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

UNDERWRITING

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Name _____

Office Address _____

_____

_____

Mailing Address (if different from above) _____

_____

Applicable Med. License No. _____

NPI No. _____

Office Phone No. _____

Cell Phone No. _____

Email Address _____

Website Address _____

Specialty Board Certification No. (if applicable) _____

Type of Practice (Check as many as apply)

- ☐ 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)

- ☐ 1 million/3 million
- ☐ 3 million/5 million
- ☐ 6 million/8 million
- ☐ 9 million/11 million
- ☐ 2 million/4 million
- ☐ 4 million/6 million
- ☐ 7 million/9 million
- ☐ 10 million/12 million
- ☐ 2 million/6 million (VIRGINIA ONLY)
- ☐ 5 million/7 million
- ☐ 8 million/10 million

Name of most recent insurance carrier _____

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

FOR OFFICE USE ONLY

Revised 2.2020

	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.

Hospital	City/State	Types of Privileges	Send Verification (yes/no)

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

- ☐ Abortion
- ☐ Acupuncture
- ☐ Amniocentesis
- ☐ Anesthesia
  - ☐ General
  - ☐ Spinal (including caudal)
  - ☐ Regional
  - ☐ Conscious sedation
  - ☐ Local only
- ☐ Angiography
- ☐ Angioplasty (with or without stents)
  - ☐ Coronary
  - ☐ Peripheral
- ☐ Appendectomy
- ☐ Assist in major surgery
  - ☐ On own patients only
  - ☐ On patients of others
- ☐ Bariatric surgery
  - ☐ Only at MBSAQIP accredited center
- ☐ Biopsy — endoscopic
- ☐ Breast biopsy
- ☐ Cardiac catheterization
  - ☐ Diagnostic
  - ☐ Therapeutic
- ☐ Chelation therapy (for other than heavy metal poisioning)
- ☐ Cholangiography
- ☐ Cosmetic surgery
  - ☐ Abdominoplasty
  - ☐ Breast implant
  - ☐ Facial cosmetic surgery
  - ☐ Liposuction
  - ☐ Other cosmetic procedures

  Please list:

  _____

  _____
- ☐ Cosmetic/dermatological procedures
  - ☐ Blepharoplasty
  - ☐ Chemical peel
  - ☐ Chemabrasion
  - ☐ Collagen injection
  - ☐ Dermabrasion
  - ☐ Fat transfer
  - ☐ Hair transplant
  - ☐ Laser skin resurfacing
  - ☐ Lipodissolve/mesotherapy
  - ☐ Microdermabrasion
  - ☐ Silicon injection
  - ☐ Other

    _____
- ☐ Electroconvulsive/shock therapy
- ☐ Endoscopy
  - ☐ Arthroscopy
  - ☐ Bronchoscopy
  - ☐ Colonoscopy
  - ☐ Colposcopy
  - ☐ Cystoscopy
  - ☐ EGD
  - ☐ ERC
  - ☐ ERCP
  - ☐ Hysteroscopy
  - ☐ Laparoscopy
  - ☐ Sigmoidoscopy
  - ☐ Thoracoscopy
  - ☐ Esophogeal dilation
- ☐ Interventional cardiology
- ☐ Interventional radiology
- ☐ Hemorrhoidectomy
- ☐ Lumbar puncture
- ☐ Myleography
- ☐ Obstetrics
  - ☐ Non-surgical ☐ Surgical
- ☐ Orthopedics — hand surgery only
- ☐ Orthopedics — fracture reduction
  - ☐ Open
  - ☐ Closed
- ☐ Orthopedics — spine surgery
  - ☐ With instrumentation
  - ☐ Without instrumentation
- ☐ Pacemaker insertion
- ☐ Pain management
  - ☐ Medication only
  - ☐ Selective nerve block
  - ☐ Facet joint injection
  - ☐ Rhizotomy
  - ☐ Lumbar epidural
  - ☐ Cervical epidural
  - ☐ Spinal cord stimulator
  - ☐ Trigger point injection
- ☐ Penile implants
- ☐ Percutaneous vertebroplasty
- ☐ Prenatal care past 1st trimester
- ☐ Prolotherapy
- ☐ Pulmonary artery catheterization (Swan-Ganz)
- ☐ Radiation therapy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Tubal ligations
- ☐ Tumor ablation therapy

  List types

  _____
- ☐ Vascular surgery
- ☐ Vein procedures
  - ☐ Endovenous laser ablation
  - ☐ Sclerotherapy
  - ☐ Surface laser for spider veins
- ☐ Vena cava filter placement

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
☐ None		
☐ Anesthesiologists Assistant – Certified		
☐ Clinical Nurse Specialist		
☐ Nurse Anesthetist (CRNA)		
☐ Nurse Midwife (no deliveries)		
☐ Nurse Midwife (with deliveries)		
☐ Nurse Practitioner		
☐ Optometrist		
☐ Perfusionist		
☐ Physician Assistant		
☐ Psychologist		
☐ Radiology Practitioner Assistant		
☐ Registered Radiology Assistant		
☐ 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.

_____ _____

Signature of Applicant 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 <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 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 _____

Revised 5.16.16

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.

SVMIC

ContactSVMIC@svmic.com
800.342.2239 | svmic.com

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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).**

☐ **<u>Decline</u> 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

JAN 2020