Medical PL EZApp™

QUICK QUOTE APPLICATION

Designed to take 5 minutes or less **"QUICK & EZ"**

1. First Name:	
2. Last Name:	
3. Medical Designation:	Open and Select from List in this Box
4. Medical Specialty:	Open and Select Specialty from List in this Box
5. Medical Subspecialty (please specify or input N/A):	
6. Are you ABMS American Board Certified?	Open and Select YES or NO Answer from this Box
7. Do you practice Full Time or Part Time?	Open and Select Answer from this Box
8. Date of Birth:	MM/DD/YYYY
9. Primary practice location - street address:	
10. County, Parish or Borough that the practice is located in:	
11. City:	
12. State:	Open and Select State from this Box
13. Zip Code:	
14. Primary Contact Phone Number:	
15. Primary Contact Email Address:	
16. What best describes your medical practice setting?	Open and Select Answer from this Box
17. Do you or the medical practice have a registered legal entity such as a Corporation, LLC or Other?	Open and Select YES or NO Answer from this Box
18. Name of Entity as it appears on your Articles of Incorporation (or input N/A if there is no entity):	
19. Are there any Ancillary Medical Staff EMPLOYEES or Independently CONTRACTED Medical Practitioners who will need to be insured under your Malpractice policy?	Open and Select YES or NO Answer from this Box
20. Please provide your medical practice Web Site address (or input N/A if you do not have one):	
21. Current Malpractice Insurance Company:	Open and Select Insurer from this Box
22. How many CONTINUOUS years have you been insured by your CURRENT Malpractice Insurance Company?	Open and Select Answer from this Box
23. Current Malpractice Policy Expiration Date:	
24. Current Malpractice Policy Retroactive Date:	

25. If you did not provide a Retroactive date does that mean you are on an Occurrence policy now? — Open and Select Answer from this Box

26. Limits of Liability that you are requesting: — Open and Select Limits from this Box

27. In the past 10 years have there been any times at which you were not actively practicing medicine or not actively insured or had ANY gaps in Malpractice Insurance coverage? — Open and Select YES or No Answer from this Box

28. Have you experienced any CLAIM PAYOUTS or CLAIM SETTLEMENTS within the past 10 years? — Open and Select YES or NO Answer from this Box

29. Are you or any member of your practice (for whom you have collaborative or supervisory responsibility) performing any of the items shown below? — Open and Select YES or NO Answer from this Box

PART 1 - Please select answer in the box to the right

PART 2 – see list below

- Employed or Contracted as a Medical Director?
- Employed or Contracted by a Nursing Home or Long Term Care facility?
- Employed or Contracted by a Correctional Facility?
- Employed or Contracted by a Methadone Clinic
- Employed or Contracted by an Abortion Clinic?
- Performing Abortions either by surgical or medicinal means?
- Family Practice or General Practice and performing 1st, 2nd or 3rd trimester prenatal care?
- Performing VBAC's or High Risk Deliveries?
- Performing Cosmetic / Aesthetic / MedSpa procedures? (i.e. Botox, Fillers, Laser, etc)
- Performing Tumescent Liposuction or any other type of Liposuction?
- Performing Suture Suspension Face Lifts / Contour Thread Lifts / Feather Lifts?
- Weight Control by prescribing or administering of medications?
- Hormone Replacement Therapy by prescribing or administering of medications?
- Performing Naturopathic or Homeopathic medicine?
- Performing Acupuncture or Acupressure?
- Performing MUA's (Manipulation Under Anesthesia)?
- Performing Lap Band procedures for weight control?
- Performing Pain Management procedures or prescribing of Pain Medications?
- Performing Sex Change operations or Penile Implants?
- Performing procedures or administering medications not approved by the FDA? (i.e HCG, etc)
- Performing procedures not customary to your Residency or Fellowship training?
- Performing Telemedicine or Telehealth services? (other than Teleradiology)
- Working in the ER? (other than for maintaining your hospital privileges)
- Employed or Contracted as a Hospitalist?

I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER ATTEST TO THE FOLLOWING:

> I have no known losses, claims, summons or notices of intent that have not yet been reported to my current or previous insurers.
> I have no knowledge of any request for medical records which might result in a claim or is likely to result in a claim.
> I have no knowledge or information relating to a medical incident "act, error or ommission" which could reasonably result in a claim.
> I have no knowledge or information regarding any "adverse outcome" related from a medical procedure performed, medical treatment provided or medical diagnosis provided or lack thereof, in the past 30 months, that I have not yet reported to my current or previous insurers.

ACKNOWLEDGED AND AGREED:

Applicant Name (Printed)	Applicant Signature (Required)	Date Signed

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING – THANKS!

- ☐ Application must be signed and dated at the time of completion.
- ☐ Please provide your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.
- ☐ Please provide copies of any applicable current policy endorsements that affect your coverage so that we are able to try and obtain coverage aspects equal to or better than what you currently have in place.
- ☐ Please provide a copy of an Up-to-date CV (curriculum vitae - also known as a resume).
- ☐ Please provide current Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years.

"ADDITIONAL DETAILS"