FAIRWAY PHYSICIANS INSURANCE COMPANY

A RISK RETENTION GROUP

APPLICATION INSTRUCTIONS

PROFESSIONAL PARTNERSHIPS/CORPORATION APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

In order to hasten your request for coverage and avoid any unnecessary delay, please complete all questions. If a question does not apply to your entity, mark "None" or "N/A" (Not Applicable). Do not leave any question unanswered! Please use separate paper for any additional comments, explanation or clarification if necessary.

Before submitting your application, please review this checklist to ensure the information below has been included. Missing information could delay the approval of your application.

- ☐ **Sign, initial and date the application where indicated. The company will not issue quotes for unsigned applications.**
- ☐ **Include a copy of your most recent professional liability declaration page and claims history with retroactive date.**
- ☐ **Complete the "Remarks" section for any questions requiring additional details.**
- ☐ **In addition to this application, every physician practicing with this partnership or corporation must complete an individual application for coverage, Physicians and Surgeons Application.**

If you need assistance with the application, please call (818) 889-7399 and ask to speak with a medical liability specialist.

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

PARTNERSHIPS/CORPORATION PROFESSIONAL LIABILITY INSURANCE APPLICATION

APPLICATION FOR PROFESSIONAL PARTNERSHIPS/CORPORATION FOR PROFESSIONAL LIABILITY INSURANCE
(CLAIMS MADE BASIS)

APPLICANT INSTRUCTIONS:

1. Indicate your requested effective date of coverage: ______ / ______ / ______
2. Please type or print. Answer all questions. If the answer requires detail, please attach a separate sheet.
4. Application must be signed and dated by owner, partner or officer.
5. Please complete application at least **45 days** before the proposed effective date.
6. Please carefully read the statements at the end of this application.

I. GENERAL INFORMATION

Check one: The Applicant Entity is a ☐ Partnership ☐ Corporation (More Than One Shareholder)

1. **Exact Name of Professional Partnership/Corporation** ______________________
2. **Primary Office Address** ______________________
   City ______________________ State __________ Zip __________
   ☐ Leased / Rented ☐ Owned Approximate Square Footage __________
3. **Phone Number** (   ) __________ **Fax Number** (   ) __________
4. **E-Mail Address** ______________________ 5. **IRS Tax No.** __________
6. **Secondary Office Address** ______________________
   City ______________________ State __________ Zip __________
   ☐ Leased / Rented ☐ Owned Approximate Square Footage __________

   LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 5.
7. **Name of President / Senior Partner** ______________________
8. **Name of Business Manager / Administrator** ______________________

II. ENTITY INFORMATION

1. **Does the partnership/corporation currently have a separate professional liability insurance policy?** ☐ YES ☐ NO
2. **List all previous professional liability carriers for the last 5 years, <u>beginning with your current carrier first</u>.** If none, state 'None.'

INSURANCE CARRIER	LIMITS OF LIABILITY (i.e. $1M/$3M)	PREMIUM	POLICY PERIOD	
			FROM	TO
	/	$	/ /	/ /
	/	$	/ /	/ /
	/	$	/ /	/ /
	/	$	/ /	/ /

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II. ENTITY INFORMATION (CONTINUED)

3. Date partnership/corporation was formed ______ / ______ / ______

4. Does the partnership/corporation have a currently effective Certificate of Registration as a professional partnership/corporation under the Business and Professions Code of the applicable jurisdiction? ☐ YES ☐ NO

5. List the names of all partners (partnership) or shareholders (corporation) and all physicians who are salaried employees of the entity:

NAME	PROFESSIONAL LIABILITY INSURANCE COMPANY	POLICY NUMBER	SOCIAL SECURITY NUMBER	OWNER
			- -	YES / NO
			- -	YES / NO
			- -	YES / NO
			- -	YES / NO
			- -	YES / NO
			- -	YES / NO

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REMARKS SECTION, PAGE 5.

6. List the names of all physicians who provide services to the entity as independent contractors:

NAME	PROFESSIONAL TITLE / DUTIES	PROFESSIONAL LIABILITY INSURANCE COMPANY

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE REMARKS SECTION, PAGE 5.

7. If the entity is a corporation, list the following:

a. Names of all Directors:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

b. Names of all Officers:

President ______________________ Secretary ______________________

Vice President ______________________ Treasurer ______________________

Other ______________________

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II. ENTITY INFORMATION (CONTINUED)

1. Healthcare Professionals

The Company charges an additional premium for Physician Assistants and Nurse Practitioners and may charge an additional premium as a condition to coverage for all other healthcare professionals. In addition, the Company may decline to approve a healthcare professional. The approval or declination action will be in accordance with the Company then-current rules, rates and rating plans.

a. List healthcare professionals who provide services at any of the entity's facilities or offices as salaried employees of the partnership/corporation:

NAME	PROFESSIONAL TITLE / DUTIES

b. List healthcare professionals who provide services at any of the entity's facilities or offices as independent contractors of the partnership/corporation:

NAME	PROFESSIONAL TITLE / DUTIES	PROFESSIONAL LIABILITY INSURANCE COMPANY

c. Indicate the number of the following types of individuals who provide services in the entity's office:

HEALTHCARE PROFESSIONAL	NUMBER	HEALTHCARE PROFESSIONAL	NUMBER
Administrative Personnel		Physician Assistant	
Medical Assistant		Technician (Dialysis, Lab, Pathological)	
Nurse (Registered or Licensed Vocational)		Technician (X-Ray, Radium)	
Licensed Nurse Anesthetist		Other: ___________________________________	
Nurse Practitioner		Other: ___________________________________	

Attach a copy of the Physician Assistant's license and the Nurse Practitioner's license to this application.

Each Licensed Nurse Anesthetist, Physician Assistant and Nurse Practitioner who is an employee of the partnership/corporation must complete an individual application for Professional Liability Coverage, Physicians and Surgeons Application.

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III. MISCELLANEOUS INFORMATION

1. **Does the partnership/corporation maintain an outpatient surgical facility?** q YES q NO

   If YES, does the partnership/corporation currently have a separate professional liability insurance policy for the surgical facility? q YES q NO

   Name of Carrier ____________________ Policy Number ____________________

2. **Has any insurance company canceled, declined coverage, modified (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any similar partnership/corporation insurance?** q YES q NO

   If **YES**, describe, giving company name and policy number in Remarks Section, Page 5.

3. **Has the partnership/corporation ever been investigated by the State Board of Medical Examiners and/or the State Licensing Authority, Narcotics Bureau, State Board of Dental Examiners, or other governmental agency?** q YES q NO

   If **YES**, describe in Remarks Section, Page 7, and forward a copy of any formal accusation or decision.

4. **Has a claim or suit for any alleged malpractice and/or business liability ever been made or brought against the partnership/corporation in the past ten (10) years?** q YES q NO

   If **YES**, complete a Claim Information Sheet for each claim (Page 6).

5. **Does the partnership/corporation manufacture, sell or distribute any drug, pharmaceutical or medical device or other product to persons other than its patients or patients of its physician members?** q YES q NO

   If **YES**, describe the product or the activities of the partnership/corporation in connection with the product in the Remarks Section, Page 5.

6. **Does the partnership/corporation own any other corporation or is the partnership/ corporation under common ownership or the control of any subsidiary corporation?** q YES q NO

   If **YES**, describe ownership and activities of the partnership in the Remarks Section.

7. **Is the partnership/corporation a party to any joint venture agreement or any other contract under which professional or business activities are or will be conducted in conjunction with any other person or partnership/corporation?** q YES q NO

   If **YES**, describe the agreement and activities in the Remarks Section.

8. **Does any facility of the partnership/corporation conduct treatment, storage or disposal of hazardous wastes on-site or in a matter which requires a permit under either federal or state hazardous waste control laws?** q YES q NO

9. **Has any facility of the partnership/corporation ever been alleged to be in non-compliance with the substantive or procedural requirements of either federal or state hazardous waste control laws?** q YES q NO

   If **YES**, please describe each such allegation and its resolution in the Remarks Section.

10. **Has the partnership/corporation been named as a defendant in any administrative or judicial proceeding in which it is alleged that the company is liable for response costs incurred or natural resource damages arising from the actual or threatened release of hazardous substances?** q YES q NO

    If **YES**, please describe each such proceeding and the allegations made against the partnership/corporation in Remarks.

11. **Please attach a copy of the partnership/corporation's letterhead.**

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IV. REMARKS SECTION

Please attach separate sheets as needed and indicate the Question Number(s) referred to.

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V. CLAIMS INFORMATION

PLEASE COPY THIS PAGE FOR ALL ADDITIONAL CLAIMS YOU ARE REPORTING TO FPIC.

NOTE: This **Claims Information Form** pertains to lawsuits, claims or demands for arbitration or incidents which could lead to claims. A claims form must be completed for each lawsuit, claim, demand for arbitration or incident. Sufficient information must be provided to evaluate the medical aspects of the case specifically relating to the physician's involvement.

1. **Patient's Name:** ______________________ 2. **Age:** _____ 3. **Sex (M/F):** _____
4. **Your relationship to patient** (i.e. Attending Physician, Primary Surgeon, Assistant Surgeon, etc):
____
5. **Date of Incident:** ___/___/___ 6. **Location:** ______________________
7. **Insurance Carrier:** ______________________ 8. **Other Defendants:** ______________________
9. **Present Status:** ☐ OPEN ☐ CLOSED ___/___/___ DATE

☐ INCIDENT ONLY ☐ 90-DAY NOTICE ☐ SUIT FILED ☐ SUIT SERVED ☐ ARBITRATION

Method of Closing: ☐ DISMISSED ☐ DEFENSE VERDICT

☐ SETTLED AMOUNT PAID ON YOUR BEHALF: $ ________ TOTAL SETTLEMENT: $ ________

☐ JUDGMENT AMOUNT PAID ON YOUR BEHALF: $ ________ TOTAL SETTLEMENT: $ ________

The following questions should be answered in explicit clinical detail to allow proper evaluation by the FPIC Underwriting Department. Attach additional sheets as required.

10. **Patient's allegations or circumstances brought to your attention:** ______________________
11. **Condition and diagnosis at time of incident:** ______________________
12. **Dates and description of treatment rendered:** ______________________
13. **Condition of patient subsequent to treatment (and dates of follow-up treatment):** ______________________

I understand information submitted herein becomes part of the FPIC's Named Insured's records and part of the Professional Partnerships/Corporation Application as submitted.

___/___/___ DATE

______________________ APPLICANT NAME (PLEASE PRINT)

______________________ SIGNATURE

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VI. RETROACTIVE COVERAGE

The following questions refer to your application for retroactive coverage (i.e. "Prior Acts" or "Nose Coverage") with Fairway Physicians Insurance Company ("FPIC").

If you are approved for retroactive coverage, you will receive a certificate of coverage with a specified retroactive coverage date. Thereafter and subject to the terms, conditions and exclusions of the Fairway Physicians Insurance Company policy, you will be entitled to claims defense and claims payment services described in your policy with FPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences subsequent to the retroactive date indicated in your certificate of insurance with FPIC.

Retroactive coverage is only available from FPIC to those physicians who have maintained continuous and uninterrupted "Claims-Made" medical professional liability coverage up to the commencement date of their coverage with FPIC.

Whether or not you believe you were at fault:

1. **Are you aware of any incidents resulting in injury or death to a patient where your professional services were utilized** (e.g. Attending Physician, Assistant, Consultative, etc? ☐ YES ☐ NO

2. **Are you, your employees or associates aware of any threats or complaints that could lead to legal action against you or your medical practice?** ☐ YES ☐ NO

   If **Yes**, please indicate the number of threats or complaints and describe below (use separate paper if necessary):

   ____

   ____

3. **Have you ever been the subject of a deposition or subpoena as a result of medical services provided by you on behalf of a patient** (other than as an expert witness, but including consultative services)? ☐ YES ☐ NO

OBLIGATION OF DISCLOSURE

California law requires you to disclose to Fairway Physicians Insurance Company ("FPIC") any information known to you that would influence FPIC's decision to approve your application for coverage, including the information you provided in this claims section. You also have an obligation to inform FPIC of any information that becomes known to you between the date of your signature below and the effective date of coverage with FPIC that could alter your previous response to the claims information requested herein. You are advised to notify FPIC of any additional information not previously disclosed in your application for coverage.

☐ **YES**, I request retroactive coverage from FPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences in California and subsequent to my retroactive coverage date with FPIC.

I represent and warrant that I will maintain my current professional liability coverage up to the commencement date of my membership with Fairway Physicians Insurance Company. I make this representation with the understanding that should any future investigation reveal that I did not maintain continuous claims-made professional liability coverage, FPIC may deny all claims defense and claims payment services for any claim arising out of professional services that I rendered to patients during the retroactive coverage period.

I also make this representation with the understanding that my failure to meet my obligation of disclosure may result in the termination of my policy with FPIC and the loss of all claims defense and claims payment services.

Requested Retroactive Date*: ______ / ______ / ______
MM DD YYYY

***The partnership/corporation has been continuously insured for professional liability coverage under a claims made and reported policy since this date.**

☐ **NO**, I decline retroactive coverage from FPIC.

This application for Retroactive Coverage is deemed part of your Application for Membership in FPIC and is incorporated by this reference into the FPIC policy.

I declare under penalty of perjury that the foregoing is true and correct. Executed this ____________ of
DAY

______________, 200____ in ______________, __________, by ____________________________.
MONTH YR CITY STATE SIGNATURE

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VII. APPLICANT RETROACTIVE COVERAGE (CONTINUED)

DISCLOSURES

REPRESENTATIONS AND WARRANTIES: I hereby warrant the truth of all statements and answers contained in this application. I have not withheld any facts about my professional practice which are reasonably calculated to or may influence the judgment of Fairway Physicians Insurance Company in considering this application. I understand that if I have withheld any material facts concerning the risk exposure of my professional practice and FPIC is made aware of my lack of disclosure, I will have no coverage for any claims that may arise due to my lack of disclosure and my coverage with FPIC may be declined. I agree to notify FPIC in a timely manner of any change to my practice or to the information regarding an open claim or incident as it becomes available to me. I acknowledge that coverage through FPIC is governed by the terms of my FPIC policy. I agree that upon FPIC's acceptance of my application, my execution of the insurance agreement and the initiation of payments of my insurance premium, I will be deemed to have professional liability coverage by Fairway Physicians Insurance Company. I understand that my execution of this application does not bind FPIC to admit me as a member in FPIC, nor does it bind me to become a member of FPIC, if accepted. In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons by FPIC concerning my application for coverage. I further understand that my membership and my professional liability coverage does not become effective until my application has been accepted by FPIC and payments for coverage have been received.

ARBITRATION: I agree that any dispute or controversy arising out of or in connection with this application shall be submitted to, determined and resolved by, binding arbitration in Los Angeles, California before three (3) arbitrators. The arbitration shall be conducted pursuant to my underwriting policy.

REFERENCES: I authorize and direct any individual, government agency, medical society, physician, hospital, insurance agent or company representative to furnish information concerning me or my medical practice which FPIC may require. This authority extends to the release of information regarding professional liability coverage and claims. I also agree that any person or organization, together with the officers, directors and agents, will not be liable in any way for furnishing such information even though the information may be incomplete or incorrect.

Should I employ the services of an insurance broker/consultant through FPIC to assist me in securing professional liability coverage, I hereby authorize FPIC to release any and all necessary information to such individuals or agency/organizations.

______________________	______________________	___/___/___
NAME OF APPLICANT (PLEASE PRINT)	SIGNATURE	DATE

VIII. COVERAGE INFORMATION

1. **Requested Effective Date:** ___/___/___ **Requested Retroactive Date:** ___/___/___

IMPORTANT: The Declarations Page of your current policy must be attached if a retroactive date is requested. The company may not provide requested dates.

2. **Policy Limits:** $1,000,000 EACH CLAIM / $3,000,000 POLICY AGGREGATE

Physicians must carry the same limits of coverage as the partnership/corporation.

Coverage is solely as stated in your FPIC policy, and provided on a "*Claims-Made*" basis for **those claims first reported (i.e. "Tail Coverage") against the insured during the policy period** unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I warrant to FPIC my understanding and acceptance of the notice stated above and that the information contained herein is true and shall be inclusive of the basis of the policy of insurance and deemed incorporated therein, should the insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of all claims information from any prior insurer to Fairway Physicians Insurance Company.**

____
NAME OF APPLICANT (PLEASE PRINT)

______________________	___/___/___
SIGNATURE	DATE

Signing this application does not bind the applicant or the insurer or the underwriting manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.