5005 Maryland Way, Suite 300
Brentwood, Tennessee 37027
P: 800.342.2239 F: 615.843.0347

UNDERWRITING

APPLICATION FOR AN SVMIC INSURED PRACTICE ENTITY OR PHYSICIAN'S EXTENDER EMPLOYEE FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Name of Applicant: _____ _____ _____
First Name Middle Name Last Name

Certification/
Licensure No.: _____ NPI No.: _____ Coverage Effective Date: _____

Date of Birth: _____ Place of Birth: _____

Practice Address: _____ Phone No.: _____

Employer: _____ _____ _____
Physician or Group Name Account No. Supervising/Collaborating MD (if applicable)

Is the Extender practicing at the physician's primary practice location? YES ☐ NO ☐

If no, provide practice location: _____

Profession (Check One):

- ☐ Anesthesiologists Assistant – Certified
- ☐ Clinical Nurse Specialist
- ☐ Nurse Anesthetist (CRNA)
- ☐ Nurse Midwife (no deliveries)
- ☐ Nurse Midwife (with deliveries)
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ Optometrist (no surgery)
- ☐ Optometrist (surgery)
- ☐ Perfusionist
- ☐ Clinical Pharmacist
- ☐ Psychologist
- ☐ Radiology Practitioner Assistant
- ☐ Registered Radiology Assistant

Education:

_____ _____ _____
Name of Professional Academic Program City State

_____ _____
Dates (From) (To)

Practice History (Please List Prior Practice Locations):

Practice/Physician Name	Street Address, City, State	Dates of Employment

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. Have you ever been the subject of any DISCIPLINARY proceedings or reprimand by any administrative agency, medical society, licensing board, hospital or professional organization?

☐☐ 4. Have you ever been convicted of, or plead nolo contendere, to a VIOLATION of any law or ordinance other than a traffic offense?

☐☐ 5. Has any hospital, medical society, administrative agency, or professional organization ever requested or required you to be EVALUATED for any allegations in the following areas: medical condition, alcohol and/or drug abuse/dependency, anger or behavior problems or sexual boundary questions?

☐☐ 6. Have you ever had or do you currently have an ILLNESS OR DISABILITY that impaired, impairs or could impair your ability to practice medicine 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.

☐☐ 7. 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.

☐☐ 8. 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?

☐☐ 9. 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?

☐☐ 10. Has your 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.)

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 coverage for which the application is hereby made.

I **UNDERSTAND** that the coverage 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 **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 coverage, but that this application shall be the basis of the contract should coverage be issued.

Signature of applicant	Print or type name of applicant	Date
Signature of employer	Print or type name of employer	Date

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CLAIMS DETAIL ADDENDUM

Please supply the following information for each claim or suit of alleged malpractice brought against the extender applying for coverage. 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

Applicant's Name (please print): _____

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

Patient/Plaintiff's Name: _____ Insurance carrier involved: _____

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

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

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff at trial
☐ Dropped ☐ Dismissed ☐ Found for Defendant at trial

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 _____