

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.

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

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?
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____

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	_____

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.

	<u>Income</u>	<u>Payroll</u>		<u>Income</u>	<u>Payroll</u>
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

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

- | | | | |
|---|-------------|--|-------------|
| <input type="checkbox"/> Family planning | _____ /year | <input type="checkbox"/> Family | _____ /year |
| <input type="checkbox"/> Abortion | _____ /year | <input type="checkbox"/> Marital | _____ /year |
| <input type="checkbox"/> STD | _____ /year | <input type="checkbox"/> Child abuse | _____ /year |
| <input type="checkbox"/> Infertility | _____ /year | <input type="checkbox"/> Crisis intervention | _____ /year |
| <input type="checkbox"/> Drug/Alcohol abuse | _____ /year | <input type="checkbox"/> Hotline | _____ /year |
| <input type="checkbox"/> Legal | _____ /year | <input type="checkbox"/> 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

- | | | | |
|---|-------------|---|-------------|
| <input type="checkbox"/> Primary care (family medicine) | _____ /year | <input type="checkbox"/> Anesthesiology | _____ /year |
| <input type="checkbox"/> General pediatrics | _____ /year | <input type="checkbox"/> Major surgery* | _____ /year |
| <input type="checkbox"/> Family planning/contraception | _____ /year | <input type="checkbox"/> Orthopedics | _____ /year |
| <input type="checkbox"/> Minor surgery* | _____ /year | <input type="checkbox"/> Acupuncture | _____ /year |
| <input type="checkbox"/> Vasectomies | _____ /year | <input type="checkbox"/> Chiropractic | _____ /year |
| <input type="checkbox"/> Prenatal and/or postnatal care | _____ /year | <input type="checkbox"/> Podiatry | _____ /year |
| <input type="checkbox"/> Abortions | _____ /year | <input type="checkbox"/> Optometry | _____ /year |
| <input type="checkbox"/> Infertility testing | _____ /year | <input type="checkbox"/> X-ray | _____ /year |
| <input type="checkbox"/> Artificial insemination | _____ /year | <input type="checkbox"/> Lab tests | _____ /year |
| <input type="checkbox"/> Deliveries | _____ /year | <input type="checkbox"/> 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

- | | | | |
|---|-------------|--|-------------|
| <input type="checkbox"/> Alcohol detoxification | _____ /year | <input type="checkbox"/> WIC program | _____ /year |
| <input type="checkbox"/> Alcohol rehabilitation | _____ /year | <input type="checkbox"/> Abuse shelter | _____ /year |
| <input type="checkbox"/> Drug detoxification | _____ /year | <input type="checkbox"/> Home health | _____ /year |
| <input type="checkbox"/> Drug methadone | _____ /year | <input type="checkbox"/> Hospice | _____ /year |
| <input type="checkbox"/> Pharmacy | _____ /year | <input type="checkbox"/> Other (specify) | _____ /year |

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

HEALTHCARE PERSONNEL

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:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please submit evidence of coverage.			
<u>Dentist performs the following procedures:</u>	<input type="checkbox"/> Oral surgery; administration of:	<input type="checkbox"/> Local anesthesia	<input type="checkbox"/> Intravenous sedatives
	<input type="checkbox"/> General anesthesia		

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:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> Volunteer
Date provider joined clinic	_____		
	Average number of hours per week _____		

_____ Provider's Name		_____ Professional Title	
Provider is a:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> Volunteer
Date provider joined clinic	_____		
	Average number of hours per week _____		

_____ Provider's Name		_____ Professional Title	
Provider is a:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> Volunteer
Date provider joined clinic	_____		
	Average number of hours per week _____		

_____ Provider's Name		_____ Professional Title	
Provider is a:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> Volunteer
Date provider joined clinic	_____		
	Average number of hours per week _____		

_____ Provider's Name		_____ Professional Title	
Provider is a:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> Volunteer
Date provider joined clinic	_____		
	Average number of hours per week _____		

_____ Provider's Name		_____ Professional Title	
Provider is a:	<input type="checkbox"/> Clinic employee	<input type="checkbox"/> Independent contractor	<input type="checkbox"/> 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.

<u>Title</u>	<u>Number Employed</u>	<u>Total Hours Per Week</u>
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
- 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, list in "Additional Comments" on page 9 who interprets x-rays?

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.

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	<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence Basis
Name of Carrier	Policy Numbers			
Policy Effective Date	Cancellation/Expiration Dates	Policy Number	<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence Basis
Name of Carrier	Policy Numbers			
Policy Effective Date	Cancellation/Expiration Dates	Policy Number	<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence Basis
Name of Carrier	Policy Numbers			
Policy Effective Date	Cancellation/Expiration Dates	Policy Number	<input type="checkbox"/> Claims Made	<input type="checkbox"/> 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. 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


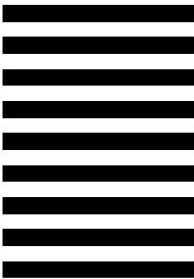

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

You can send in your application by:

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

.....
(DETACH ALONG DOTTED LINE)

			<div data-bbox="1156 470 1349 613"><p>NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES</p></div> 
<div data-bbox="358 627 979 726"><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>			
			

PRE-PAID MAILING LABEL - FIRMLY ATTACH TO YOUR ENVELOPE