



Medical Professional Liability Insurance Application

**** Please include a copy of your: i.) Curriculum Vitae (CV) ii.) Company Letterhead iii.) Current Declarations Page**

Name:

First Middle Last Suffix

Professional Degree Medical License Number

Date of Birth / /

Section I: Contact Information

Phone () - Fax () - Cell () - Home () -

E-Mail Address Website

Primary Practice Address: *Number/Street*

City State County Zip Code

Home Address: *Number/Street*

City State County Zip Code

Preferred Method of Contact

Primary Contact

Preferred Mailing Address Practice Address Home Address Other Address (*please list on Remarks Page*)

Section II: Professional Practice Information

List Medical Specialty for which you wish coverage

List all counties in which you practice

Do you perform any procedures outside of the specialty for which you are applying?

Yes No (*If yes, please fully explain in the Additional Remarks Page*)

If you are applying as an OB/GYN, are you a member of Florida NICA?

Yes No (*If yes, please provide proof of membership*)

Have you practiced continuously for the last 5 years?

Yes No (*If no, please fully explain in the Additional Remarks Page*)

What Risk Management Program(s) and/or System(s) have you implemented and use in your practice?

Are you Board Certified?

Yes No Eligible

Name of Board(s)

Do you wish to purchase separate corporate policy limits for your corporation?

Yes No

Do you employ any of the following healthcare professionals listed below?

(If yes, please include the number of each in order for vicarious liability/defense coverage to be provided to you. These individuals must provide proof of individual coverage with this application or apply to MDIC for coverage. Proof of insurance must show policy limits of at least \$250,000 / \$750,000 and reflect the retroactive date.)

| | | |
|----------------------|----------------------------|------------------------------|
| Nurse Anesthetist | Shared limits with insured | Separate limits from insured |
| Nurse Midwife | Shared limits with insured | Separate limits from insured |
| Nurse Practitioner | Shared limits with insured | Separate limits from insured |
| Physicians Assistant | Shared limits with insured | Separate limits from insured |

Who is your current medical professional liability carrier?

Have you ever practiced without medical professional liability insurance?

Yes No

If yes, what day did you resume coverage? / / or, still not covered

Have you ever had your license to practice medicine, permit to dispense or prescribe drugs, or your privileges with a hospital, managed care organization, or other healthcare facility denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited; or are any currently under investigation?

Yes No *(If yes, please fully explain in the Additional Remarks Page)*

Have you ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations?

Yes No *(If yes, please fully explain in the Additional Remarks Page)*

Have you ever been evaluated, treated, or hospitalized for: alcohol, mental or emotional disorders, narcotics, or central nervous system stimulants or depressants?

Yes No *(If yes, please fully explain in the Additional Remarks Page)*

Are you currently involved in or have you ever been involved in a malpractice claim or suit including any expression of an intent by a third party (i.e. records request, incident reports and Notices of Intent, even if the suit was never filed)?

Yes No *(If yes, complete the attached Incident/Claim form for each claim, incident, or potential claim)*

Do you know or is it reasonably foreseeable from the facts, reasonable inferences, or circumstances (including, but not limited to, complications, unexpected or potentially problematic results or any communication from a patient or patient's representative, friend, relative or attorney) regarding any procedure, treatment or diagnosis you have performed or made in the past that might reasonably lead to a claim or suit being brought against you?

Yes No *(If yes, complete the attached Incident/Claim form for each claim, incident, or potential claim)*

Are there outstanding incidents, claims or suits, or potential incidents, claims or suits (even if you believe the outstanding claim or suit would be without merit) that have not been reported to your current or prior professional liability insurance carrier?

Yes No *(If yes, complete the attached Incident/Claim form for each claim, incident, or potential claim)*

Have you ever been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, alleged improper care of a patient, unprofessional conduct, unethical conduct or fraud?

Yes No *(If yes, complete the attached Incident/Claim form for each claim, incident, or potential claim)*

How did you hear about MedMal Direct?

Additional Remarks

Please include any additional information or attach documentation as needed to best inform MedMal Direct Insurance Company of anything that would be useful in the underwriting of your application for insurance.

Agreement and Authorization

(A copy of this agreement and Authorization shall be considered as effective and valid as the original)

I hereby agree that the foregoing information and applicable attachments constitutes my application for insurance with MedMal Direct Insurance Company (MDIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences, or circumstances related to each particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of MDIC in considering this application.

If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. Insurance coverage is subject to underwriting review and approval and I understand that no insurance will be afforded unless and until this application is accepted by MDIC and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by MDIC. I consent to any investigation or inquiry and authorize the release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physicians Recovery Network, individuals and MDIC.

I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source. I understand that, if insured by MDIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with MDIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of MDIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to MDIC.

Signature: _____

Printed Name: _____

“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or any application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.”

-Section 817.234(1)(b), Florida Statutes

MDIC Authorized Representative

FL Insurance License Number

