

Partnership / Corporation / Association Application for Claims-Made Professional Liability Insurance

IMPORTANT INSTRUCTIONS – PLEASE READ CAREFULLY

This application is specifically for physician partnerships, multi-shareholder medical corporations, or associations.

If not, please go to the “**Applications**” page under the resources tab of www.miec.com and complete either the application titled:
MIEC Solo Physician OR
MIEC Joining Group/Entity Affiliation for Physicians and Surgeons

- **COMPLETE ALL QUESTIONS:** A complete application will allow us to process your application as quickly as possible.
- **ATTACHMENTS:** Certain portions of the application may require information that is already reflected on personal documents such as curriculum vitae, etc. For your convenience we include the option to indicate “Attachment contains this information” rather than require that you type in all information. When you indicate “Attachment contains this information” you **warrant** to MIEC that the information contained in the attachments is true and correct. MIEC is relying upon the information in the attachments to make a determination of whether to issue coverage.
- **ADDITIONAL COMMENTS:** If you wish to provide detailed responses to any of the questions in the application, please use the “Additional Comments” section on page 6 of the application.

For assistance, you may call our main office at the number below from 8:00 a.m. to 5:00 p.m. PST, M-F, or E-mail us at the address below. Please include in your E-mail the location of your practice or where you plan to practice including the city, state and zip code.

800-227-4527
(510) 428-9411
FAX: (510) 654-4634
E-MAIL: UNDERWRITING@MIEC.COM



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Partnership / Corporation / Association Application for Claims-Made Professional Liability Insurance

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.

PARTNERSHIP / CORPORATION / ASSOCIATION INFORMATION

ANSWERS 1-5

1. GENERAL INFORMATION

Name of Clinic/Group _____ DBA _____

Mailing Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Tax ID Number _____

Confirmation E-mail Address _____ Website Address or N/A

Administrator _____ Medical Director _____

Contact Person (if other than administrator) _____

2. REQUESTED COVERAGE EFFECTIVE DATE

Date (mm/dd/yyyy) _____

I request that this insurance commence at 12:01 AM 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 the initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

3. REQUESTED LIABILITY LIMITS

Check one: Limit Per Claim / Annual Aggregate

- \$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

NOTE: When specifying your desired limits of liability, it is important that you take into account all partners or associates. Due to the potential for shared liability, we recommend that all physicians practicing in an employer-employee relationship, ostensible or formal partnership, medical association or medical corporation be insured with MIEC at the same limits of liability.

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

4. LEGAL STRUCTURE

Check one:

- Medical Corporation (attach articles of incorporation)
- Unincorporated Professional Association

- Partnership
- Other (describe) _____

5. MEMBERS / EMPLOYEES / CONTRACTORS

Attachment contains this information

A.	<u>Partners/Shareholders</u>	<u>Employed Doctor (not partners/shareholders)</u>	<u>Independent Contractors</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Are all of the above insured by MIEC? Yes No Attachment contains this information

If no, please provide name(s) of carrier(s), limits of liability and attach a copy of their certificate of insurance.

Carrier	Limits of Liability
Carrier	Limits of Liability
Carrier	Limits of Liability
Carrier	Limits of Liability

PRACTICE, SCOPE AND PROCEDURES

6. LOCATIONS

Attachment contains this information

A. List full street address. If you desire premises coverage for any of these locations, check appropriate boxes "Yes" or "No." Any additional locations may be listed on separate attachment or in the Additional Comments section on page 6.

i. _____

Street Address	City	State
----------------	------	-------

_____ Own? Yes No Lease? Yes No Other tenants? Yes No

_____ Sq. Footage _____ # of Floors

Premises Liability Coverage Yes No

ii. _____

Street Address	City	State
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_____ Own? Yes No Lease? Yes No Other tenants? Yes No

_____ Sq. Footage _____ # of Floors

Premises Liability Coverage Yes No

6. LOCATIONS, cont'd.

B. Do additional insureds (such as landlords, etc.) require to be named on any of the above locations? Yes No
 If yes, please list name and applicable location. There is an additional premium.

Name	Location	City	State	Zip Code
------	----------	------	-------	----------

C. Do you carry separate 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.

Carrier	Limits of Liability
Carrier	Limits of Liability

7. PRACTICE VOLUME

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

Number of Annual Patient Visits for Physicians: _____ Number of Annual Patient Visits for Allied Health Care Providers: _____

Approximate yearly percentages of medical service provided in the following categories:

Medicare _____%	Medi-Cal Medicaid _____%
Direct Payment _____%	Private Insurance _____%
HMO/IPA Members _____%	PPO Members _____%
Industrial (Workers' Compensation) _____%	

8. MEDICAL PRACTICE ADVERTISEMENTS

Do you advertise? Yes No

If yes, please provide copies of any printed material, such as brochures, business plan, advertisements used, or a narrative which describes specific services offered.

9. NON-PHYSICIAN HEALTH CARE PROVIDER

A. Technicians

Please indicate below and list the hours worked per week if you employ individuals in the following categories to render health care services. (No charge for nurses and medical assistants.)

Check here if none.

	Total Hours Per Week	Number of Employees		Total Hours Per Week	Number of Employees
<input type="checkbox"/> Laboratory technician	_____	_____	<input type="checkbox"/> X-ray technician	_____	_____
<input type="checkbox"/> Physiotherapist	_____	_____	<input type="checkbox"/> Other (describe)	_____	_____

9. NON-PHYSICIAN HEALTH CARE PROVIDER, cont'd.

B. Mid-Level Practitioner

Indicate if you employ any health care professionals in the following categories. List the hours worked per week. Attach a protocol of the services performed and a curriculum vitae of each practitioner.

Check here if none.

	Total Hours Per Week	Number of Employees		Total Hours Per Week	Number of Employees
<input type="checkbox"/> Nurse anesthetist (CRNA)*	_____	_____	<input type="checkbox"/> Physician assistant*	_____	_____
<input type="checkbox"/> Nurse midwife*	_____	_____	<input type="checkbox"/> Psychologist*	_____	_____
<input type="checkbox"/> Nurse perfusionist*	_____	_____	<input type="checkbox"/> Scrub nurse*	_____	_____
<input type="checkbox"/> Nurse practitioner*	_____	_____	<input type="checkbox"/> Surgical technician*	_____	_____
<input type="checkbox"/> Optometrist/optician*	_____	_____	<input type="checkbox"/> Other (describe)	_____	_____

*Special application or additional information required. Contact MIEC, or go to our website www.miec.com

10. RISK MANAGEMENT

Describe your formal quality assurance process/procedures: _____

Does the group have its own utilization review committee? Yes No

If yes, who performs utilization reviews? _____

Please describe your peer review procedures/process. _____

INSURANCE HISTORY

ANSWER 11

11. INSURANCE HISTORY

Attachment contains this information

None

List all professional liability carriers (including current) who have insured you. Use separate sheet, if necessary.

Name of Carrier Address Policy Number Coverage Dates: From To

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Complete an "Authorization to Release Information" for carriers listed above (see page 9).

If current policy is claims-made, have you or do you intend to purchase "tail" coverage? Yes No

NOTE: If your most recent coverage was a claims-made policy, you must either purchase "tail" coverage from your former carrier, or apply for "Prior Acts" (also called "nose") coverage with MIEC. Prior Acts coverage may be available if you are currently insured under a claims-made policy in a state where MIEC provides professional liability insurance. 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 complete the Supplementary Application: Prior Acts "Nose" Coverage (page 8). Coverage is provided only after review and underwriting approval by MIEC.

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.

12. PRACTICE INFORMATION

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

- A. Do you have a laboratory? Yes No
- B. Is the lab facility available to outside patients? Yes No
- C. Do you have an x-ray, CT scan, or MRI facility? (If so, list in "Additional Comments" below who interprets x-rays) Yes No
- D. Do you have any contracts or agreements, written or oral, with any entity or agency to provide professional healthcare services? Yes No
- If so, attach a copy of the agreement(s) as these contracts or agreements may contain "hold harmless" or indemnification clauses.
- E. Has your group 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 the attached Claim Information Form on page 7 for each claim or suit.
- F. Has your group ever been investigated or audited by a governmental or regulatory agency? Yes No
- G. Has any physician, patient or insurance plan filed with a medical society or foundation a complaint of any kind against your group? Yes No
- H. Has any insurance carrier ever denied, declined, canceled, refused to renew, restricted, or rated up your professional liability Insurance? Yes No

ADDITIONAL COMMENTS

SUPPLEMENTARY APPLICATION: PRIOR ACTS "NOSE" COVERAGE

****Complete ONLY if applying for Prior Acts coverage****

1. Prior professional liability coverage was provided by the following claims-made policies and each remained in full force and effect for its entire term:

Company	Policy #	Policy Period From / To		Retroactive Date	Per Claim Limit	Aggregate Limit

2. **Attach a complete copy of your previous policy or policies, including declarations and all endorsements.**

3. Have you reported any claims, suits or incidents to the companies listed in Question 1? Yes No

If yes, complete a claim information form for each (page 7). Please include acknowledgment that your prior carrier is defending you for all such known claims. *MIEC will not provide any coverage for previously known claims or suits.*

4. Has there been any incident, notification from a patient or patient's attorney, oral or written threat of legal action, subpoena, summons & complaint or any other indication that leads you to believe a malpractice claim or suit will be lodged against you arising from professional services rendered while you were insured with your prior carrier during the period shown under Question 1? Yes No

If yes, provide full details on your letterhead and report all such incidents to your prior carrier immediately.

5. Have you been classified and rated in the same classification for the entire duration of your coverage with your prior carrier? If no, please explain and describe any practice changes during the above policy periods on your letterhead. Yes No

The undersigned 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.

Signature

Date

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 limits in 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

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

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

Print Name

Date

Address

City

State

Zip

APPLICATION CHECK LIST

To avoid delays in your application, please remember to:

- Complete all questions or indicate "not applicable" (n/a)
- Complete the "Claim Information Form," if applicable (page 7)
- Sign your application (page 8)
- Sign the Subscriber's Agreement (page 9)
- Complete and sign the "Supplementary Application: Prior Acts "Nose" Coverage," if applicable (page 8)
- Complete and sign the "Authorization to Release Information" forms (page 9)

Please check all items that are to be included so we are sure we have received all attachments:

- Your letterhead
- Advertisements
- The Declarations Page from your current carrier
- Current written contracts/service agreements

- Other _____

You can send in your application by:

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

The image shows a template for a Business Reply Mail label. It features a postal barcode at the top right, a box with the text "NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES", and a central box with the text "BUSINESS REPLY MAIL FIRST CLASS PERMIT NO. 739 OAKLAND, CA". Below this, it says "POSTAGE WILL BE PAID BY ADDRESSEE" and provides the address: "Medical Insurance Exchange of California, Attn: UNDERWRITING, 6250 Claremont Avenue, Oakland, CA 94618-9983". There are also horizontal bars on the right side and a long postal barcode at the bottom.

PRE PAID MAILING LABEL – PLEASE FIRMLY ATTACH TO YOUR ENVELOPE