capson Physicians Insurance

Group / First Named Insured
Application for Professional Liability Coverage

Type of coverage: Medical Professional Liability

Group Name / First Named Insured (FNI)

Primary Contact: _____ Primary Contact Title: _____

Contact Email Address: _____ Primary Contact Phone: _____

Office Website: _____

Federal Employer Identification Number: _____

Practice Address: _____

City State Zip

Primary Practice State: _____ Primary Practice County: _____

Effective Date: _____ Retroactive Date: _____
(Claims Made only)

Current Carrier: _____ Current Limits of Liability: _____

Please List Additional Practice Locations:

Name/Address City County State Zip

Name/Address City County State Zip

Select type of coverage for Group / First Named Insured (choose one):

☐ Separate Limits
The Group / First Named Insured will carry its own separate limits of liability.

☐ Shared Limits
The Group / First Named Insured shall not have its own limit of liability, but shall share in the limits of liability of the insured physicians.

☐ Defense Costs Only
The Group / First Named Insured does not have individual coverage but will be provided coverage for defense costs only.

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LIMITS OF LIABILITY* (choose only one)

Claims Made Coverage

All states except Indiana, Louisiana and Nebraska:
- ☐ Limits $200,000 per claim / $600,000 aggregate
- ☐ Limits $500,000 per claim / $1.5 million aggregate
- ☐ Limits $1 million per claim / $3 million aggregate

Indiana:
- ☐ Limits $250,000 per claim / $750,000 aggregate
  Will you be enrolling in the Indiana Patient's Compensation Fund? ☐ Yes ☐ No

Louisiana:
- ☐ Limits $100,000 per claim / $300,000 aggregate
  Will you be enrolling in the Louisiana Patient's Compensation Fund? ☐ Yes ☐ No
- ☐ Limits $200,000 per claim / $600,000 aggregate
- ☐ Limits $500,000 per claim / $1.5 million aggregate
- ☐ Limits $1 million per claim / $3 million aggregate

Nebraska:
- ☐ Limits $200,000 per claim / $600,000 aggregate
- ☐ Limits $500,000 per claim / $1 million aggregate
  Will you be enrolling in the Nebraska Patient's Compensation Fund? ☐ Yes ☐ No
- ☐ Limits $1 million per claim / $3 million aggregate

Occurrence Coverage

New Mexico:
- ☐ Limits $200,000 per occurrence / $600,000 aggregate
  Will you be enrolling in the New Mexico Patient's Compensation Fund? ☐ Yes ☐ No

ADDITIONAL NAMED INSUREDS

Please indicate additional named insureds who need coverage under this policy:

☐ Physicians (A separate application is required for each physician)

☐ Employed Non-Physician Healthcare Providers (ENPHP) or contracted (A separate application is required for each ENPHP)

Select type of Coverage for Employed Non-Physician Healthcare Provider: There is no individual coverage for ENPHPs unless specifically stated on the Declaration and/or endorsements.

☐ Vicarious Liability Only
The First Named Insured coverage will include vicarious liability for the named Employed Non-Physician Healthcare Provider(s) for professional services rendered while employed for or in connection with the First Named Insured. The Employed Non-Physician Healthcare Provider(s) have no individual coverage.

☐ Shared Limits
The named Employed Non-Physician Healthcare Provider(s) will share in the limits with the First Named Insured. The coverage for the named Employed Non-Physician Healthcare Provider(s) is included within and part of the total limits of liability provided to the First Named Insured and is not stacked upon or added to the limits of liability provided to the First Named Insured. (A separate application is required for each Non-Physician Healthcare Provider).

☐ Separate Limits
The named Employed Non-Physician Healthcare Provider(s) each carry their own separate limits of liability. (A separate application is required for each Non-Physician Healthcare Provider).

☐ Separate Single Limits
The named Employed Non-Physician Healthcare Provider(s) will all share in the limits of liability with each other. The coverage provided shall be separate and apart from the limits of liability of the First Named Insured.

Select type of Coverage for Ancillary Personnel:

☐ Shared Limits
The Ancillary Personnel will share in the limits with the First Named Insured. The coverage for Ancillary Personnel is included within and part of the total limits of liability provided to the First Named Insured and is not stacked upon or added to the limits of liability provided to the First Named Insured. (Default coverage in Capson policy)

☐ Separate Limits
The Ancillary Personnel each carry their own separate limits of liability.

☐ Separate Single Limits
The Ancillary Provider(s) will all share in the limits of liability with each other. The coverage provided shall be separate and apart from the limits of liability of the First Named Insured.

Other Entities: (Other Entities will always share in the limits of the First Named Insured; *Please attach Articles of Incorporation or Assumed Name Certificate*)

☐ A Professional Association (PA) Name: _____

☐ Assumed Name (DBA) Name: _____

LOSS EXPERIENCE
If you answer "yes" to any of the below, please provide copy of current carrier loss run.

Has any medical negligence lawsuit and/or claim EVER resulted in an indemnity payment in the amount of $50,000 or more on the entity's behalf?

☐ Yes ☐ No

If the answer is **Yes**, please provide the number of claims paid with indemnity in excess of $50,000 and the REPORT DATE (date reported to prior carrier) of the most recent medical negligence lawsuit and/or claim in which an indemnity payment of $50,000 or more was paid on behalf of the entity: _____ _____

number paid | most recent report date

Has the entity had more than one medical negligence lawsuit and/or claim made against it if during the 3 years prior to the proposed Capson effective date?

☐ Yes ☐ No

If the answer is **Yes**, please indicate the number of medical negligence lawsuits and/or claims in this period of time _____

Does the entity have any OPEN or pending medical negligence lawsuits and/or claims that have been made against it?

☐ Yes ☐ No

If the answer is **Yes**, please indicate the number of open or pending medical negligence lawsuits and/or claims and provide the REPORT DATE of the most recent OPEN medical negligence lawsuit and/or claim:

_____ _____

number open | most recent report date

PLEASE ATTEST TO THE FOLLOWING STATEMENTS.

Please understand that Capson may require additional information or documentation based on your responses below. Please provide details for any questions in which you answer "Disagree" below.

Agree	Disagree	
☐	☐	1. I am not aware of any of the following circumstances for the First Named Insured or any named providers: • A request for records from a patient, family member of a patient, or attorney; • A letter from an attorney regarding treatment of a patient; • A patient, family member of a patient, or a patient representative's dissatisfaction with the outcome of a procedure, treatment, diagnosis or fee; or • Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit.
☐	☐	2. This entity has NEVER operated without medical professional liability coverage in force.
☐	☐	3. This entity has NEVER had medical professional liability insurance declined, canceled or non-renewed **(MO APPLICANTS ARE NOT REQUIRED TO ANSWER)**

Agree ☐	Disagree ☐	4. Less than 10% of this practice is dedicated to seeing patients in nursing homes, long-term acute care (LTAC) facilities, skilled nursing facilities, and/or assisted living facilities.
Agree ☐	Disagree ☐	5. I understand that the Capson policy excludes coverage for Medical Directorships.
Agree ☐	Disagree ☐	6. I certify that I have accessed and reviewed the Capson Policy Specimen and any applicable state-specific policy endorsement.
Agree ☐	Disagree ☐	7. I certify that I have accessed and reviewed the Business Associate Agreement and agree to its terms.
Agree ☐	Disagree ☐	8. If any information supplied on this application changes between the application date and the effective date of insurance, I will immediately notify Capson of such changes and Capson may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. I understand that my failure to notify Capson of any changes may be grounds for cancellation of the policy.
Agree ☐	Disagree ☐	9. I understand that any material omission or misrepresentation made by me may act to render any contract of insurance void or give Capson the right to rescind the contract. By making this application, I am not relying on any oral or written representation by Capson that coverage has or will be extended to me or that a policy of insurance will be issued. I understand that Capson is relying on the statements made by me in this application.
Agree ☐	Disagree ☐	10. I certify that I have the authority to purchase coverage on behalf of this First Named Insured Entity.
Agree ☐	Disagree ☐	11. I authorize Capson to contact individuals, hospitals, employers, schools, insurance agents, professional liability insurers, licensing boards, or other entities to verify and/or obtain information provided by me in this application. By completing this application, I, hereby authorize any such person or entity to release to Capson any information which Capson, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance.

Questions for Claims-Made Policies Only

Agree ☐	Disagree ☐	12. I understand that if I am applying for Prior Acts Coverage with Capson, there will be no coverage for medical incidents in any state other than the state in which I am applying for coverage from Capson.
Agree ☐	Disagree ☐	13. I represent and agree that coverage provided will be for claims reported after the policy effective date and the medical incident must also have occurred after the policy retroactive date. I will have no right to report claims, suits or medical incidents that occurred prior to the policy retroactive date for any medical incident occurring prior to such date. Capson will have no obligation to indemnify or defend me for any medical incident occurring prior to the policy retroactive date.
Agree ☐	Disagree ☐	14. I represent and agree that Capson will not provide defense or indemnity for any medical incident, claim or suit of which I am aware, or reasonably should have been aware, prior to the effective date of the Capson policy.

Question for Occurrence Policies Only

Agree	Disagree	
☐	☐	15. I represent and agree that there is no coverage for medical incidents occurring prior to or after the policy period. Capson will have no obligation to indemnify or defend the First Named Insured for any medical incidents occurring prior to or after the policy period.

Please provide details for any question(s) to which you responded “Disagree” above:

PROFESSIONAL MEDICAL LIABILITY POLICY APPLICATION FRAUD WARNING

NOTICE TO APPLICANTS FOR STATES OTHER THAN AR, CO, DC, FL, HI, KY, LA ME, MD, NJ, NM, NY, OH, OK, OR, PA, TN, VA, WA, WV: "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."

NOTICE TO ARKANSAS, LOUISIANA AND WEST VIRGINIA 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 FINES AND CONFINEMENT IN PRISON."

NOTICE TO 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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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."

NOTICE TO 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."

NOTICE TO 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."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

NOTICE TO 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."

NOTICE TO 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."

NOTICE TO 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."

NOTICE TO NEW MEXICO 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."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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."

NOTICE TO 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 (365:15-1-10, 36 §3613.1)."

NOTICE TO OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

NOTICE TO 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."

NOTICE TO 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, 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."

Declaration and Signature:

I declare that the statements or information provided by me or any statements or information provided by me in any and all other documents, applications, supplemental pages or attachments for the purpose of my initial or renewal application, are true and accurate and that I have not knowingly omitted or misstated material facts. I agree that this application and any other documents, applications, supplemental pages or attachments shall be the basis of the contract of insurance with Capson Physicians Insurance Company. I agree to notify Capson Physicians Insurance Company if there are any future material changes in any answer, including, but not limited to, any change in my professional practice or specialty, or working arrangement with any other physicians or professional associations.

Name of Signatory:_____

Signature:_____

Signed Date:_____

Coverage will not be effective until: (1) Capson has received and accepted a completed application; (2) the applicant accepts the Capson quote within the terms of the quote provided by Capson Underwriting; (3) Capson has received payment of the premium due; and, (4) an email has been sent to the applicant confirming coverage.

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Insurance Agent/Producer/Broker
(Please Print)