

Granite State Insurance Company

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
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Name/Address	City	County	State	Zip
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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.

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? 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	Yes	No
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? Limits \$1 million per claim / \$3 million aggregate	Yes	No

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
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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 the Company 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 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 the Company 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	<p>1. I am not aware of any of the following circumstances for the First Named Insured or any named providers:</p> <ul style="list-style-type: none"> • 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.
Agree	Disagree	<p>2. This entity has NEVER operated without medical professional liability coverage in force.</p>
Agree	Disagree	<p>3. This entity has NEVER had medical professional liability insurance declined, canceled or non-renewed (MO APPLICANTS ARE NOT REQUIRED TO ANSWER)</p>

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 Company policy excludes coverage for Medical Directorships.
Agree	Disagree	6. I certify that I have accessed and reviewed the Company 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 the Company of such changes and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. I understand that my failure to notify the Company 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 the Company the right to rescind the contract. By making this application, I am not relying on any oral or written representation by the Company that coverage has or will be extended to me or that a policy of insurance will be issued. I understand that the Company 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 the Company 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 the Company any information which the Company, 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 the Company, there will be no coverage for medical incidents in any state other than the state in which I am applying for coverage from the Company.
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. The Company 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 the Company 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 Company 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. The Company will have no obligation to indemnify or defend the First Named Insured for any medical incidents occurring prior to or after the policy period.
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Please provide details for any question(s) to which you responded "Disagree" above:

FRAUD WARNINGS

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ALABAMA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

NOTICE TO ARKANSAS, NEW MEXICO 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 AUTHORITIES.

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 KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 LOUISIANA 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 MAINE 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 MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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 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.

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 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, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

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 the Company. I agree to notify the 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) the Company has received and accepted a completed application; (2) the applicant accepts the Company quote within the terms of the quote provided by the Company Underwriting; (3) the Company has received payment of the premium due; and, (4) an email has been sent to the applicant confirming coverage.

Insurance Agent/Producer/Broker
(Please Print)