State Volunteer
Mutual Insurance Company
UNDERWRITING
101 Westpark Drive
Suite 300
Brentwood, TN 37027

P 800.342.2239 **F** 615.843.0347

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Partnership, Association or Corporation

Group Name (please print): _____

NPI Number: _____

Type of Group Practice:

- ☐ Partnership, not incorporated, with sharing of income
- ☐ Professional Association
- ☐ Association for expense sharing, not incorporated
- ☐ Other (Please Describe): _____

Location of Office: _____

(List other locations(s) on separate paper and attach)

Person to Contact for Information:

Name: _____

Email: _____ Phone: _____

Date Coverage Desired: _____

Limits Requested for Professional Liability Insurance: $ _____

Has any claim or suit for alleged malpractice ever been brought against this entity?

☐ Yes ☐ No If Yes, complete & attach Claims Addendum

List All Partners, Stockholders or Member Physicians:

Partner, Stockholder, Member Physician	% of Ownership	Current Insurance Carrier

Name All Employed Licensed Physicians and Surgeons Other than Members:

_____ _____

_____ _____

_____ _____

Premium Payment Plan Desired:

☐ Annual ☐ Semi-annual ☐ Quarterly ☐ 10 Monthly

Retroactive Date of Last Policy: _____

Insurance Regulations require the following warning statement on all applications for insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Execution of this application by the applicant does not bind the company to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

Applicant represents that the statements and answers made herein are true, and makes the same for the purpose of inducing the company to issue a policy for which application is hereby made. If a policy is issued, it is understood and agreed that the entire policy shall be void if, whether before or after a loss or claim, the applicant willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Authorized Signature: _____ Date: _____

Print or type name as it appears above: _____

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CLAIMS DETAIL ADDENDUM

Applicant's Name (please print) _____

Please supply the following information for a "yes" response to a previous claim or suit brought against this entity:

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)

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff
☐ Dropped ☐ Dismissed ☐ 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 _____

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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 <u>not</u> 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 Professional Liability Insurance for Partnership, Association or Corporation ("Application"), and I certify that I 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 _____