

ATTN: UNDERWRITING DIVISION

Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
www.ismie.com

Processing Number _____

Application for Partnership/Corporation -or- Clinic Option Professional Liability Insurance

Claims-Made

“A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations Page, and as defined in the policy.”

Instructions: It is essential that all statements be completed and all questions answered. If the answer to any question is “no”, be certain to check **no** on the Application. **Please do not leave any question unanswered. If additional space is required to answer any question, use the “Remarks Addendum” section.**

INDICATE TYPE OF POLICY DESIRED:

A. **PARTNERSHIP/CORPORATION POLICY** Traditional entity coverage.

B. **CLINIC OPTION POLICY** A coverage alternative for corporations, partnerships or other legal entities with 2 or more physicians. The ISMIE Mutual Clinic Option covers each physician as an additional named insured on a single policy form, eliminating the need for multiple bills and statements. Only the Clinic Option is available with unique shared aggregate limits of liability.

1. Partnership/Corporation or Clinic Name:

2. Desired effective date of coverage (12:01 a.m. Standard Time):

_____/_____/_____
Month Day Year

3. Desired retroactive date for prior acts (nose coverage) only (12:01 a.m. Standard Time):

_____/_____/_____
Month Day Year

Partnership/Corporation/Clinic General Information

4. Mailing Address:

Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____ Telephone: () - _____

Fax: () - _____ E-mail Address: _____

5. Billing Address: Same as #4

Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____ Telephone: () - _____

Fax: () - _____ E-mail Address: _____

6. Name of President/Partner: _____

7. Name of Business Manager/Administrator: _____

8. The legal entity applying for coverage is a:

- | | |
|--|--|
| <input type="checkbox"/> Partnership
(Submit a copy of the partnership agreement) | <input type="checkbox"/> Limited Liability Company
(Submit a copy of State Issued Organizational Documents) |
| <input type="checkbox"/> Multi-Shareholder Corporation
(Submit a copy of State issued Organizational Documents) | <input type="checkbox"/> Sole Shareholder of Medical Corporation
(Submit a copy of State Issued Organizational Documents) |
| <input type="checkbox"/> Other (Describe)
_____ | |

9. Federal Tax Identification Number: _____

10. Does the Partnership/ Corporation/ Clinic operate under any other names (d.b.a. "doing business as")?

YES ___ NO ___

If Yes, please list all "doing business as" names of the Partnership/Corporation/ Clinic:

1.
2.
3.
4.

11. Previous Insurance Carriers - Last ten years*:

Please indicate in chronological order, most recent first.

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

*It is necessary that you obtain a current Loss History from each carrier listed above. (See Claim History letter included with this packet)

12. Please provide total Group premiums paid, by year, for the last ten years.

<u>Year</u>	<u>Annual Premium</u>
1. Current Year	\$ _____
2.	\$ _____
3.	\$ _____
4.	\$ _____
5.	\$ _____
6.	\$ _____
7.	\$ _____
8.	\$ _____
9.	\$ _____
10.	\$ _____

13. Have any malpractice claims or suits been brought against your entity within the past ten (10) years?

Yes No

If "Yes", please provide the following:

- Brief description of each claim (Use Claim Information Supplement included in application)
- Reserves on pending claims (both indemnity and expense)
- Payments on any closed claim/suit (both indemnity and expense)
- Complete copies of all office/hospital medical records and summons and complaint.

14. **Limits of Liability** (Please skip this section if your entity is domiciled in a state with a Patient’s Compensation Fund.)

The offering of the following policy limits by ISMIE Mutual should not be deemed to express or imply that any particular policy limit is or is not adequate for an insured. It is the sole responsibility of each insured to select an appropriate limit of coverage.

A. Limits of Liability: Corporation/ Partnership Only – Not applicable for Clinic Option

- \$500,000/\$1,500,000 “each person”/ “aggregate”
 \$1,000,000/\$3,000,000 “each person”/ “aggregate”
 \$2,000,000/\$4,000,000 “each person”/ “aggregate”

B. Limits of Liability: Clinic Option Only – Not applicable for Corporation/Partnership

<u>“Each Person” Limit</u>	<u># of Exposures*</u>	<u>Aggregate Limit</u>	
		<u>\$1M</u>	<u>\$2M</u>
	2	5M	6M
<input type="checkbox"/> \$1 million each person	3	8M	10M
	4	10M	12M
<input type="checkbox"/> \$2 million each person	5	15M	16M
	6	16M	18M
	7	18M	22M
	8	20M	24M
	9	22M	28M
	10-19	25M	30M
	20-39	40M	45M
	40-59	55M	60M
	60-79	70M	75M
	80-99**	85M	90M

*Includes legal entity and each physician affiliate.

**For each additional 20 physicians insured, increase the aggregate by \$15M.

Increased aggregate limits may be purchased. For each additional limit, an additional premium of 1% of the aggregate physician and Allied Health Professional premiums will be charged.

Partnership/Corporation /Clinic Census

17. Please provide census information on physicians who are partners, shareholders, officers, directors, employees or independent contractors. If additional space is required to complete this question, use "Remarks Addendum" section.

Codes: 01-Partner 02-Shareholder 03-Officer 04-Director 05-Employee 06-Independent Contractor

Code	Physician Name	Insurance Carrier	Limits of Liability	Policy Number	Specialty
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
21)					
22)					
23)					
24)					
25)					
26)					

18. Allied Health Personnel

Please provide census information on your employed Allied Health Personnel.

Coverage for the following Allied Health Personnel are offered on either a Shared or Separate Limit basis for an additional charge. A separate application is required, and is available on our website- www.ismie.com.

	Total		Total
A. Certified Registered Nurse Anesthetist	_____	H. Physician Assistant	_____
B. Certified Clinical Nurse Specialist	_____	I. Psychologist / Psychotherapist	_____
C. Certified Nurse-Midwife	_____	J. Social Worker	_____
D. Certified Nurse Practitioner	_____	K. Surgical Assistant	_____
E. Dialysis Technician	_____	L. Other (Specify Below)	
F. Obstetrical Nurse (other than Nurse Midwife)	_____	_____	_____
G. Orthopaedic Technician/Nurse	_____	_____	_____

Coverage for the following Licensed Health Care Professionals is only offered on Separate Limit basis for an additional charge. A separate application is required, and is available on our website- www.ismie.com.

	Total		Total
M. Chiropractor	_____	P. Podiatrist	_____
N. Dentist	_____	Q. Pharmacist	_____
O. Optometrist	_____		_____

Note: Coverage for all Licensed Health Care Professionals is limited to the scope of employment and services rendered on behalf of the ISMIE Mutual insured Physician, Corporation/Partnership or Clinic.

19. Practice Information

List all current Office/Outpatient Practice Locations in this section. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please indicate additional locations on the "Remarks Addendum" section. Please include facility code(s) to identify all that are applicable.

Facility Codes (Please indicate all that apply)	06- Nursing Home/Extended Care Facility	12-Weight Reduction Clinic
01- Physician Office	07-HMO, IPA, PPO	13-Pharmacy
02- Hospital	08-Urgent Care Center	14-Abortion Clinic
03- Extended Hour Walk-In Clinic	09-Clinic with overnight stays	15-Drug Control Clinic
04- Surgicenter	10-Industrial Clinic	16-Commercial Laboratory
05- Day Spa / Medi-Spa	11- Government Location	17-Other

<p>A. Office Name: _____</p> <p>Facility Code: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____</p> <p>Is this the group's primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Distance to Hospital: Miles _____ Minutes _____</p> <p>Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance. _____</p>	<p>Is ISMIE Mutual Insurance desired for this location?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "No," describe activity not to be covered and state by whom insured:</p> <p>_____</p> <p>Name of Office Manager/Administrator (if other than listed in question 7)</p> <p>_____</p>
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<p>B. Office Name: _____</p> <p>Facility Code: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____</p> <p>Is this the group's primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Distance to Hospital: Miles _____ Minutes _____</p> <p>Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance. _____</p>	<p>Is ISMIE Mutual Insurance desired for this location?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "No," describe activity not to be covered and state by whom insured:</p> <p>_____</p> <p>Name of Office Manager/Administrator (if other than listed in question 7)</p> <p>_____</p>
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19. Practice Information (continued)

Facility Codes (Please indicate all that Apply)

01- Physician Office

02- Hospital

03- Extended Hour Walk-In Clinic

04- Surgicenter

05- Day Spa / Medi-Spa

06- Nursing Home/Extended Care Facility

07-HMO, IPA, PPO

08-Urgent Care Center

09-Clinic with overnight stays

10-Industrial Clinic

11- Government Location

12-Weight Reduction Clinic

13-Pharmacy

14-Abortion Clinic

15-Drug Control Clinic

16-Commercial Laboratory

17-Other

C. Office Name: _____	Is ISMIE Mutual Insurance desired for this location?
Facility Code: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Address: _____	If "No," describe activity not to be covered and state by whom insured:
Suite/Room Number: _____	_____
City, State, Zip: _____	_____
County: _____ Telephone: _____	Name of Office Manager/Administrator (if other than listed in question 7)
Is this the group's primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Distance to Hospital: Miles _____ Minutes _____	_____
Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.	_____

D. Office Name: _____	Is ISMIE Mutual Insurance desired for this location?
Facility Code: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Address: _____	If "No," describe activity not to be covered and state by whom insured:
Suite/Room Number: _____	_____
City, State, Zip: _____	_____
County: _____ Telephone: _____	Name of Office Manager/Administrator (if other than listed in question 7)
Is this the group's primary office location? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Distance to Hospital: Miles _____ Minutes _____	_____
Do you own or operate a Pharmacy at this location? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.	_____

20. Do your physicians maintain hospital privileges at one or more facilities? Yes No
 If yes, please complete section A and B (please copy this page for additional hospital locations)
 If your physicians do not maintain hospital privileges, please explain in the "Remarks Addendum" section.

<p>A. Hospital Name: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____ Fax: _____</p> <p>Category of privileges (active, consulting, etc.) _____</p> <p>Specialty department of: _____</p> <p>Do your physicians staff the ER at this hospital other than to maintain hospital privileges? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", average number of hours weekly: _____</p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "no," describe activity not to be covered and state by whom insured: _____</p> <p>Is this your group's primary hospital location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do your physician's teach at this hospital? Yes <input type="checkbox"/> Classroom <input type="checkbox"/> Clinical <input type="checkbox"/></p> <p>Is this location a Nursing Home or Extended Care Facility? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<p>B. Hospital Name: _____</p> <p>Address: _____</p> <p>Suite/Room Number: _____</p> <p>City, State, Zip: _____</p> <p>County: _____ Telephone: _____ Fax: _____</p> <p>Category of privileges (active, consulting, etc.) _____</p> <p>Specialty department of: _____</p> <p>Do your physicians staff the ER at this hospital other than to maintain hospital privileges? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "Yes", average number of hours weekly: _____</p>	<p>Is ISMIE Mutual Insurance desired for this location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If "no," describe activity not to be covered and state by whom insured: _____</p> <p>Is this your group's primary hospital location? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do your physician's teach at this hospital? Yes <input type="checkbox"/> Classroom <input type="checkbox"/> Clinical <input type="checkbox"/></p> <p>Is this location a Nursing Home or Extended Care Facility? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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Certificate(s) of Insurance

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED.

21. If your insurance request is accepted, as a service to its insureds ISMIE Mutual can provide evidence of your coverage on an automated basis to a hospital, employer, etc. by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a hospital or other health care institution on your behalf, complete the following:

A. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

Medical Director Administrator
 Medical Staff Office Other _____

Specific Policy Limits will be printed on Certificate.

B. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

Medical Director Administrator
 Medical Staff Office Other _____

Specific Policy Limits will be printed on Certificate.

C. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

Medical Director Administrator
 Medical Staff Office Other _____

Specific Policy Limits will be printed on Certificate.

D. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

Medical Director Administrator
 Medical Staff Office Other _____

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

Partnership/Corporation or Clinic Name
(please print)

Signature of President/Partner or
Authorized Person

Date

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and Illinois State Medical Insurance Services, Inc. (ISMIS) shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability 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 ISMIE Mutual or its duly authorized representative. I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer.

Partnership/Corporation or Clinic Name
(please print)

Signature of President/Partner or
Authorized Person

Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor to offer insurance to the applicant.

A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original.

Insurance Agent/Producer/Broker (please print)

Signature

Date

Claim Information Supplement (please print). In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant

Name _____ Age _____ Sex _____

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? Yes No If "Yes", state when _____ / _____
Month Year

4. Name of insurance carrier defending you: _____

5. Policy Number. _____

6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

7. Disposition or current status of claim or suit:

Open - Indicate case value established by carrier \$ _____

Closed-With no payment made Date _____

Closed-With payment made. Indicate amount of settlement or award:

- Has carrier indicated desire to settle?

Yes No

a. Your policy \$ _____ Date _____

b. Total (if additional defendants involved) \$ _____

-----NEXT CLAIM-----

1. Patient/Claimant

Name _____ Age _____ Sex _____

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? Yes No If "Yes", state when _____ / _____
Month Year

4. Name of insurance carrier defending you: _____

5. Policy Number. _____

6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

7. Disposition or current status of claim or suit:

Open - Indicate case value established by carrier \$ _____

Closed-With no payment made Date _____

Closed-With payment made. Indicate amount of settlement or award:

- Has carrier indicated desire to settle?

Yes No

a. Your policy \$ _____ Date _____

b. Total (if additional defendants involved) \$ _____

