OneBeacon
PROFESSIONAL INSURANCE®

877.701.0171 t | 888.777.3719 f
199 Scott Swamp Road, Farmington, CT 06032

onebeaconpro.com

Homeland Insurance Company of New York | Homeland Insurance Company of Delaware
(Stock companies owned by the OneBeacon Insurance Group)
(hereinafter referred to as the "Underwriter")

Application

PHYSICIANS PROFESSIONAL LIABILITY RETROACTIVE INSURANCE

THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDES CLAIMS MADE AND REPORTED COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. READ THE POLICY AND THIS APPLICATION CAREFULLY AND CONTACT YOUR PRODUCER WITH ANY QUESTIONS.

For the purposes of this Application, "Retroactive Period" means the period of time requested in question 14 of this Application, during which a "Professional Services Wrongful Act" must be committed or allegedly committed.

Instructions:

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.

- Applicant's curriculum vitae (CV)
- Applicant's current medical professional liability policy
- Currently valued carrier loss runs for the previous seven (7) years

A. ACCOUNT INFORMATION

1. Applicant Name			
2. Date of Birth		3. Federal DEA Number	
4. Mailing Address	Street:		
	City:	State:	County: Zip:
	Telephone Number:	Email Address:	

5. List all locations where the Applicant practiced during the requested "Retroactive Period:"
(please attach a separate sheet for additional locations)

a. Practice Name: _____ Period: _____

Practice Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Telephone Number: _____ Website Address: _____ Email Address: _____

b. Practice Name: _____ Period: _____

Practice Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Telephone Number: _____ Website Address: _____ Email Address: _____

c. Practice Name: _____ Period: _____

Practice Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Telephone Number: _____ Website Address: _____ Email Address: _____

6. Practice Type:

Check all applicable types of practice during the requested "Retroactive Period:"

- ☐ Employed physician
- ☐ Solo physician
- ☐ Partnership
- ☐ Independent contractor
- ☐ Professional corporation
- ☐ Other: _____

7. Applicant's current specialty: _____ Practice %: _____

Applicant's current sub-specialty: _____ Practice %: _____

8. Did the Applicant's specialty and/or types of procedures performed change during the requested "Retroactive Period?" ☐ Yes ☐ No

If "Yes," please explain:

9. Did the Applicant performed any procedure that is outside the practice of his/her specialty or sub-specialty during the requested "Retroactive Period?" ☐ Yes ☐ No

If "Yes," please explain:

10. Is the Applicant board eligible or board certified? ☐ Yes ☐ No

If "Yes," please provide the name of the board, the date of certification and the expiration date of certification:

_____

If "No," please explain: _____

11. Please provide the following information regarding the Applicant's medical education and training:

a. Medical school

Name of school: _____ City: _____ State: _____

Year graduated: _____ Degree: _____

b. Internship

Name of school: _____ City: _____ State: _____

From: _____ To: _____

c. Residency

Name of hospital: _____ City: _____ State: _____

Year completed: _____ Specialty: _____

12. Is the Applicant a foreign medical school graduate? ☐ Yes ☐ No

If "Yes," please provide all information pertinent to the Applicant's ECFMG certification: _____

B. CURRENT AND REQUESTED COVERAGE - Please note that requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

13. Briefly describe the reason(s) why the requested coverage is needed:

_____

14. Retroactive period: From: _____ To: _____

15. Requested effective date of coverage: _____

16. Duration of coverage: ☐ 1 Year ☐ 3 Years ☐ 5 Years ☐ 7 Years ☐ Unlimited ☐ Other: _____

17. Limits requested: Each claim: _____ Aggregate: _____

18. Limit structure requested:

☐ Limits for insured physician only

☐ Separate limits for insured physician and separate limits for insured entity (if applicable)

☐ Shared limits for insured physician and insured entity (if applicable)

Note: In all cases, any non-physician insureds share in the insured physician or insured entity limits, as applicable, unless otherwise scheduled.

Separate limits may be subject to a policy maximum aggregate limit.

19. Deductible requested: Each claim: _____ Aggregate: _____

20. **MISSOURI RESIDENTS - DO NOT ANSWER THIS QUESTION**. Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant? ☐ Yes ☐ No

If "Yes," please provide details:

21. Does the Applicant's current medical professional liability policy allow the Applicant to report known facts, circumstances, situations, transactions, events, acts, errors or omissions that could give rise to a claim that would fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "No," please explain: _____

22. List current and previous medical professional liability policies for the past seven (7) years:

Insurance Carrier	Policy Period MM/DD/YY – MM/DD-YY	Limits	Ded/SIR	Retroactive Date	Premium

C. PRACTICE INFORMATION

23. Has the Applicant or any individual or entity proposed for coverage under this insurance ever:

a. Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐ Yes ☐ No

b. Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐ Yes ☐ No

c. Been treated for any alcohol, narcotics or substance abuse? ☐ Yes ☐ No

d. Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐ Yes ☐ No

e. Had hospital privileges reduced, suspended or revoked? ☐ Yes ☐ No

f. Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐ Yes ☐ No

If "Yes" to any of the above, please explain:

24. List all states where the Applicant is licensed to practice and the applicable license number and status:

State: _____ License number: _____ ☐ Active ☐ Inactive

State: _____ License number: _____ ☐ Active ☐ Inactive

State: _____ License number: _____ ☐ Active ☐ Inactive

State: _____ License number: _____ ☐ Active ☐ Inactive

25. During the requested "retroactive period," did the Applicant work part-time? ☐ Yes ☐ No

If "Yes," please explain:

26. Did the Applicant's practice during the requested "Retroactive Period" include the following?

☐ No surgery ☐ Minor surgery (including minor invasive procedures) ☐ Major surgery

27. Did the Applicant's practice during the requested "Retroactive Period" include any of the following:

If "Yes," please provide the percentage of practice where applicable.

a. Obstetrics? ☐ Yes ☐ No _____ % of practice

b. Weight loss/bariatric surgery? ☐ Yes ☐ No _____ % of practice

c. Pediatrics? ☐ Yes ☐ No _____ % of practice

d. Cosmetic surgery? ☐ Yes ☐ No _____ % of practice

e. Services for any professional sports organizations? ☐ Yes ☐ No _____ % of practice

If "Yes" to any of the above, please explain:

28. Within the requested "Retroactive Period," did the Applicant use any locum tenens physicians? ☐ Yes ☐ No

If "Yes," please explain:

29. During the requested "Retroactive Period," did the Applicant own, operate or control any specialized medically related unit including, but not limited to, a pharmacy, laboratory, physical therapy center or surgery center? ☐ Yes ☐ No

If "Yes," please explain:

30. Allied Health Care Providers:

Please provide the number of healthcare professionals described below who were employed by or worked under the control of the Applicant during the requested "Retroactive Period:"

_____ Certified registered nurse anesthetists

_____ Physician assistants

_____ Nurse practitioners

_____ Physical/occupational therapists

_____ Surgical assistants

_____ Psychologists

_____ Registered nurses/licensed practical nurses

_____ Other (describe): _____

D. CLAIMS HISTORY

31. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide a completed Physician Claim Supplement for each such claim.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 31 IS EXCLUDED FROM THE PROPOSED INSURANCE.

32. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such entity, or any such individual has reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please attach details for this Application.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 32 IS EXCLUDED FROM THE PROPOSED INSURANCE.

E. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or 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.

ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 APPLICANTS: 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 APPLICANTS: 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 APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any 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, NEW MEXICO AND RHODE ISLAND APPLICANTS: 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 civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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 a denial of insurance benefits.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA APPLICANTS: 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 AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA APPLICANTS: 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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

F. SIGNATURE AND AUTHORIZATION

The undersigned declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application and the application submitted by the Applicant Entity is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance upon this Application and the application submitted by the Applicant Entity, and this Application and the application submitted by the Applicant Entity will be the basis of the contract.

The Underwriter will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind you or the Underwriter to complete the insurance or issue a policy. The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

NEW YORK APPLICANTS: 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.

Applicant Signature		
Print Name		Date

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:
Email Address	

Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.