Physicians Insurance
A MUTUAL COMPANY

APPLICATION FOR EMPLOYMENT PRACTICES AND/OR DIRECTORS & OFFICERS LIABILITY ENDORSEMENT CLAIMS - MADE

Broker Name: ______________________________

PART I – GENERAL APPLICANT INFORMATION

Name of Applicant Company: ______________________________

D/B/A Name: ______________________________

Parent/Subsidiaries: ______________________________

Mailing address: ______________________________

Business address: ______________________________

Billing address (if different): ______________________________

Website: ______________________________

Contact person (name and title): ______________________________

Phone: ______________ E-mail address: ______________________________

PART II – COMPANY INFORMATION

Type of Organization: Corporation: ☐ Partnership: ☐ LLC: ☐ Other: ______________

Date established under current ownership: ______________________________

Is the Applicant Organization publicly held? Yes: ☐ No: ☐

Has the Applicant been involved in any actual, negotiated, or attempted merger, acquisition, or divestment in the past 18 months?
If yes, provide details on a separate page. Yes: ☐ No: ☐

Is the Applicant considering any merger or acquisition in the next 12 months?
If yes, provide details on a separate page. Yes: ☐ No: ☐

PART III – FINANCIAL INFORMATION

Current Assets	$ ______	Total Assets	$ ______	Annual Revenues	$ ______
Current Liabilities	$ ______	Long Term Liabilities	$ ______	Net Income/(Loss)	$ ______

Does the Applicant anticipate restructuring, legal/financial reorganization, or bankruptcy filing in the next 12 months?
If yes, provide details on a separate page. Yes: ☐ No: ☐

Has the Applicant considered restructuring, legal/financial reorganization, or bankruptcy filing in the past 24 months?
If yes, provide details on a separate page. Yes: ☐ No: ☐

PART IV – COVERAGE INFORMATION

Requested effective date: ______ Current policy expiration date, if applicable: ______ Retroactive date of current policy, if applicable: ______

Coverages		**Limits of Liability**		
Employment Practices Liability	$300k/$300k: ☐	$500K/$500k: ☐	$1M/$1M: ☐	$2M/$2M: ☐
Directors & Officers Liability	$300k/$300k: ☐	$500K/$500k: ☐	$1M/$1M: ☐	$2M/$2M: ☐
Are limits to be shared?	Yes: ☐	No: ☐		

PART V – EMPLOYMENT PRACTICES LIABILITY, IF APPLICABLE

Provide the total number of employees:

Full-time: ______ Part-time: ______ Temporary or Contract: ______ Volunteer: ______ Other: ______

Percentage of employees who are union: ______

In the past 12 months, how many employees left the Applicant's employment for reasons that were:

Voluntary: ______ Involuntary: ______ Laid off: ______

Do you conduct background checks on volunteers? N/A: ☐ Yes: ☐ No: ☐

Do the Applicant's employees (including owners, officers, partners, or shareholders) work in any other state? **If yes, please list other states.** Yes: ☐ No: ☐

Have more than 25% of the officers or management left the company (voluntary or terminated) within the past 18 months? **If yes, provide details on a separate page.** Yes: ☐ No: ☐

Does the Applicant anticipate layoffs, staff reductions, or facility changes in the next 12 months? **If yes, what percentage of the workforce will be affected?** Yes: ☐ No: ☐

Does the Applicant have a separate Human Resources Department? Yes: ☐ No: ☐

Does the Applicant publish and distribute an employee handbook to every employee? Yes: ☐ No: ☐

Does the Applicant have written procedures for handling employee grievances or complaints? Yes: ☐ No: ☐

PART VI – DIRECTORS AND OFFICERS, IF APPLICABLE

Number of directors: ______ Number of voting shareholders: ______ How many directors are also shareholders? ______

Do the Directors and Officers as a whole directly or indirectly own or control more than 50% of the Applicant's outstanding securities? Yes: ☐ No: ☐

Do the major shareholders (either individually or collectively) own any other healthcare-related organization or entity, including any provider of medical services, management/consulting services, etc? **If yes, provide details on a separate page.** Yes: ☐ No: ☐

Has the Applicant transacted or attempted a private debt or equity offering of securities within the last 18 months? **If yes, provide details on a separate page.** Yes: ☐ No: ☐

Does the Applicant anticipate any private debt or equity offering of securities in the next 18 months? **If yes, provide details on a separate page.** Yes: ☐ No: ☐

Does the Applicant anticipate any public offering of securities in the next 18 months? **If yes, provide details on a separate page.** Yes: ☐ No: ☐

Has the Applicant entered into a management services agreement with any entity? Yes: ☐ No: ☐

PART VII – CLAIMS HISTORY

Are there any circumstances known to your organization which may give rise to a claim or lawsuit? Yes: ☐ No: ☐

If *Yes*, give details below:

Date of Loss	Date Reported	Amount Paid	Status	Claimant name and/or Incident description (Attach separate sheet, if necessary.)

Please note that your POLICY will not cover, nor will PHYSICIANS INSURANCE be liable for, CLAIMS based upon, arising from, or in consequence of any EVENT, if written notice of, or constructive notice of, such EVENT has previously been given to another insurer that covers CLAIMS under any coverage section of which this AGREEMENT is a replacement, or if the INSURED has constructive notice of such an EVENT and fails to disclose the EVENT to PHYSICIANS INSURANCE.

PART VIII - REMARKS

THE FOLLOWING DOCUMENTS ARE REQUIRED TO BE SUBMITTED WITH THIS APPLICATION:

1. Most recent audited Financial Report
2. List of shareholders, along with percent ownership (if applying for D&O coverage)
3. Name of parent company and/or current list of Subsidiaries
4. Loss History with a valuation date within the past ninety days, with details of losses

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I, the undersigned, hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree to notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (READ CAREFULLY)

I, the undersigned, acknowledge that Physicians Insurance may, at its sole discretion, conduct an inquiry and investigation in connection with the information or disclosures provided in this application. I expressly consent to any such inquiry and investigation and hereby authorize, release, and discharge the providers of information, Physicians Insurance, and its duly authorized representatives from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives.

____ ________________________

Signature of Applicant (Owner or Officer) **Date**

____

Print Full Name

Washington State law requires us to inform you of the following: 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.

Oregon Fraud Statement: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be subject to prosecution for insurance fraud.

Idaho Fraud Statement: Any person who knowingly, with the intent to defraud or deceive an insurer, presents a false or fraudulent claim for payment of a loss or benefit is guilty of a felony.

Wyoming Fraud Statement: Any person who knowingly or willfully makes any false or fraudulent statement or representation in any application for insurance for the purpose of obtaining any money or benefit or presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

I understand that signature of this application does not bind the company to complete this insurance.
(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)