MIEC

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

Emergency Medicine Services Contractors
Patient Visit Rating Basis
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 6 and 7

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

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

A. 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

B. Limits of liability to apply (check one):

☐ Separately to each location listed in question 5.

☐ Jointly to all locations insured under the policy.

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

OWNERSHIP / LOCATION(S) / VISITS / HOURS ANSWER 4-8

4. OWNERSHIP

Please describe the ownership of the facility (in detail), i.e., sole proprietor, partnership, corporation. Provide names of owners, partners, or shareholders.

_____

_____

_____

5. LOCATION(S)

List all hospitals or other facilities where emergency services are provided. Do you wish to be covered for Premises Liability as defined in Part III of MIEC's policy? If yes, check appropriate box. Attach separate sheet if more than three (3) locations.

_____
Name of Hospital (or other facility)

_____ _____ _____ _____
Address City State Zip Code

Premises Liability: ☐ Yes ☐ No

_____
Name of Hospital (or other facility)

_____ _____ _____ _____
Address City State Zip Code

Premises Liability: ☐ Yes ☐ No

_____
Name of Hospital (or other facility)

_____ _____ _____ _____
Address City State Zip Code

Premises Liability: ☐ Yes ☐ No

5. LOCATION(S), cont'd.

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

6. PATIENT VISITS

What is the estimated number of annual ER patient visits at each location? (Attach separate sheet if necessary.)

Location	Estimated Number of Annual ER Patient Visits

7. HOURS OF OPERATION

Are all facilities operated on a seven day per week, 24 hour per day basis? ☐ Yes ☐ No

If no, what are the hours of operation?_____

8. OTHER MEDICAL SERVICES

Do you provide other medical services? ☐ Yes ☐ No

If yes, please provide the following:

Number of urgent care or "fast track" visits _____

Number of employment physicals _____

Number of industrial medicine visits _____

Other types of visits (please describe)_____

What means of triage are employed to physically separate patients from ER patients?_____

HEALTHCARE PERSONNEL — ANSWER 9-10

9. PHYSICIAN PROVIDERS

List all physicians who render medical services for or on behalf of the facility, and their weekly hours worked. Each physician must complete an Employed, Subcontracting, or Volunteer Emergency Physician Application. (Attach separate list if necessary.)

Name	Effective Date	Hours Per Week

10. NON-PHYSICIAN HEALTHCARE PROVIDERS

Do you employ any health care personnel in the following categories?

- ☐ Nurses (RN, LVN, LPN)
- ☐ Medical assistants (give injections, draw blood, etc.)
- ☐ Nurse practitioner*
- ☐ Physician's assistant*
- ☐ Laboratory technician
- ☐ X-ray technicians
- ☐ Other (Describe)_____

*Attach curriculum vitae for each practitioner and attach a description of protocol of services provided.

If any of the ancillary personnel carries his/her own professional liability insurance which extends to services rendered on behalf of the facility, attach verification of the coverage, including carrier name, policy number, limits of liability, and expiration date.

PROCESSES / INSURANCE HISTORY / CLAIMS — ANSWER 11-16

11. ARBITRATION

Do you use arbitration agreements? ☐ Yes ☐ No If yes, attach a copy.

12. CONTRACTS

Do you have any contracts or agreements, written or oral, with any entity or agency to provide services? ☐ Yes ☐ No

If yes, submit a copy of each contract.

13. INSURANCE HISTORY

List all prior professional and general liability carriers which have insured the facility in the past ten (10) years. Attach a separate sheet, if necessary.

I. _____ _____
Name of Carrier (not broker or agent) Limits of Liability

_____ _____ _____ _____
Address of Carrier City State Zip Code

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

PROCESSES / INSURANCE HISTORY / CLAIMS, cont'd. ANSWER 11-16

II. _____ _____
Name of Carrier (not broker or agent) Limits of Liability

_____ _____ _____ _____
Address of Carrier City State Zip Code

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

Please attach copy of current policy, including all endorsements.

14. INSURANCE

Has any insurance carrier ever denied, declined, canceled, refused to renew, restricted, placed a surcharge on the premium, or reduced the scope of your professional liability insurance? ☐ Yes ☐ No

If yes, please provide full details including dates, actions taken, and reasons. _____

_____

15. CLAIMS

Has the contractor entity or any health care professional rendering services on its behalf ever been notified of involvement in a general or professional liability claim, suit, or incident, resulting either directly or indirectly from the operation of the facility? ☐ Yes ☐ No

If yes, complete a Claims Information Form for each incident on page 8.

16. RISK MANAGEMENT

A. Provide an outline of the risk management/loss prevention program, including what courses are taken by employed/contract physicians, whether such courses are mandatory, what existing mechanisms are maintained for periodic review of protocols, procedures, quality assurance and charting.

B. Please provide a description of what methods are used in the hiring/credentialing process for new employee candidates.

PRIOR ACTS ANSWER 17

17. PRIOR ACTS

Prior Acts: If your most recent coverage was a claims-made policy you may either purchase "tail" coverage from your former carrier, or you may wish to apply for "Prior Acts" coverage with MIEC. If MIEC approves you for prior acts coverage, MIEC premiums will be at the claims-made step rate based on the number of years you have been insured by your previous claims-made carrier. If you wish to apply, please contact MIEC for the special prior acts application. Coverage is provided only after review and underwriting approval by MIEC.

If prior acts is requested, we'll need the history of all locations insured to present, the number of patient visits at each location each year, and the number of full-time equivalent physicians rendering emergency medical services at each location each year.

Prior acts coverage will insure you for new claims arising from covered professional services rendered while you were insured under the previous claims-made policy but are first made against you after you become insured by MIEC, subject to the terms, conditions, exclusions and limits of liability of your MIEC policy and the Prior Acts Endorsement.

If you have purchased tail coverage from your former carrier, and do not need prior acts coverage from MIEC, please attach a copy of the tail coverage endorsement to this application.

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 all statements and answers in this application 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

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

I 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 _____

Please sign and complete one form for each prior professional liability carrier.

Name of Carrier (or other organization releasing information): _____

If applicable, provide:

1. Policy Number _____
2. Expiration Date _____

Name of Carrier (or other organization releasing information): _____

If applicable, provide:

1. Policy Number _____
2. Expiration Date _____

Name of Carrier (or other organization releasing information): _____

If applicable, provide:

1. Policy Number _____
2. Expiration Date _____

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 instrument 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 thereto, 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

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