Square Footage	Number of Floors	Own/Lease	Other Tenants?
☐	☐					
☐	☐					
☐	☐					

Do you carry Comprehensive General Liability Insurance on each of the above locations? ☐ Yes ☐ No

If yes, please provide name(s) of the carrier(s) and limits of liability:

Name of Carrier _____ Limits of Liability _____

Name of Carrier _____ Limits of Liability _____

Name of Carrier _____ Limits of Liability _____

5. HOURS OF OPERATION

What are your hours of operation? _____

6. LICENSURE

Is the facility licensed? ☐ Yes ☐ No

If yes, please provide type of licensure and license number.

Type of Licensure _____ License Number _____

7. VISITS

Please indicate the approximate number of patients seen annually by physicians, dentists, or allied health care professionals such as nurse practitioners, physician assistants, counselors, therapists, nurses, etc.

	Number of Annual Patient Visits
Physicians	
Dentists	
Allied health care providers	

LOCATION(S) / HOURS / VISITS, cont'd. ANSWER 4-10

8. FUNDING

What sources of funding (such as federal, state, county, etc.) are available to the clinic? Are patients charged for services? Are services provided without charge to indigents?_____

9. FISCAL INFORMATION

Provide the following fiscal information for the current and prior fiscal years.

	Income	Payroll		Income	Payroll
Current	_____	_____	Prior	_____	_____

10. ADVERTISEMENTS

Do you advertise? ☐ Yes ☐ No

If yes, please provide copies of any printed material, such as brochures or advertisements used.

PROCEDURES ANSWER 11

11. PROCEDURES

Check each type of service rendered/procedure performed at the clinic. Indicate the estimated number of patient visits/procedures to be performed during the current year for each service checked.

Counseling

☐ Family planning	_____/year	☐ Family	_____/year
☐ Abortion	_____/year	☐ Marital	_____/year
☐ STD	_____/year	☐ Child abuse	_____/year
☐ Infertility	_____/year	☐ Crisis intervention	_____/year
☐ Drug/Alcohol abuse	_____/year	☐ Hotline	_____/year
☐ Legal	_____/year	☐ AIDS counseling	_____/year

Check each type of service rendered/procedure performed at the clinic. Indicate the estimated number of patient visits/procedures to be performed during the current year for each service checked.

Medical Treatment

☐ Primary care (family medicine)	_____/year	☐ Anesthesiology	_____/year
☐ General pediatrics	_____/year	☐ Major surgery*	_____/year
☐ Family planning/contraception	_____/year	☐ Orthopedics	_____/year
☐ Minor surgery*	_____/year	☐ Acupuncture	_____/year
☐ Vasectomies	_____/year	☐ Chiropractic	_____/year
☐ Prenatal and/or postnatal care	_____/year	☐ Podiatry	_____/year
☐ Abortions	_____/year	☐ Optometry	_____/year
☐ Infertility testing	_____/year	☐ X-ray	_____/year
☐ Artificial insemination	_____/year	☐ Lab tests	_____/year
☐ Deliveries	_____/year	☐ AIDS treatment	_____/year

*Minor surgery is defined as the removal of skin lesions, suture of lacerations, removal of moles and warts, etc.; major surgery includes cutting procedures, orthopedics, gynecology and anesthesiology.

11. PROCEDURES, cont'd.

Other

☐ Alcohol detoxification	_____/year	☐ WIC program	_____/year
☐ Alcohol rehabilitation	_____/year	☐ Abuse shelter	_____/year
☐ Drug detoxification	_____/year	☐ Home health	_____/year
☐ Drug methadone	_____/year	☐ Hospice	_____/year
☐ Pharmacy	_____/year	☐ Other (specify)	_____/year

What types of health care services are provided in addition to those listed above?

_____

_____

_____

12. PHYSICIAN PROVIDERS

List all physicians who render services on behalf of your clinic. The list should include both employed or volunteer physicians and independent contractors whose services are provided under your clinic's name. Any such physicians who have not been previously approved by MIEC must complete individual MIEC applications and be approved before coverage goes into effect.

If insured elsewhere, please submit evidence of coverage if carrier will cover the physician(s) for this activity.

_____ _____

Physician's Name Specialty

Physician is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date physician joined clinic_____ Average number of hours per week_____

Insurance Coverage:

_____ _____ _____

Insurance Carrier Limits Expiration Date

Does physician's insurance cover services he/she renders on behalf of the clinic? ☐ Yes ☐ No

If yes, please submit evidence of coverage.

Hospitals where physician maintains staff privileges and type of privileges maintained:

_____

_____ _____

Physician's Name Specialty

Physician is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date physician joined clinic_____ Average number of hours per week_____

Insurance Coverage:

_____ _____ _____

Insurance Carrier Limits Expiration Date

Does physician's insurance cover services he/she renders on behalf of the clinic? ☐ Yes ☐ No

If yes, please submit evidence of coverage.

12. PHYSICIAN PROVIDERS, cont'd.

Hospitals where physician maintains staff privileges and type of privileges maintained:

_____

_____ _____
Physician's Name Specialty

Physician is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date physician joined clinic_____ Average number of hours per week_____

Insurance Coverage:

_____ _____ _____
Insurance Carrier Limits Expiration Date

Does physician's insurance cover services he/she renders on behalf of the clinic? ☐ Yes ☐ No

If yes, please submit evidence of coverage.

Hospitals where physician maintains staff privileges and type of privileges maintained:

_____

13. DENTISTS

List all dentists who render services on behalf of your clinic. The list should include both employed or volunteer dentists and independent contractors whose services are provided under your clinic's name. Any such dentists who have not been previously approved by MIEC must complete individual MIEC applications and be approved before coverage goes into effect.

_____ _____
Dentist's Name Specialty

Dentist is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date dentist joined clinic_____ Average number of hours per week_____

Does dentist's insurance cover services he/she renders on behalf of the clinic? ☐ Yes ☐ No

If yes, please submit evidence of coverage.

Dentist performs the following procedures: ☐ Oral surgery; administration of: ☐ Local anesthesia ☐ Intravenous sedatives ☐ General anesthesia

_____ _____
Dentist's Name Specialty

Dentist is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date dentist joined clinic_____ Average number of hours per week_____

Does dentist's insurance cover services he/she renders on behalf of the clinic? ☐ Yes ☐ No

If yes, please submit evidence of coverage.

Dentist performs the following procedures: ☐ Oral surgery; administration of: ☐ Local anesthesia ☐ Intravenous sedatives ☐ General anesthesia

13. DENTISTS, cont'd.

Dentist's Name ______________________ Specialty ______________________

Dentist is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date dentist joined clinic______________________ Average number of hours per week______________________

Does dentist's insurance cover services he/she renders on behalf of the clinic? ☐ Yes ☐ No

If yes, please submit evidence of coverage.

Dentist performs the following procedures: ☐ Oral surgery; administration of: ☐ Local anesthesia ☐ Intravenous sedatives ☐ General anesthesia

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14. ADDITIONAL HEALTHCARE PROVIDERS

List all nurse practitioners, licensed physician's assistants, nurse midwives, and nurse anesthetists who render services on behalf of your clinic. Each health care provider must complete a supplemental application to be submitted with this application.

Provider's Name ______________________ Professional Title ______________________

Provider is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date provider joined clinic______________________ Average number of hours per week______________________

Provider's Name ______________________ Professional Title ______________________

Provider is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date provider joined clinic______________________ Average number of hours per week______________________

Provider's Name ______________________ Professional Title ______________________

Provider is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date provider joined clinic______________________ Average number of hours per week______________________

Provider's Name ______________________ Professional Title ______________________

Provider is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date provider joined clinic______________________ Average number of hours per week______________________

Provider's Name ______________________ Professional Title ______________________

Provider is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date provider joined clinic______________________ Average number of hours per week______________________

Provider's Name ______________________ Professional Title ______________________

Provider is a: ☐ Clinic employee ☐ Independent contractor ☐ Volunteer

Date provider joined clinic______________________ Average number of hours per week______________________

15. OTHER CLINIC PROVIDERS

Indicate how many of the following providers render services on behalf of your clinic.

Title	Number Employed	Total Hours Per Week
Psychologist*	_____	_____
Registered Nurse	_____	_____
Licensed Vocational Nurse	_____	_____
Medical Assistant (give injections, takes blood samples)	_____	_____
Physical therapist	_____	_____
EKG technician	_____	_____
X-ray technician	_____	_____
Detoxification coordinator	_____	_____
Training director	_____	_____
Outreach Coordinator	_____	_____
Social Worker/Counselor**	_____	_____
Laboratory Technician	_____	_____
Lay Health Worker***	_____	_____
Dental Hygienist	_____	_____
Dental Assistant	_____	_____
Optometrist*	_____	_____
Optician*	_____	_____

Other:

_____

_____

_____

_____

*On a separate sheet of paper, please provide name, duties performed, submit a curriculum vitae, and, if applicable, his/her professional liability carrier, policy number, limits of liability and expiration date.

**On a separate sheet of paper, please provide name, duties performed and submit a curriculum vitae.

***On a separate sheet of paper, please provide name, supervisor and the extent of supervision.

16. GENERAL INFORMATION

If you answer "yes" to any of following questions, please provide full details under "Additional Comments" on page 9. If additional space is needed, please attach a separate sheet.

A. Does the clinic have a laboratory? ☐ Yes ☐ No

B. Is the lab facility available to other than clinic patients? ☐ Yes ☐ No

C. Does the clinic have an x-ray facility? ☐ Yes ☐ No

If yes, list in "Additional Comments" on page 9 who interprets x-rays?

D. Does the clinic have bed and board accommodations? ☐ Yes ☐ No

E. Does the clinic have a pharmacy*? ☐ Yes ☐ No

F. Is general or regional anesthesia administered at your clinic? ☐ Yes ☐ No

G. Does your clinic use arbitration agreements? ☐ Yes ☐ No

If yes, attach a copy of the agreement.

H. Has the clinic or any health care professional rendering services on its behalf ever been notified of involvement in a malpractice claim, suit or incident, either directly or indirectly? ☐ Yes ☐ No

If yes, complete a Claim Information Form for each (page 12).

I. Has your clinic ever been investigated or audited by a governmental or regulatory agency? ☐ Yes ☐ No

J. Has any physician, patient or insurance plan filed with a medical society or foundation a Complaint of any kind against the clinic? ☐ Yes ☐ No

K. Has any company ever declined, canceled, refused to renew, restricted, or surcharged your professional liability insurance? ☐ Yes ☐ No

*Pharmacy – Please provide us with the name of the pharmacist and the annual gross receipts of the pharmacy. If applicable, provide us with the name of the pharmacist's professional liability insurance carrier, policy number, limits of liability and expiration date. Please attach curriculum vitae.

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17. INSURANCE HISTORY

Give name(s) and policy dates of all professional liability carriers who have insured you:

Name of Carrier ______________________ Policy Numbers ______________

Policy Effective Date ________ Cancellation/Expiration Dates ________ Policy Number ________ ☐ Claims Made ☐ Occurrence Basis

Name of Carrier ______________________ Policy Numbers ______________

Policy Effective Date ________ Cancellation/Expiration Dates ________ Policy Number ________ ☐ Claims Made ☐ Occurrence Basis

Name of Carrier ______________________ Policy Numbers ______________

Policy Effective Date ________ Cancellation/Expiration Dates ________ Policy Number ________ ☐ Claims Made ☐ Occurrence Basis

Name of Carrier ______________________ Policy Numbers ______________

Policy Effective Date ________ Cancellation/Expiration Dates ________ Policy Number ________ ☐ Claims Made ☐ Occurrence Basis

ADDITIONAL COMMENTS

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that the above statements and answers are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose the limits option checked on this application.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature _____ Date _____

Title _____

AUTHORIZATION TO RELEASE INFORMATION

We authorize the release to MIEC of information regarding past and pending claims and underwriting matters from our prior professional liability insurance carriers, or from my past and present medical association or society.

We further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

Signature _____ Title _____ Date _____

Print Name _____

Address _____ City _____ State _____ Zip Code _____

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MEDICAL UNDERWRITERS OF CALIFORNIA, herein called "MUC," to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MUC to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MUC as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MUC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MUC and the Board of Governors or its Executive Committee shall be borne by MUC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with *Section 1399* and *1400* or *1401* or *1401.5* of the *Insurance Code of the State of California* subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises, it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This agreement can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber hereto, and all other subscribers to this and any other like agreements.

_____ _____

Signature Date

_____

Title

CLAIM INFORMATION FORM

☐ None [Please be sure to check here if no claims]

1. Last Name of Patient/Claimant _____ Gender _____ Age _____
2. Condition and diagnosis of patient prior to treatment and/or surgery:

_____

_____

3. Date(s) and type of treatment and/or surgery rendered by you. Indicate which health care professional(s) rendered these services.

_____

_____

4. Condition of patient subsequent to treatment and/or surgery by you:

_____

_____

5. Nature of allegation:

_____

6. Was a suit ever filed against you? ☐ Yes ☐ No

   If yes, was it served? ☐ Yes ☐ No

   When? _____

7. Names of other doctors and hospital, if any, involved:

_____

_____

8. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

_____

_____

9. Disposition or current status of claim or suit (be specific). If settled or tried to plaintiff verdict, give amounts and dates of settlement or verdict.

_____

_____ _____

Name of Insurance Carrier Defending You Name of Attorney Defending You

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

You can send in your application by:

1. Mail – [Print PRE-PAID Mailing Label]
2. Fax – (510) 318-6700
3. E-mail – underwriting@miec.com

(DETACH ALONG DOTTED LINE)

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 739 OAKLAND, CA

POSTAGE WILL BE PAID BY ADDRESSEE

Medical Insurance Exchange of California
Attn: UNDERWRITING
6250 Claremont Avenue
Oakland, CA 94618-9983

PRE-PAID MAILING LABEL - FIRMLY ATTACH TO YOUR ENVELOPE