Physicians Insurance
A MUTUAL COMPANY

HEALTH CARE FACILITY APPLICATION

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers.

Corporation/Partnership Name (Please type):_____

Address:_____

City/State/Zip:_____ Telephone_____

Email:_____ Fax:_____

Taxpayer ID No:_____ Practice Administrator:_____

If applicable, please write Web site address related to your practice: _____

PLEASE INDICATE THE COVERAGE YOU ARE APPLYING FOR AND COMPLETE THE CORRESPONDING SECTION ON THE APPLICATION

Coverage:

A. ☐ HEALTH CARE FACILITY PROFESSIONAL LIABILITY
B. ☐ ADDITIONAL NAMED INSURED PROFESSIONAL LIABILITY

Are you converting from a Corporation/Partnership Policy? ☐ Yes ☐ No ☐ N/A

Section I: Underwriting And Rating Information

A.& B. Health Care Facility Professional Liability and Additional Insured Professional Liability

Please submit copy of current declarations page (if already insured by Physicians Insurance, this is not necessary).

Desired effective date:_____ Retroactive date:_____

1. The legal entity named above is:

a. ☐ Professional Service Corporation
b. ☐ Partnership
c. ☐ Other Corporation
d. ☐ Other (please describe)_____

_____

Years in business:_____ Organized in the state of:_____

Are any owners non-physicians? ☐ Yes ☐ No If "Yes," list names and percentage of ownership below.

Name **% of Ownership**

_____

_____

Are you affiliated with or do you anticipate forming alliances with any other clinics, practice associations or hospitals? ☐ Yes ☐ No

If "Yes," which other are you planning to associate with?

2. Describe the principal activity of this organization. (Give detailed description if other than usual specialty)

3. List all practice locations of the organization.

4. Does your Partnership/Corporation owns or operates any of the following?
   Surgery Center ☐ Yes ☐ No Extended Hours Walk-In Clinic ☐ Yes ☐ No
   Commercial Laboratory ☐ Yes ☐ No Sleep Laboratory ☐ Yes ☐ No
   If yes, indicate name and location of entities: _____
   If yes, are any of the above-marked entities staffed by physicians who are not members of your group? ☐ Yes ☐ No
   If yes, are any of these facilities **NOT** staffed by a physician? ☐ Yes ☐ No
   If no, please explain who staffs the facility: _____

5. Do you operate any practice activities under a name other than the partnership/corporation's? ☐ Yes ☐ No
   If yes, please provide names: _____

6. Name and policy number of previous insurer, if any (if already insured by Physicians Insurance, this is not necessary).

7. Desired Limits ☐ $1/5 million ☐ $2/6 million ☐ $3/7 million ☐ $4/8 million ☐ $5/9 million

8. List the names and medical specialties of the individual physicians who are stockholders, partners, employees, or independent contractors. Indicate if individual physicians are applying for coverage with the company and specify professional liability insurance limits. Attach an extra page if necessary.

Physician	Specialty	Insured by	Policy No.	Limits

9. Does your group have any contracts with individual physicians (other than those listed on the back page)? ☐ Yes ☐ No
   If yes, please list names and provide a copy of the contract: _____

10. Does your group employ (issue W-2s) any non-physicians: ☐ Yes ☐ No

11. Do you employ, subcontract with, supervise or sponsor any nurse anesthetists, nurse midwives, nurse practitioners, or registered physician assistants? ☐ Yes ☐ No

    If "Yes," list names, describe their specialties, attach copies of their credentials, indicate whether or not they have their own professional liability insurance coverage, and describe the nature of your professional relationship. Attach an extra page if necessary.

Name	Title	Insured by	Policy No.	Limits

12. For the past five years, please list all claims paid on behalf of, or suits brought against, the entity including employment-related claims (other than workers comp) and other general liability claims or suits. Attach an extra page if necessary.

13. If your group has five (5) or more member physicians, does your group participate in the Coordinated Quality Improvement Program (CQIP) with the Washington State Department of Health? ☐ Yes ☐ No

14. Does your group use an electronic medical record? ☐ Yes ☐ No

15. Does your group use a problem list in your charts? ☐ Yes ☐ No

16. Are allergies clearly documented in the medical charts? ☐ Yes ☐ No

17. Please describe your protocol for managing telephone calls from patients asking for advice:

18. What is your protocol for lab work?

19. Who is responsible for communicating results of lab work to patients?

20. Please list the major medical equipment you lease or own:

Do you have service agreements in place for each piece of equipment? ☐ Yes ☐ No

Section II: Current Policy Information (Complete if insured by company other than Physicians Insurance)

Name of Current Carrier:

Renewal Date: Policy No.:

Type of policy: ☐ Claims Made ☐ Occurrence

If Claims Made: Retroactive Date: ____/____/____

Current Limits of Liability $/$

Do you carry an excess policy? ☐ Yes ☐ No If "Yes," limits: $

REMARKS

AUTHORIZATION (Please Read Carefully)

The undersigned authorized Clinic Manager of the applicant declares that the statements set forth herein are true. The undersigned authorized Clinic Manager agrees that if the information supplied on this application changes between the date of this application and the effective date of coverage, he/she will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant nor the insurer to complete the insurance, but it is agreed that this shall be the basis of the contract should a policy be issued, and will be attached to and become a part of the policy.

Signature and title of clinic manager

Date

WARRANTY (Please Read Carefully)

We hereby represent and warrant the truth of all statements and reasons mentioned herein and that we have not withheld any information that is likely to influence the judgment of Physicians Insurance in considering this application for professional liability insurance. We agree to notify Physicians Insurance promptly of any change in the information contained in this application. We further agree to be bound by the underwriting guidelines of Physicians Insurance.

We understand that the submission of this application does not bind Physicians Insurance to issue an insurance policy, but it shall be the basis of the contract should a policy be issued.

Date:

By:

Signature of President/Partner

Clinic Manager, if authorized to act on behalf of
the organization in all capacities

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.