



Copic Application for Medical Professional Liability Insurance

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Direct Patient Care DPC Program Physician Application

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

This policy covers Family Practice, Family Practice Minor Surgery, Internal Medicine NOC and Pediatrics Only

With your completed application, we require the following information:

- Curriculum Vitae (C.V.)
- A loss run report. To obtain this information, please call your prior carrier(s) and request a currently-valued loss run for the past ten (10) years
- Current CARE application
- Please provide any new or updated changes from your current CARE application
- Current Certificate of Insurance

Additional information may be requested.

APPLICANT DATA

1. First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____ Title: _____
2. Date of Birth: ____/____/____ 3. National Provider Identifier (NPI): _____
4. Personal/Confidential Email Address (Required for Online Access): _____
5. Legal Residency:

Physical Street/Home Address: _____

City: _____ State: _____ ZIP: _____ Cell Phone Number: _____

Rural Mailing Address/PO Box (if applicable): _____

City: _____ State: _____ ZIP: _____ Home Phone Number: _____
6. Primary Practice Location:

Address: _____

City: _____ State: _____ ZIP: _____ Office Phone Number: _____

Website Address: _____ Primary Contact Name: _____

Primary Contact Email Address: _____ Primary Contact Phone Number: _____
7. Preferred Mailing Address (Confidential)

Choose one: ☐ Office ☐ Office PO Box ☐ Residence ☐ Residence PO Box ☐ Billing Address

Preferred Mailing Address for Policy-Related Documents

Choose one: ☐ Office ☐ Office PO Box ☐ Residence ☐ Residence PO Box ☐ Billing Address

PRACTICE CHARACTERISTICS

8. Requested Effective Date: ____/____/____ Retroactive Date: ____/____/____
9. Limits of Liability Per Incident: \$_____ Per Aggregate: \$_____ (For example, \$1M/\$3M)
10. What is your specialty? _____

Percentage of your practice devoted to your specialty: _____ %
11. What is your subspecialty? _____

Percentage of your practice devoted to your subspecialty: _____ %
12. Do you perform surgical procedures? ☐ Yes ☐ No

If yes, please provide details _____
13. Average number of hours worked per week? ☐ 1-15 ☐ 16-20 ☐ 21-25 ☐ ≥26
14. For Family Practice Physicians, do you perform pre-natal care past the first trimester? ☐ Yes ☐ No
15. Does your practice include Pain Management? ☐ Yes ☐ No

If yes, what percentage? _____ %
16. Does your practice include Cosmetic Procedures? ☐ Yes ☐ No

If yes, what procedures? _____
17. Do you accept commercial health insurance?..... ☐ Yes ☐ No
18. Has anything in your practice changed since completing the Care RRG application?..... ☐ Yes ☐ No

If yes, please provide additional information. _____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! As a condition of being insured, I understand and agree to the requirement to submit to a health and skills assessment by a physician of Copic RRG's choice. This assessment may be required at Copic RRG's discretion.

I hereby declare and represent that all answers and statements in this application are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and, as such, will be relied upon by Copic RRG to determine whether to issue my liability insurance, to determine the amount of limits available, or to specifically exclude a risk. If I or any other person making application or providing information on my behalf misstate(s) or fail(s) to disclose any material information, my application may be declined. If my application is approved and it includes any material misstatement or it fails to disclose material information, Copic RRG has the right to rescind my insurance. Copic RRG also has the right to decline coverage for a specific claim if Copic RRG would have declined to issue insurance or would have limited my coverage if I had not made the material misstatement or omission.

I authorize any state board of medical examiners or medical board, or any licensure, hospital board or committee, hospital records department, insurance company, professional society or association, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to Copic RRG or its assigns. This authorization applies regardless of whether I am currently affiliated with the above persons or entities, or have been in the past. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with Copic RRG policy, I hereby consent to Copic RRG's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to medical boards and boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: my name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank. To the fullest extent permitted by law, I hereby release all providers of such information, including Copic RRG, its employees and agents, from any and all liability therefore.

Physician signature _____ Date _____

Please PRINT your name _____

RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

The following Insurance Fraud Warnings are required to be provided with all applications.

CALIFORNIA

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO

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.

DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

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.

KENTUCKY

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.

LOUISIANA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

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 or denial of insurance benefits.

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who 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.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON

Any person who knowingly provides false, incomplete, or misleading material information to an insurance company with the intent to knowingly defraud may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA

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.

RHODE ISLAND

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.

Warranty Statement



The Applicant understands and agrees that all information contained in the application(s) and supplemental information submitted to Copic¹ in connection with the insurance being applied for will be relied upon by Copic underwriters in issuing the policy and are the basis for the proposed insurance. Such application(s) and information submitted to Copic shall be deemed attached to, and made a part of, this Warranty Statement.

The Applicant also understands and agrees that the policy, for which this Warranty and application are made subject to its terms and conditions, does not apply to claims or potential claims the Applicant is aware of, or should be aware of after reasonable inquiry, prior to the effective date of coverage. All claims or potential claims should be reported to the Applicant's carrier prior to the effective date of the new policy.

The Applicant warrants, after reasonable inquiry, that it is not aware of any dispute, error, omission, act or circumstance that is, or could reasonably be expected to become, a claim under the policy of which the application(s) and supplemental information are submitted to Copic, including, but not limited to, an attorney's request for records, patient/family dissatisfaction, or unanticipated death/paralysis/disability.

☐ Check this box if the Applicant warrants that the above statements are true.

- I. By signing below, the Applicant warrants that the foregoing is true and complete and acknowledges that the insurer is relying on the accuracy of this statement in acceptance of the risk. This does not bind the company to offer insurance.
- II. The Applicant acknowledges and agrees that this warranty statement shall be the basis of the proposed insurance and shall be considered incorporated into and constituting part of the proposed insurance.
- III. The Applicant agrees that if the information supplied on this warranty statement changes between the date of the warranty statement and the inception date of the insurance, the Applicant will immediately notify the insurer of such a change, and the insurer may modify or deny coverage.

Print Name: _____ Title: _____

Signed: _____ Date: _____

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

¹ The reference to Copic may be to either Copic Insurance Company or Copic, A Risk Retention Group. Each of those companies are members of the Copic family of companies. The specific Copic company to which this Warranty applies is the company from which you are seeking coverages.

Proxy for RRG Applicants

In consideration of the Copic RRG's issuance of insurance to the Applicant, the Applicant hereby constitutes and appoints the Chairman of the Board of Copic RRG as the Applicant's proxy to attend all meetings of the members of Copic RRG, with full power to vote as proxy for the Applicant and act in the Applicant's name, place and stead, in the same manner, to the same extent, and with the same effect that the Applicant might if personally present, giving to the Chairman of the Board full power of substitution. This grant of a proxy shall continue in force indefinitely until either (1) the Applicant ceases to be a policyholder of Copic RRG or (2) the Applicant revokes the proxy.

Name of Applicant

Signature of Applicant or Authorized Officer

Print Name

Title

Date
