CONVENTUS
MEDICAL PROFESSIONAL LIABILITY INSURANCE

Group Professional Liability Insurance Application

Section I: Group Demographic Information

Practice/Group Name ______________________ Practice/Group DBA, Fictitious Name, etc. ______________________

Federal Tax ID Number ______________________ Entity National Provider Identifier Number ______________________ Date Entity Formed ______________________

Type of Legal Entity: ☐ PA ☐ LLC ☐ LLP Corporation ☐ Joint Venture

Contact Name ______________________ Contact Title ______________________

Contact Phone ______________________ Contact Email ______________________

Office Address ______________________

Mailing address (if different) ______________________ Billing Address (if different) ______________________

Office Phone ______________________ Office Fax ______________________ Office Email ______________________

Website ______________________

Section II: Group Practice Locations. List all office locations:

Name of Location	Address	State	Zip

In which state(s) is this group authorized to do business?

State of incorporation		Authorized States								

Section III: Type of Coverage

Policy Type:

☐ Claims Made (Coverage does not include extended reporting period (tail) coverage)

☐ Modified Claims Made "occurrence type" (claims made coverage that includes extended reporting period (tail) coverage)

Effective Date: ______________________________ Retroactive Date (claims made): ______________________

Limits of Liability requested for Physicians (select one):

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ $3,000,000/$5,000,000 ☐ $5,000,000/$7,000,000

Corporation/Business Entity/Partnership

Is coverage needed for a corporation/business entity/partnership name? Yes No

If yes, what type of coverage is being requested? Shared limit Separate limit

If yes to **separate limit**, what option? Option A – (Vicarious Liability) Option B – (Non-Vicarious Liability-defense only)

Limits requested for corporate coverage (for separate limit):

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ $3,000,000/$5,000,000 ☐ $5,000,000/$7,000,000

Section IV - Group Professional Liability Insurance History

	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior
Insurance Company					
Limits					
Type of Policy					
Policy Period					
Retroactive Date					

Yes	No	
		If the group's previous policy was claims-made, did the group obtain extended reporting period "tail" coverage? *If yes, please include a copy*
		Has any physician in the group practiced without professional liability insurance? *If yes, please attach a completed explanation including dates*
		Has the group or any physician within the group's professional liability insurance ever been canceled or non-renewed (other than at their request) or has their policy premium ever been surcharged or has any application for professional liability insurance ever been declined? *If yes, please attach a complete explanation*

Section V – Current Group Roster

Number of physicians in your group: _______________

Number of Allied Health Care Employees in your group:

Nurse Practitioner	Physician Assistant	CRNA	Nurse Midwife	Medical Assistant	Nurse	Lab Tech	PT/OT	Other Medical Employees	Non-Medical Staff

In the table below, please identify all owners, employed and contracted individuals within your group and provide information concerning each group member.
For Status column indicate if: (S) Shareholder, (P) Partner, (E) Employee, or (IC) Independent Contractor

Name and Designation (e.g., Jane Smith, DO)	Former/Alias Name	DOB (e.g., 10/18/75)	License #	Status	Specialty	Surgery No or Major or Minor	Retro Date	Hours worked per week	Will be insured with Conventus?

Yes	No	
		Will any of the group's members be performing activities which will be covered by another professional liability policy?

If yes, please list which member, what location and the insurance carrier name.

Member Name	Location	Insurance Carrier Name

List All facilities where the group and its members have staff or courtesy privileges:

Facility Name	Location	Type of Privilege	Department

Section VI: Group Practice and Procedures

Yes	No	Does any group member:
		Perform surgery in your office?
If yes, who and what specific procedures?		
		Is General anesthesia or IV conscious sedation administered for these (or any) office procedures?
If yes, by whom:		
		Perform cosmetic procedures in the practice? – If yes, please complete the *Cosmetic Procedures Supplemental Application*
		Provide any services over the internet or through virtual care? – If yes, please complete the *Virtual Care Supplemental Application*
		Perform Pain Management procedures? – If yes, please complete the *Pain Management Supplemental Application*
		Perform Bariatric Surgery? – If yes, please complete the *Bariatric Surgery Supplemental Application*
		Perform any procedures, techniques or treatment modalities that are outside the specialty the physicians are currently practicing?
If yes, please give details		

Yes	No	Does any group member:
		Hold any positions outside of the group's principal medical or surgical practice (e.g., Moonlighting in an ER, serving at a clinic or nursing home, working for an HMO or other managed care or insurance company, serving as a Medical Director, etc.)?
If yes, please provide details		
		Act as a collaborating physician with a qualified nursing professional?
If yes, please describe the extent of this practice, including number of nurses involved, and if the nurses are working within the group's practice location. Attach copies of the Joint Protocols that the group has in place with these individuals.		

Please provide estimated annual amounts regarding the following:

Clinic Visits	Nursing Home Visits	Surgeries: Major	Surgeries Minor

Section VII: Group Professional History

Any YES answer below, must provide additional details.

Yes	No	Has the group or any member:
		Had any health care facility deny, restrict, suspend, or revoke privileges or invoke probation?
		Had any state ever refuse them a license to practice medicine?
		Had any state ever restrict, suspend or revoke their license to practice medicine?
		Had to voluntarily surrender their license to practice medicine?
		Had any state place them on probation or restricted their practice?
		Had their license to practice ever been under investigation?
		Had their license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked? Voluntarily or otherwise?
		Incurred or become aware of any illness, or physical or emotional condition that impaired or could impair their ability to practice medicine?
		Currently or ever been treated for alcoholism or substance abuse?
		Been indicted for, charged with or convicted of any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?
		Had a complaint against them submitted to the Board of Medical Examiners or any regulatory authority?
		Been accused of sexual misconduct of any kind?

Section VIII: Group Loss Information

For any **Yes** answers, please complete the supplemental claim information form or provide details.

Yes	No	
		In the last 10 years, is the group or any of its members now involved, or has it ever been involved in a claim or suit arising out of the rendering or failure to render professional services?
		Is the group or any of its members aware of any complication, incident, or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes, but is not limited to the following: – Amputation, Death, Loss of Major Organ Function, Loss of Vision, Permanent Neurological Injury
		In the last 12 months, has the group or any of its members received a written request from an attorney for the treatment records concerning any current or former patient(s) that might reasonably result in a claim or suit?
		Have all claims, suits, written requests and incidents that would qualify in the questions above, been reported to the group's current insurance carrier?

Section IX: Notices and Signatures

I understand that no coverage will be bound until after *Conventus* Inter-Insurance Exchange has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression or *Conventus'* intent to provide coverage. If coverage is declined, by *Conventus*, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage by *Conventus*, no insurance will be provided for any claim (or incident that the insured has reason to believe might result in a claim) known to the insured at the effective date that has, or has not, been reported to another insurance carrier prior to the effective date.

The information provided in this application is true, complete, and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the underwriter's risk.

I authorize the release of any underwriting, credentialing and/or claim information from (and release from any and all liability for the provision of information) all prior and current insurers, all professional societies or associations, any state licensing authority, any hospitals, or any credentialing agency to *Conventus* and its subsidiaries, or agents, or Attorney-in-Fact.

NOTICE TO NEW JERSEY 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 INFORMAITON OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJCETS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Group Application Attachment: Signature of Applicants

All providers applying for coverage must sign and date application. Please print and have providers sign and date attachment.
Conventus reserves the right to reject any application that does not meet its underwriting standards.

Printed Name	Gender (M/F)	Signature	Date