



APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Name _____ Applicable Med. License No. _____

Office Address _____ NPI No. _____

_____ Office Phone No. _____

_____ Cell Phone No. _____

Mailing Address (if different from above) _____ Email Address _____

_____ Website Address _____

Type of Practice (Check as many as apply) Specialty Board Certification No. (if applicable) _____

- Solo, not incorporated
- Solo — my corporation's name is _____
- Member of a group practice called _____
- Full-time faculty member of _____
- Resident/fellow member of _____
- Practice under contract with _____
- Employed by _____
- I employ the following physician(s) _____
- Temporarily substituting for (physician's name) _____

States in which you are licensed to practice _____

If you now practice in more than one state, give the percentage of your practice in each

Date you began practice at your present professional location _____

Previous locations of practice, including dates (please attach CV)

Date of Birth _____ Place of Birth _____

Date coverage desired _____

Payment plan desired Advanced Payment Plan (5% discount) Semi-annual Quarterly 10 Monthly

Limits requested for Professional Liability Insurance (\$ each medical incident/\$ annual aggregate)

- | | | |
|--|--|---|
| <input type="checkbox"/> 1 million/3 million | <input type="checkbox"/> 2 million/4 million | <input type="checkbox"/> 3 million/5 million |
| <input type="checkbox"/> 4 million/6 million | <input type="checkbox"/> 5 million/7 million | <input type="checkbox"/> 6 million/8 million |
| <input type="checkbox"/> 7 million/9 million | <input type="checkbox"/> 8 million/10 million | <input type="checkbox"/> 9 million/11 million |
| <input type="checkbox"/> 10 million/12 million | <input type="checkbox"/> Virginia Only - Applicable Recovery Limit | |

Name of most recent insurance carrier _____

Termination date of current or last policy _____ Retroactive date of last policy _____

FOR OFFICE USE ONLY

Revised 9/2020

Institution and Location

Dates (From/To)

Medical School _____

Internship _____

Residencies/Fellowships

Institution and Location

Specialty

Dates (From/To)

1. _____

2. _____

3. _____

If you graduated from a foreign medical school, are you ECFMG certified? Yes No

What is your current specialty? _____ Percentage of practice _____

Specialties in which you are Board eligible _____

Specialty Board Certifications which you hold _____

List all hospitals where you have privileges. Indicate whether you wish us to send verification of insurance to each.

<u>Hospital</u>	<u>City/State</u>	<u>Types of Privileges</u>	<u>Send Verification (yes/no)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe the professional activities for which you are requesting coverage

How many hours per month do such activities involve? _____

Do you or will you render any medical professional services via telecommunications technology (telemedicine or internet medicine) that involves patients who reside in states other than your indicated state of practice? Yes No

Do you serve as a Medical Director? Yes No

If "yes", please list the name of the facility(ies)

Do you have other medical professional liability coverage for this exposure? Yes No

With whom? _____

Please carefully review the following list and check any procedures that apply or will apply to your practice

- | | | |
|---|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Cosmetic/dermatological procedures | <input type="checkbox"/> Orthopedics — hand surgery only |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Orthopedics — fracture reduction |
| <input type="checkbox"/> Amniocentesis | <input type="checkbox"/> Chemical peel | <input type="checkbox"/> Open |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Chemabrasion | <input type="checkbox"/> Closed |
| <input type="checkbox"/> General | <input type="checkbox"/> Collagen injection | <input type="checkbox"/> Orthopedics — spine surgery |
| <input type="checkbox"/> Spinal (including caudal) | <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> With instrumentation |
| <input type="checkbox"/> Regional | <input type="checkbox"/> Fat transfer | <input type="checkbox"/> Without instrumentation |
| <input type="checkbox"/> Conscious sedation | <input type="checkbox"/> Hair transplant | <input type="checkbox"/> Pacemaker insertion |
| <input type="checkbox"/> Local only | <input type="checkbox"/> Laser skin resurfacing | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Lipodissolve/mesotherapy | <input type="checkbox"/> Medication only |
| <input type="checkbox"/> Angioplasty (with or without stents) | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Selective nerve block |
| <input type="checkbox"/> Coronary | <input type="checkbox"/> Silicon injection | <input type="checkbox"/> Facet joint injection |
| <input type="checkbox"/> Peripheral | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Rhizotomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Electroconvulsive/shock therapy | <input type="checkbox"/> Lumbar epidural |
| <input type="checkbox"/> Assist in major surgery | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Cervical epidural |
| <input type="checkbox"/> On own patients only | <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Spinal cord stimulator |
| <input type="checkbox"/> On patients of others | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Trigger point injection |
| <input type="checkbox"/> Bariatric surgery | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Penile implants |
| <input type="checkbox"/> Only at MBSAQIP accredited center | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Percutaneous vertebroplasty |
| <input type="checkbox"/> Biopsy — endoscopic | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Prenatal care past 1 st trimester |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> EGD | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> ERC | <input type="checkbox"/> Pulmonary artery catheterization (Swan-Ganz) |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> ERCP | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Therapeutic | <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Tonsillectomy/adenoidectomy |
| <input type="checkbox"/> Chelation therapy (for other than heavy metal poisoning) | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Tubal ligations |
| <input type="checkbox"/> Cholangiography | <input type="checkbox"/> Sigmoidoscopy | <input type="checkbox"/> Tumor ablation therapy |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Thoracoscopy | List types
_____ |
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Esophageal dilation | <input type="checkbox"/> Vascular surgery |
| <input type="checkbox"/> Breast implant | <input type="checkbox"/> Interventional cardiology | <input type="checkbox"/> Vein procedures |
| <input type="checkbox"/> Facial cosmetic surgery | <input type="checkbox"/> Interventional radiology | <input type="checkbox"/> Endovenous laser ablation |
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Other cosmetic procedures | <input type="checkbox"/> Lumbar puncture | <input type="checkbox"/> Surface laser for spider veins |
| Please list:
_____ | <input type="checkbox"/> Myelography | <input type="checkbox"/> Vena cava filter placement |
| _____ | <input type="checkbox"/> Obstetrics | |
| | <input type="checkbox"/> Non-surgical <input type="checkbox"/> Surgical | |

1. If **none** of the above procedures apply to your practice, please initial here _____

2. Do you perform procedures that are outside the customary scope of practice within your specialty? Yes No

IF "YES", PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER AND INCLUDE DOCUMENTATION OF TRAINING FOR SUCH PROCEDURES.

ANSWER EACH QUESTION. FOR ALL YES ANSWERS, ATTACH COMPLETE DETAILS ON A SEPARATE SHEET

YES NO

1. Has your LICENSE to practice in any state ever been denied, suspended, revoked, voluntarily surrendered, restricted, or subject to probationary terms?
2. Has your DEA Certificate for prescribing or dispensing narcotics ever been denied, suspended, revoked, voluntarily surrendered, restricted, or subject to probationary terms?
3. Has your MEMBERSHIP in any medical society or professional organization ever been denied, suspended, revoked, or voluntarily surrendered?
4. Have you ever been the subject of any DISCIPLINARY proceedings or reprimand by any medical board, administrative agency, medical society, or licensing board?
5. Has your application for hospital staff PRIVILEGES ever been denied or restricted?
6. Have your hospital PRIVILEGES ever been modified, revoked, non-renewed, subject to probationary or disciplinary action, or voluntarily surrendered while under review?
7. Have PRECEPTOR(S) or assisting physician(s) ever been assigned to any aspect of your practice by a hospital other than during your Residency or Fellowship Program?
8. Have you ever had specialty BOARD CERTIFICATION refused, suspended, or revoked?
9. Have you ever been convicted of, or plead nolo contendere, to a VIOLATION of any law or ordinance other than a traffic offense?
10. Has any hospital, medical society, administrative agency, or professional organization ever requested or required you to be EVALUATED for any medical condition, alcohol and/or drug abuse/dependency, anger or behavior problems, or alleged sexual boundary questions?
11. Have you ever had or do you currently have an ILLNESS OR DISABILITY that impaired, impairs or could impair your ability to practice your medical specialty including, but not limited to, alcoholism, drug addiction, compulsive disorders, tremors, multiple sclerosis, or rheumatoid arthritis?
If "yes", the details required on a separate sheet must include the name and address of your treating physician.
12. Has any CLAIM OR LAWSUIT for any alleged malpractice ever been brought against you?
If "yes", how many? _____ PLEASE ATTACH A COMPLETED CLAIMS ADDENDUM FORM FOR EACH "YES" ANSWER.
13. Has any CLAIM OR LAWSUIT for alleged malpractice ever resulted in a court judgment against you or a settlement by you or by an insurance company, self-insured plan, other form of indemnification, or other form of protection on your behalf?
14. Are you aware of any INQUIRY by an attorney representing any patient (other than worker's compensation or accident claims) about medical care you provided?
 If "yes", has the inquiry (or inquiries) been reported to and accepted by another medical professional liability insurer?
15. Are you aware of any patient or family member of a patient who has expressed DISSATISFACTION with medical care you provided?
 If "yes", has the inquiry (or inquiries) been reported to and accepted by another medical professional liability insurer?
16. Has your medical professional liability INSURANCE ever been cancelled, non-renewed, or issued on special terms or has your application for such medical professional liability insurance ever been declined? (Missouri applicants are not required to respond.)

INDICATE THE NUMBER OF YOUR EXTENDER EMPLOYEES

Number at
Primary Location

Number at
Remote Location

<input type="checkbox"/> None	_____	_____
<input type="checkbox"/> Anesthesiologists Assistant – Certified	_____	_____
<input type="checkbox"/> Clinical Nurse Specialist	_____	_____
<input type="checkbox"/> Nurse Anesthetist (CRNA)	_____	_____
<input type="checkbox"/> Nurse Midwife (no deliveries)	_____	_____
<input type="checkbox"/> Nurse Midwife (with deliveries)	_____	_____
<input type="checkbox"/> Nurse Practitioner	_____	_____
<input type="checkbox"/> Optometrist	_____	_____
<input type="checkbox"/> Perfusionist	_____	_____
<input type="checkbox"/> Physician Assistant	_____	_____
<input type="checkbox"/> Psychologist	_____	_____
<input type="checkbox"/> Radiology Practitioner Assistant	_____	_____
<input type="checkbox"/> Registered Radiology Assistant	_____	_____
<input type="checkbox"/> Surgical Assistant	_____	_____

Are you a medical director or do you have a collaborative agreement to any of the above? Yes No

PLEASE CHECK ONLY ONE

I am applying for Extender Employee Professional Liability Coverage for my extender employees (provides a single separate limit of coverage for each extender employee and requires additional premium). A separate application will be required for each extender employee.

I am NOT applying for insurance for my extender employees.

I REPRESENT that the statements made and the answers provided herein are complete, true, and correct, and are for the purpose of inducing State Volunteer Mutual Insurance Company (“the Company”) to issue the policy for which the application is hereby made.

I UNDERSTAND that the entire policy shall be void if, whether before or after a loss or claim, I am found to have willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

I UNDERSTAND that the medical professional liability insurance for which I am applying covers only those medical incidents which arise from professional services or peer review services rendered on or after the retroactive date, and then only if such medical incidents are first reported to the Company during the policy period. I UNDERSTAND that upon termination of a policy, extended reporting (tail) coverage is available for additional premium, except in the event the policy is canceled for non-payment of the premium.

I AUTHORIZE all hospitals, past or present medical associates, licensing boards, past or present professional liability insurers, and all other persons or organizations to release information concerning me and my medical practice history to the Company for the purpose of evaluating my liability risk. I AUTHORIZE the Company to use a copy of this authorization in place of the original. I UNDERSTAND that any such information will be used by the Company solely for underwriting purposes.

REGULATORY NOTICE: I ACKNOWLEDGE that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company, and that penalties include imprisonment, fines and denial of insurance coverage.

I further ACKNOWLEDGE that execution of this application by me does not bind the Company to issue an insurance policy, but that this application shall be the basis of the contract should a policy be issued.

Applicant's Signature _____ Date _____

Print or type name as it appears above _____

Regulatory Notice

Notice to Alabama, Arkansas, Louisiana, and West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Florida and Oklahoma Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in Florida only.

Notice to Kansas Applicants: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Kentucky and Ohio Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. All policies are subject to a 45-day underwriting period beginning on the effective date of coverage. In accordance with §12-106 of the Insurance Article, Annotated Code of Maryland, if the Company discovers a material risk factor during the underwriting period, the Company may cancel a policy with 15 days written notice, or recalculate the premium from the effective date of the policy.

Notice to Applicants of all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Claims Detail Addendum

Applicant's Name (please print) _____

Please supply the following information for each "yes" response to questions #12-15 on the application for Medical Professional Liability Insurance:

Total number of claims, suits, incidents or inquiries: _____

Please print or type answers to each of the following questions in detail. If more than one case exists, please photocopy this sheet for each case. FULL DISCLOSURE OF THE INFORMATION REQUESTED BELOW IS NECESSARY.

Patient/Plaintiff's Name _____ Insurance carrier involved _____

Date of occurrence _____ Date reported _____ Date closed (if applicable) _____

What is the status of the case? (check one)

- | | | |
|----------------------------------|---|--|
| <input type="checkbox"/> Pending | <input type="checkbox"/> Settled Out of Court | <input type="checkbox"/> Found for Plaintiff |
| <input type="checkbox"/> Dropped | <input type="checkbox"/> Dismissed | <input type="checkbox"/> Found for Defendant |

If damages were paid, either by settlement or court award, what was the amount? _____

Paid on your behalf \$ _____ Paid by all parties \$ _____

What is/was your status? (check one) Primary Defendant Codefendant Other

In the space below (attach additional page(s) if needed), provide detailed information of the following for each case

A) Provide a brief description of the incident/claim/suit.

B) What were you alleged to have done incorrectly or failed to have done correctly?

C) Provide any other details you feel are pertinent to the case.

D) Identify any other parties who are named in the claim or suit.

Applicant's Signature _____ Date _____

Print or type name as it appears above _____

Supplemental Application for Prior Acts Coverage
for Medical Professional Liability Coverage

If you are desiring to change your professional liability coverage from another claims-made type carrier to SVMIC, you should either arrange to purchase tail coverage from that carrier or make application to SVMIC for prior acts coverage. Without one or the other of these coverages, medical incidents that occurred prior to the initial effective date of SVMIC's policy (if approved), may not be covered under either policy.

In addition to applying for prior acts coverage with SVMIC, it is important that you maintain your option to purchase tail coverage from your current or previous carrier until you have received an official approval letter or declarations page from SVMIC indicating prior acts coverage has been provided. Please note that most insurance carriers require that you notify them of your desire to purchase tail coverage within a limited period of time — usually 30 days from the termination of your policy. Prior Acts Coverage is not granted automatically and requires separate approval from SVMIC.

Applicant's Name (please print) _____

Option 1. _____ **I am requesting Prior Acts Coverage from SVMIC.**

What is the Prior Acts date requested? _____

This generally should be the date stated as the "Retroactive Date" under your current policy. **Please attach a copy of the policy document showing your current retroactive date and limits of liability.**

During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g. different states, procedures, coverage, etc.) Yes No

IF "YES", DESCRIBE SUCH CHANGES, INCLUDING ALL APPLICABLE DATES, ON A SEPARATE SHEET

Option 2. _____ **I am not requesting Prior Acts Coverage from SVMIC.**

By making this selection, it is assumed that you either do not need or desire this coverage, or that you have made arrangements with your current carrier to purchase tail coverage.

This Supplemental Application is being submitted with SVMIC's Application for Medical Professional Liability Insurance ("Application"), and I certify that I have specifically referred to questions #12, #13, #14, #15 on page 5 of such Application and have fully disclosed any requested claims, suits, incidents or inquires and the details thereof.

(In order for this application to be considered, *ONE* of the above Options must be marked indicating your request.)

Signature of Applicant _____ Date _____

Print or type name as it appears above _____

Loyalty Pays Well. The Mutual Value Plan[®]

The MVP is SVMIC's physician loyalty program. We make an initial contribution into an account for each physician policyholder. The account grows over time with quarterly allocations as long as the physician continues to be insured by SVMIC. Upon retirement, disability, or death, the balance is paid in a lump sum to the physician.*

How The Program Works

ELIGIBILITY

- If you have an individual policy with SVMIC, you're good to go; you can be full-time or part-time, but you have to individually opt-in to be part of the plan. There's no cost to you for the program.
- Opt-in by logging in to your account at vantage.svmic.com.

FUNDING

- Your initial allocation is based on several factors, but it's roughly equal to one year's premium at \$1 Million/\$3 Million limits. Additional quarterly allocations are determined by the Board of Directors on an annual basis.

DISTRIBUTION

- Upon permanently leaving the practice of medicine, through retirement over the age of 50, death, or disability, you'll receive the full balance of your account. Even if you haven't been in the MVP for 5 years, you'll still get a pro-rated distribution.



* Please refer to the MVP Owner's Manual, available at svmic.com, for the full Terms and Conditions of the Mutual Value Plan.



ContactSVMIC@svmic.com
800.342.2239 | svmic.com



Mutual Value Plan® Request to Participate

On the date indicated below, I, the undersigned Insured Policyholder of State Volunteer Mutual Insurance Company (SVMIC):

Request to participate in the Mutual Value Plan (MVP).

Decline to participate in the Mutual Value Plan (MVP).

If I have requested to participate in the State Volunteer Mutual Insurance Company Mutual Value Plan (MVP), I acknowledge and agree that my request may be accepted or rejected by State Volunteer Mutual Insurance Company in its sole discretion in accordance with the eligibility requirements for participation in the MVP now or hereafter in effect. I also acknowledge and agree that my participation in the MVP will be governed by the Mutual Value Plan Document (MVP Plan Document) and certain policies, procedures, and requirements adopted by State Volunteer Mutual Insurance Company's Board of Directors from time to time.

I acknowledge that I have received, read, and understand the MVP Plan Document and accept and agree to abide by and honor the details, terms and conditions of the MVP as described in the MVP Plan Document. I understand that State Volunteer Mutual Insurance Company's Board of Directors, in its sole discretion and without prior notice, may withdraw, cancel, or modify the MVP.

Print Insured Name: _____

SVMIC Account Number,
Medical License Number,
or NPI Number: _____

Email Address: _____

Insured Signature: _____

Date: _____

I would like SVMIC to create a Vantage™ account on my behalf. If you choose this option, your account information will be emailed to you. Otherwise, you can create your Vantage account on your own at any time.

Phone: 800.342.2239
Fax To: 615.843.0347
Email To: ContactSVMIC@svmic.com

