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 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.

With your completed application, we require the following information:

- Curriculum Vitae (C.V.) If you have any gaps in practice over 90 days, an explanation must be included.
- 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

Additional information may be requested.

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Risk Retention Group

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: _____

6. Primary Practice Location:

Address: _____

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

Website Address: _____ Primary Contact Name: _____

Primary Contact Email Address: _____ Primary Contact Phone Number: _____

COVERAGE REQUESTED

7. Requested Effective Date: _____/_____/_____ Retroactive Date*: _____/_____/_____

*If you are requesting prior acts coverage, please complete prior acts supplement.

8. Limits of Liability Per Incident: $_____ Per Aggregate: $_____ (For example, $1M/$3M)

9. Practicing as: ☐ Individual ☐ Joining Group ☐ Forming Group

(a) Name Practice: _____

(b) Your % of Ownership: _____%

(c) Are you requesting the practice be added as additional insured (shared limit) under your policy? ……..…… ☐ Yes ☐ No

LICENSES/CERTIFICATION

10. List all states in which you will be practicing including treating remote patients via telehealth.

State: _____ License #: _____ Date Issued: _____ # Hours/Week: _____

State: _____ License #: _____ Date Issued: _____ # Hours/Week: _____

State: _____ License #: _____ Date Issued: _____ # Hours/Week: _____

11. Are you ABMS or AOA Board Certified? …… ☐ Yes ☐ No

If "No", have you ever failed any licensing or Board Certification Examinations? ……..…. ☐ Yes ☐ No

If “No”, are you eligible by a member board of the ABMS or AOA? ……..……..…. ☐ Yes ☐ No

12. Have you ever been denied a medical license or certification by a specialty board? ……..…... ☐ Yes ☐ No

13. If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ……..…. ☐ Yes ☐ No ☐ N/A

PRACTICE CHARACTERISTICS

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

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

16. What is your current total patient count? _____

17. Average number of hours worked per week ☐ 1-15 ☐ 16-20 ☐ 21-25 ☐ ≥26

18. Do you accept commercial insurance? ..... ☐ Yes ☐ No

19. Do you perform Surgical Procedures? ..... ☐ Yes ☐ No

If "Yes", please list the procedures performed: _____

_____

20. Does your practice include Pain Management? ..... ☐ Yes ☐ No
If "Yes", please list the percentage of your practice devoted to pain management and the procedures performed. _____%

Procedures: _____

21. Do you perform or supervise anyone who performs aesthetic or cosmetic procedures? ..... ☐ Yes ☐ No
If "Yes", please provide an Elective Aesthetic & Cosmetic Procedures Supplemental Application.

22. For Family Practice Physicians, do you perform prenatal care past the first trimester? ..... ☐ Yes ☐ No ☐ N/A

23. Do you provide medical services to professional athletes/sports teams or celebrities? ..... ☐ Yes ☐ No

24. Do you utilize any patient-facing artificial intelligence technologies, such as chatbots or similar tools in your practice? ☐ Yes ☐ No

If "Yes", do you confirm/review the information being provided to the patient? ..... ☐ Yes ☐ No

25. After your effective date, will you maintain professional liability coverage with another carrier for activities or exposures not covered by Copic? ..... ☐ Yes ☐ No

If "Yes," please explain: _____

OTHER INFORMATION

ALL 'YES' ANSWERS REQUIRE AN EXPLANATION. PLEASE ATTACH ADDITIONAL SHEETS, IF NECESSARY

26. Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? (Include any disciplinary actions by the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity. Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations which are currently pending.) ..... ☐ Yes ☐ No

27. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ..... ☐ Yes ☐ No

28. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? ..... ☐ Yes ☐ No

29. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? (Note: You must answer "Yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned, or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.) ..... ☐ Yes ☐ No

30. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, healthcare facility, or any other healthcare entity? ..... ☐ Yes ☐ No

31. With in the past 5 years incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e. serious neurologic illness or injury, uncontrolled seizure disorder, mental health diagnoses, sexual addiction, alcohol, opioid, or other substance use disorder, serious physical illness or injury, etc.) ..... ☐ Yes ☐ No

If "Yes", state the condition(s) and date(s), and identify your treating physician(s) below. A statement from your physician attesting to your fitness to practice your specialty is required to be submitted with this application.

Description of condition: _____

Date(s) of treatment(s): From _____/_____ To: _____/_____ ☐ Currently in treatment

Name of treating physician(s): _____

32. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended, or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action? ..... ☐ Yes ☐ No

33. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing board, Board of Medical Examiners, health plan, managed care organization, or other medical review committee? ..... ☐ Yes ☐ No

34. Are you personally registered as a patient or recipient on any state's medical marijuana registry, or are you personally a frequent or habitual user of marijuana? ..... ☐ Yes ☐ No

35. Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee, or an employee of a hospital or surgery center; or have you been accused by a patient or been investigated by any state regulatory authority for boundary violations of a sexual nature? ..... ☐ Yes ☐ No

36. Have you ever been reported to the National Practitioners Data Bank? ..... ☐ Yes ☐ No

CLAIMS INFORMATION

Important information regarding questions 36 and 37 (including sub-questions):

1. The word "claim" as used in questions 36 and 37 below refers to:

- **a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or**
- **b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.**

2. If you answer "Yes" to question 36 and 37 (including sub-questions), please complete the attached Supplementary Claims Information Form.

37. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? ..... ☐ Yes ☐ No

38. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome? ..... ☐ Yes ☐ No

b. A letter from an attorney regarding your medical treatment of a patient? ..... ☐ Yes ☐ No

c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ..... ☐ Yes ☐ No

d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ..... ☐ Yes ☐ No

e. Any other circumstances that might reasonably lead to a claim or suit? ..... ☐ Yes ☐ No

39. If "yes", to any of the above, have they been reported to your current or prior professional liability insurance carrier? ..... ☐ Yes ☐ No ☐ N/A

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SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Initials: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____
_____
_____

6. What is the present condition of the patient? _____
_____
_____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ☐ Yes ☐ No

8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed but dropped by claimant		
☐ Summary judgment in your favor	☐ Court outcome in favor of plaintiff:	☐ Awaiting court action:
	Amount of Loss payment: $_____	Reserve Amount: $_____
☐ Suit settled out of court		

a. Date claim paid:_____
b. Amount paid: $_____
c. Did you want to settle this claim? ☐ Yes ☐ No

9. To your knowledge, was any settlement paid by another party involved(i.e., your P.A., P.C., partners, employees, etc.)? .....☐ Yes ☐ No
If "yes," amount was $_____

Signature: _____ **Date**: _____

Name (Printed): _____

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 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.