

Catlin Underwriting Agency, U.S., Inc.
 1330 Post Oak Boulevard, Ste. 2325
 Houston, TX 77056

**APPLICATION FOR MULTI-PRACTICE CLINIC OR GROUP PRACTICE
 FOR PROFESSIONAL LIABILITY INSURANCE**

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

I. IDENTIFYING INFORMATION

Name of Organization as it should appear in the Declarations:				Telephone Number:	
				Fax Number:	
*If more than one location, please include the complete address of each location, see page 2.					
Location Street Address:	City:	State:	Zip Code:	County:	
Mailing Street / P.O. Box Address:	City:	State:	Zip Code:	County:	
Tax Identification Number:					

II. NAMES AND DESCRIPTION OF ALL LEGAL ENTITIES (Indicate below if entity to be insured.)

A	Name:	Description:	Entity Type:	To be Insured?		Prior Acts Date:
				Yes	No	
B				<input type="checkbox"/>	<input type="checkbox"/>	
C				<input type="checkbox"/>	<input type="checkbox"/>	
D				<input type="checkbox"/>	<input type="checkbox"/>	
E				<input type="checkbox"/>	<input type="checkbox"/>	

III. COVERAGE REQUESTED

Effective Date:	Retroactive Date:	Deductible/SIR:
<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$250,000/\$750,000
<input type="checkbox"/> \$500,000/\$1,000,000	<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> \$1,000,000/\$3,000,000
A "tail" policy is generally available as an option of your expiring Claims Made Policy. Are you purchasing a tail? <input type="checkbox"/> Yes <input type="checkbox"/> No 		

IV. PROFESSIONAL LIABILITY INSURANCE COVERAGE (for previous five year period).

Insurance Company	Policy Number	Policy Period	Limits of Liability	Deductible or SIR and Amount	Coverage Form
Carrier:		Effective:	\$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Retro Date:
Premium:		Expiration:			
Carrier:		Effective:	\$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Retro Date:
Premium:		Expiration:			
Carrier:		Effective:	\$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Retro Date:
Premium:		Expiration:			
Carrier:		Effective:	\$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Retro Date:
Premium:		Expiration:			
Carrier:		Effective:	\$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence Retro Date:
Premium:		Expiration:			

Has any insurance company canceled, refused to issue or renew your Professional Liability insurance policy(ies)?

Yes No If yes, explain: _____

Main Location

Street _____ City _____ State _____ Zip _____
 Owned Sq. feet _____ No. of floors _____ Date Acquired _____
 Leased

Additional Locations

Location No. 2

Street _____ City _____ State _____ Zip _____
 Owned Sq. feet _____ No. of floors _____ Date Acquired _____
 Leased

Type of Operation (if not a clinic) _____

Location No. 3

Street _____ City _____ State _____ Zip _____
 Owned Sq. feet _____ No. of floors _____ Date Acquired _____
 Leased

Type of Operation (if not a clinic) _____

Location No. 4

Street _____ City _____ State _____ Zip _____
 Owned Sq. feet _____ No. of floors _____ Date Acquired _____
 Leased

Type of Operation (if not a clinic) _____

Location No. 5

Street _____ City _____ State _____ Zip _____
 Owned Sq. feet _____ No. of floors _____ Date Acquired _____
 Leased

Type of Operation (if not a clinic) _____

If additional space is required, use additional sheet.

- a. Date group entity was established: _____
- b. Length of time at main location: _____
- c. Within the next 12 month period, does the facility plan to:
- obtain another facility or entity? Yes No
 - add to the number of physicians? Yes No
 - expand the number of locations? Yes No

IF ANSWER IS YES TO ANY QUESTION ABOVE, PLEASE DESCRIBE ON YOUR LETTERHEAD.

V. ADMINISTRATION

- a. Name of Chief Executive Officer: _____
- b. Name of Administrator/Risk Manager: _____
- c. Name of Medical Director(s): _____

VI. PHYSICIANS (Individual applications required) (for previous five year period)

a. Please indicate the number of:

	20__	20__	20__	20__	20__
Full-time Physicians					
Part-time Physicians					
Other					
Other					
Other					
Total*					

* Please explain any year-to-year change that occurred in excess of 10%.

b. Are all physicians, surgeons, and medical personnel duly licensed/certified to practice medicine in your state? Yes No

c. How are qualifications of new physicians checked? (Describe) _____

d. Are all prospective physicians required to be Certified or Board Eligible? Yes No

If No, explain reasons on your letterhead.

VII. SUPPORT STAFF - Administrative

Employed _____

Contracted _____

Total _____

Note: Liability for the acts of omissions of any person within the scope of their duties as an employee of the entity is included under this insurance. If any employees are to be provided individual coverage for their own acts of a professional nature, indicate in Column II on page 4. An additional charge will be applied. A Supplemental Application must be completed for each person listed in Section A. of the classifications who requests, or is required to have individual coverage.

Please enter the total number of employees/contractors by classification on page 4.

CLASSIFICATIONS

	I. Number of Employed	II. Number of Contracted
Section A		
Certified Nurse Midwife	_____	_____
Certified Registered Nurse Anesthetist	_____	_____
Nurse Practitioner	_____	_____
Operating Room Technician (Surgical)	_____	_____
Operating Room Technician (Non-Surgical)	_____	_____
Paramedic	_____	_____
Physician Assistant	_____	_____
Surgeon	_____	_____
Surgeon Assistant	_____	_____
Total Ancillary Personnel	_____	_____
Section B		
Audiologist	_____	_____
Laboratory Technician	_____	_____
Nurse (R.N. & L.P.N.)	_____	_____
Optometrist	_____	_____
Perfusionist	_____	_____
Physical / Pulmonary / Occupational Therapists	_____	_____
Psychologist	_____	_____
Registered Pharmacist	_____	_____
X-Ray Technician (w/o Therapy)	_____	_____
X-Ray Technician (with Therapy)	_____	_____
Other Miscellaneous Medical Personnel	_____	_____
Total Miscellaneous Medical Personnel	_____	_____

** This classification applies to physician or surgeon assistants who have completed an approved course of study leading to university certification, national certification if required by the state, and who perform their duties under the direct supervision of a licensed physician or surgeon, assisting in the facility and/or research endeavors of the physician or surgeon.

VIII. OPERATIONS

a. Are any of the Named Insureds a party to any agreement or contract with any entity/individual which is not a part of this entity? Yes No
If yes, explain: _____

b. Patient Mix:

1. Fee for service	_____	10	_____	%
2. Pre-paid (HMO, PPO)	_____	30	_____	%
3. Medicare	_____	15	_____	%
4. Medicaid	_____	45	_____	%

c. Average annual patient load: _____ (to be audited at policy expiration)

Percentage of transient patients _____ %

d. Does the clinic attract patients because of reputation in any particular field of medicine? Yes No

If Yes, please specify _____

e. Does the organization own, control, or staff any of the following:

- a. Birthing Center Yes No
- b. Emergency Room Yes No
- c. Facilities for overnight patient care or monitoring Yes No
- d. Hearing Aid Store – If Yes, indicate annual gross sales \$ Yes No
- e. Hospital Yes No
- f. Imaging Center Yes No
- g. Laboratory (Limited Lab facilities for patients only) Yes No
- h. Optical Goods Store – If Yes, indicate annual gross sales \$ Yes No
- i. Pharmacy – Annual gross sales if Druggists Liability is requested \$ Yes No
- j. Radiation and/or Shock Therapy Facility Yes No
- k. Substance Abuse Programs Yes No
- l. Surgicenter/Clinic, Surgical Outpatient Facility Yes No
- m. Other, please identify Yes No

IF ANSWER IS YES TO ANY QUESTIONS ABOVE, PLEASE DESCRIBE ON YOUR LETTERHEAD.

Specify hospitals at which the physicians hold staff or courtesy privileges:

Hospital Name	General	Child	JCAHO or ADA APPROVED	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IX. LOSS CONTROL / RISK MANAGEMENT

- a. Does the clinic have a Loss Control program? Yes No
 If Yes, show date of last site inspection _____
 Also, please describe nature of program on your letterhead.
- b. Does the clinic have an arbitration plan? Yes No
 If Yes, please describe nature of program on your letterhead.
- c. Does a Peer Review Committee exist? Yes No
- d. Please describe how fee related complaints are handled. _____

- e. Does the clinic provide for continuing education programs? Yes No
- f. Is any research or teaching program conducted? Yes No
 If Yes, please describe on your letterhead.
- g. Is there a Credentials Committee? Yes No
- h. Are informed consent forms used? Yes No
- i. Describe how you dispose of contaminated materials, human tissue, nuclear materials, or other hazardous materials. _____

- j. Do you have an EPA Registration Number? Yes No
 If Yes, attach the RCRA or Super Fund application Forms.
- k. Are oxygen and other gas cylinders used? Yes No
 If Yes, indicate where stored. _____
- l. Radiation
 Does the clinic use radium or other isotopes? Yes No
 If Yes, describe on your letterhead safety precautions taken.
 Describe type and frequency of tests for stray X-Ray radiation.
- m. Do floor and ceiling of room in which radium and X-Ray are used have lead lining or equivalent protection? Yes No
- n. Does the clinic edit or sell publications, video tapes or other media? Yes No
 If Yes, please explain. _____

- o. Does the organization have any accreditations? Yes No
 If Yes, please identify. _____

X. MEDICAL RECORDS PROCEDURES (Check those applicable)

- a. Alphabetic
- Centralized
- Color Coded
- Drug Allergies Noted in Patient File
- Electronic - Method: _____
- Fastened in Folder
- Loose Leaf Binder
- Medical Records Committee
- Medical Records Librarian
- Medical Records Supervisor
- Numerical with Cross Reference File
- Progress Notes Typed (signed by Dictating Physician)
- Progress Notes Written (signed and dated by Physician)
- Terminal Digit
- Other, please specify: _____

b. How are records keeping deficiencies handled? _____

c. Are all records kept at the Main Facility Location? Yes No
If No, indicate where and by whom they are kept.

XI. ACCREDITATION

a. Are you a member of a national organization? Yes No
Explain: _____

b. Is the organization certified or accredited? Yes No
Explain: _____
(Include copy of most recent survey, certification, or accreditation.)

XII. CLAIMS INFORMATION

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim of suit? Yes No

If yes, complete a claims supplement for each claim.

Total Number of Claims: Open Closed

Please provide the following information.*

- a. On a separate page, list Names, Specialty Field, State of License, and Number of Hours Worked of all employed physicians, employed surgeons, interns and residents.
- b. Breakdown of surgical procedures being performed at the facility annually, by type.
- c. JCAHO Report with Recommendations including Status of Recommendations.
- d. Current Financial Statement.
- e. Copy of by-laws of the Clinic.
- f. The Job Description of the Risk Manager.
- g. All Hold Harmless Agreements.
- h. Actuarial Review for the S.I.R., if applicable.
- i. Trust Agreement for the S.I.R., if applicable.
- j. Samples of contracts with Independent Physician's Groups
- k. Transfer agreements with Area Hospitals

We hereby certify that if Prior Acts coverage is being requested, we have no knowledge of any professional liability claims which have been asserted against us, or any affiliated professional association, corporation or subsidiary, or of any occurrence, incident, or circumstance likely to result in such claim on or after the requested initial effective date of the Prior Acts coverage, except the following. (Provide a brief description of each such claim, occurrence, incident or circumstance):

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

Chief Executive Officer or
Chief of Medical Staff
(Signature Required)

Date

Clinic Administrator
(Signature Required)

Date

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

FRAUD NOTICE

Arkansas	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.
Colorado	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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	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	Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Kentucky	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.
Louisiana	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.
Maine	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 denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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.
New York	<p>All commercial insurance forms, except as provided for automobile insurance: 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.</p> <p>Automobile insurance forms Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.</p> <p>Fire Insurance: 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. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.</p>
Ohio	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.
Oklahoma	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.
Pennsylvania	<p>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.</p> <p>Auto: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to \$15,000.</p>
Puerto Rico	Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars (\$5,000), not to exceed ten thousands dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Rhode Island	<p>Property Insurance, Real Or Personal: The insurance application form shall indicate the existence of a criminal penalty for failure to disclose a conviction of arson.</p>
Tennessee	<p>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.</p> <p>Workers Compensation: It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.</p>
Virginia	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.
West Virginia	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.