Capitol Specialty Insurance Corporation
A Stock Company

P. O. Box 5900
Madison, WI 53705-0900

Medical Director Professional Liability Insurance Application

The application is subject to review and acceptance by The Company and does not bind coverage. Additional information may be requested by The Company.

Agency Name:
Agency Location:
Producer Name:

- Please complete the entire application, sign, and date. Please indicate not applicable (n/a) where appropriate.
- If an explanation is required for any answer, please use a separate piece of paper.
- Please sign and date the completed application.

I. GENERAL INFORMATION

A. _____
Name of Individual Applicant (Last Name, First Name, Middle Name, Suffix)

_____
Mailing Address/Principal Practice Address **Suite** **City** **State** **Zip Code**

_____/_____/_____
Professional Designation (MD, DO, Other) **Date of Birth** (MM/DD/YYYY) **Gender** (M/F):_____

Email Address: _____ **Phone:** _____ **Fax:** _____

B. _____
Medical School & Date of Graduation

If foreign graduate, are you certified by the educational commission for foreign medical graduates? □ Yes □ No

C. _____ _____
Principal Medical Specialty **Sub-Specialty**

D. **Please indicate states where you are licensed:** _____
Are all these licenses active? □ Yes □ No

E. **Are you American Board Certified?** □ Yes □ No

If yes, list specialty boards: _____

F. **Indicate number of CME credits in the last 12 months:** _____

G. **Number of years of experience working as a Medical Director:** _____

II. COVERAGE REQUESTED

A. **Requested Effective Date:** _____

B. **Prior Acts Date (Retroactive Date):** _____

C. **Limits Requested:** □ $100,000/$300,000 □ $200,000/$600,000 □ $250,000/$750,000 □ $500,000/1,500,000
□ $1,000,000/$3,000,000 □ Other:

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III. ENTITY/FACILITY INFORMATION

Provide the following information with respect to any entity where you act as, and are seeking coverage for your duties as a Medical Director. If you are applying for coverage with respect to your duties as Medical Director for more than one entity or location, please attach additional pages. Note: Entities are not covered by the policy for which you are applying.

A. _____

Legal Entity/Facility Name, as per the articles of incorporation – include any DBA (doing business as) name

_____

_____

Principal Office Address **Suite** **City** **State** **Zip Code**

B. **Describe the type of facility and the medical services provided by the facility:** _____

C. **Total number of employees in the organization for which you provide Medical Director services:** _____

D. **Does the entity provide long term care?** □ Yes □ No

If yes, number of beds: _____

Type of long term care: □ Skilled □ Intermediate □ Assisted Living □ Residential

E. **Does the entity provide overnight care?** □ Yes □ No

If yes, number of beds: _____

Explain/describe type of overnight care: _____

F. **Organization/service/facility annual receipts:** _____

G. **If known, which insurer provides medical professional insurance for the facility?** _____

Has evidence of the above insurance been procured? □ Yes □ No If yes, please attach.

IV. MEDICAL DIRECTOR DUTIES/CONTRACT

Please provide a copy(ies) of the Medical Director contract(s) between you and the facility(ies) for which you are providing medical director services.

A. **Please indicate below the medical services or responsibilities that you will be required to perform in your capacity as a Medical Director and for which you are seeking coverage:**

□ **Administrative Services**

Duties include establishing general medical protocols, serving on a standards review, peer review or credentialing committee or similar professional board or committee.

Provide details if not specifically outlined in the contract between you and the facility: _____

□ **In-direct Patient Care**

Duties include rendering patient specific medical directives, medical direction, course of medical treatment or any other patient specific guidance to other healthcare professionals whom you oversee, manage or have collaborative agreements and collaborative responsibility. This includes any and all means of telecommunication or other forms of communication between you and another healthcare professional related to patient specific guidance.

Provide total number (by type) of health care providers (ie. CRNAs, NPs, PAs, CNMs, others) that you will supervise or assist in providing indirect patient care services: _____CRNAs_____NPs _____PAs ____CNMs____Others (specify)_____

Provide details if not specifically outlined in the contract between you and the facility: _____

□ **Direct Patient Care**

Duties include rendering or failure to render medical professional services in the examination, diagnosis, testing and medical treatment to any patient.

Provide details if not specifically outlined in the contract between you and the facility: _____

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B. Revenues/Receipts being paid to you by the facility for these services: _____

C. If you currently carry your own individual medical professional liability insurance policy please provide the information requested below:

Carrier name:_____

Liability limits: _____

Coverage dates: _____

Description of the professional services provided by your practice that are covered by this insurance**:** _____

V. CLAIMS AND LICENSE SANCTIONS INFORMATION

A. Has any claim ever been made against you arising from your duties as a medical director? □ Yes □ No
If yes, complete the Supplemental Claim Information Form for each claim. Also please attach 5 years of currently valued carrier produced loss runs.

B. Are you aware of any circumstances, arising from your duties as a medical director, which may result in a claim against you? □Yes □ No
If yes, please provide details: _____

C. Have you ever had your license, certification, or privileges revoked, suspended, or restricted or have you been subject to any disciplinary proceeding, been reprimanded by an administrative agency, professional association or peer review committee? □ Yes □ No

If yes, please provide details: _____

VI. AGREEMENT

I understand that any claims whose circumstances were known before the effective date of coverage are specifically excluded from coverage under any policy of insurance that may be issued by Capitol Specialty Insurance Corporation (CSIC).

I understand that, as a condition precedent to approval for coverage, CSIC may perform a detailed inquiry and investigation of the applicant's background, competence, and qualifications. I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to CSIC and its duly authorized agents and representatives. I further expressly authorize all individuals and entities to whom such legal inquiry is made by CSIC and its duly authorized agents and representatives to provide the same with all information within their possession or under their control that pertains to the applicant's background, competence, and qualifications. I expressly release and discharge the aforesaid entities and individuals and their agents and representatives from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation, as well as in the evaluation of information so received from whatever source.

All information requested in this application is considered material and important. I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of CSIC in considering this application for insurance. I understand that any material misrepresentation in this application that CSIC relies on to its detriment could void coverage. I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to me by CSIC.

I understand that I must notify CSIC immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf and that CSIC may withdraw or modify any outstanding quotations or authorization or agreement to bind insurance.

I understand that this application is subject to acceptance by CSIC and does not bind coverage.

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THE APPLICANT AGREES IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, THAT THIS APPLICATION AND ANY ATTACHMENTS ARE DEEMED ATTACHED TO AND INCORPORATED INTO THE POLICY. BY SIGNING OR TYPING MY NAME IN THE FIELD BELOW, I AGREE IT IS MY SIGNATURE OR THE EQUIVALENT TO MY SIGNATURE ON THIS DOCUMENT AND IF SIGNATUREI IS TYPED, I CONSENT TO CONDUCT THE TRANSACTION TO WHICH THIS DOCUMENT IS APPLICABLE BY ELECTRONIC MEANS.

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 AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES.

(NOT APPLICABLE IN AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA AND WV).

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV
ANY PERSON WHO KNOWINGLY (OR WILLFULLY)* PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR 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. *APPLIES IN MD ONLY.

APPLICABLE IN CO
IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FL AND OK
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 FL ONLY.

APPLICABLE IN KS
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 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 COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN KY, NY, OH AND PA
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 (NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION)*. *APPLIES IN NY ONLY.

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APPLICABLE IN ME, TN, VA AND WA

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES (MAY)* INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS. *APPLIES IN ME ONLY.

APPLICABLE IN NJ

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN OR

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD THE INSURER BY SUBMITTING AN APPLICATION CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT MAY BE VIOLATING STATE LAW.

Applicant Signature	Date (mm/dd/yyyy)
Printed Name	Title

This Application is not valid without your complete signature.

CLAIMS HISTORY SUPPLEMENTAL APPLICATION

Attach a detailed narrative, which includes at least the information requested below, or complete this form, for each claim, suit, or incident within the past 10 years. Provide adequate detail to allow proper evaluation. Additional information may be requested

Patient Name	Age	Male Female

Date of Incident (mm/dd/yyyy)	Location of Incident

Name of Insurer	Date Reported to Insurer (mm/dd/yyyy)

Type: ☐ Suit ☐ Demand for Money ☐Incident Only ☐ Notice of Intent to ☐ Sue Request for Records ☐Other:

1. Summary of condition/diagnosis at time of incident:

2. Description of treatment rendered, including dates:

3. Allegations:

4. Other persons and entities involved:

5. Status/Disposition:

   ☐Open Describe current status and defense strategy:

   ☐Closed without indemnity payment ☐Settled ☐Judgment/Verdict for defense ☐Judgment/Verdict for plaintiff If closed, date closed (mm/dd/yyyy):

Amount reserved for you:	Indemnity: $	Defense: $
Amount reserved for other defendants:	Indemnity: $	Defense: $
Amount paid on your behalf:	Indemnity: $	Defense: $
Amount paid on behalf of other defendants:	Indemnity: $	Defense: $

6. Has there been a change in practice as a result of this claim, suit, or incident? ☐Yes ☐No If yes, explain below:

I understand this information is part of my Application.

_____	_____	_____
Signature	Printed Name	Date (mm/dd/yyyy)