

Employed/Contract or Locum Tenens Physician Application for Professional Liability Insurance Additional Insured Basis

To be completed by employed/contract/locum tenens physician

1. Name of Employer _____ Policy Number _____

2. Employer's Office Street Address _____ City _____ State _____ Zip _____

3. Your Full Name _____ 4. Date of Birth (mm/dd/yyyy) _____

5. Your E-mail _____ 6. Your License Number (in state where you will practice) _____ State _____

7. A. Exact dates on which you will work for the above-named physician(s): Permanent? Yes No
or From _____ through and including _____ # of days _____

B. Full-time on above dates? Yes No If "No", state number of hours per day _____ # of days/week _____

8. Medical Specialty _____
 Attachment contains this information

9. A. Medical School _____
Name of School _____ City _____ State _____
Year Graduated _____ Degree _____
 Attachment contains this information

B. Internship _____
Name of Hospital _____ City _____ State _____
From (mm/yyyy) _____ To (mm/yyyy) _____
 Attachment contains this information

C. Residency Yes No
Name of Hospital _____ City _____ State _____
From (mm/yyyy) _____ To (mm/yyyy) _____ Type _____ Residency completed? Yes No
 Attachment contains this information

D. Additional Residency _____
Name of Hospital _____ City _____ State _____
From (mm/yyyy) _____ To (mm/yyyy) _____ Type _____ Residency completed? Yes No

Attachment contains this information

E. Fellowships and Additional Medical Training

Hospital/Facility _____ City _____ State _____ Type of Training _____ From _____ To _____

F. Are you Board certified? Yes No

Date(s) Certified: _____
From (mm/yyyy) To (mm/yyyy)

Name(s) of American Specialty Board(s): 1) _____
2) _____

G. If eligible, have you taken: the written examination? Yes No If yes, result: Pass Fail
the oral examination? Yes No If yes, result: Pass Fail

H. Are you scheduled to take the examinations for certification? Yes - When? _____
(mm/yyyy)

I. List name(s) of any other Professional or Specialty organizations of which you are a member _____

10. Your current (or most recent) insurance carrier _____ None

a. Limits of Liability _____ b. Policy Number _____ c. Expiration Date _____

If currently insured, does your carrier cover you for your work with the MIEC insured listed in Question #1? Yes No

If yes, provide a copy of your current Certificate of Insurance.

11. Have you ever been involved in a malpractice claim, suit or arbitration proceeding, or have you reported any incident which resulted in a claim to a former carrier? Yes No

If yes, you must complete a claim information form for each (see page 3).

12. Have you ever been charged with or been convicted of a felony? Yes No

13. Have you ever been convicted of or entered a "no contest" plea to a crime, other than a traffic violation? Yes No

14. Have you ever been investigated by any state or federal regulatory body? Yes No

15. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your Medical License or your Narcotics License? Yes No

16. Have you ever been treated for any medical condition, disease or illness that affects your ability to practice medicine? Yes No

17. Has any insurance carrier ever declined, canceled, refused to renew, restricted, or rated up your professional insurance? Yes No

18. Have you ever had any hospital privileges suspended, revoked, restricted, reduced, proctored or modified in any way? Yes No

If you have answered "Yes" to any of Questions 12-18, provide full details on separate attachment or in the Additional Comments section.

ADDITIONAL COMMENTS

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.

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my 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

Date

Print Name

Phone Number

Address

CLAIM INFORMATION FORM

Attachment contains this information

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

Name of Patient/Claimant

Gender

Age

1. Condition and diagnosis of patient prior to treatment and/or surgery:

2. Date(s) and type of treatment and/or surgery rendered by you:

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

4. Nature of allegation:

5. Was a suit ever filed against you? Yes No

If yes, was it served? Yes No

When? _____

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

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

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.

PRINT ADDITIONAL COPIES AS NEEDED.

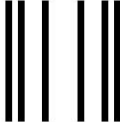
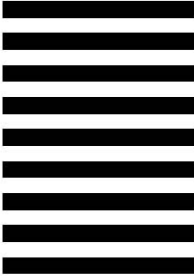

For All Applications:

When indicating "Attachment contains this information" be certain to send all your attachments. You can send in attachments and/or printed applications by:

1. Mail – [Print PRE-PAID Mailing Label]
2. Fax – (510) 654-4634
3. E-mail – Underwriting@MIEC.com

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(DETACH ALONG DOTTED LINE)

Pre-Paid Mailing Label

			<div data-bbox="1156 793 1349 934"><p>NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES</p></div> 
<div data-bbox="358 949 979 1050"><p>BUSINESS REPLY MAIL FIRST CLASS PERMIT NO. 739 OAKLAND, CA</p></div>			
<p>POSTAGE WILL BE PAID BY ADDRESSEE</p>			
<p>Medical Insurance Exchange of California Attn: UNDERWRITING 6250 Claremont Avenue Oakland, CA 94618-9983</p>			
			

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