COPIC
Better Medicine • Better Lives

Physician Application for Medical Professional Liability Insurance

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

With your completed application, you are required to submit the following information:

- ❑ Current declarations page which provides a retroactive date and indicates limits of liability for you and any entity for which you are requesting coverage.
- ❑ Written confirmation of the purchase of or your intent to purchase a reporting endorsement ("tail coverage") from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
- ❑ Please check the following specialties that apply. **Note:** An additional application will be provided.
  - ❑ Anesthesiology/Pain Management
  - ❑ Bariatric Surgery
  - ❑ Cardiology
  - ❑ Dermatology
  - ❑ Hand Surgery
  - ❑ Family Physician performing Obstetrics
  - ❑ Ophthalmology
  - ❑ Orthopedics
  - ❑ Physical Medicine & Rehabilitation
  - ❑ Radiology
  - ❑ Surgery (General, Thoracic & Vascular)
- ❑ If you are requesting coverage for your employed Advanced Practice Provider, a separate application is required.
- ❑ Current business letterhead and advertisements (including website material).
- ❑ Curriculum Vitae (C.V.)
- ❑ A loss run report. To obtain this information, please call your prior carrier(s) and request a currently valued loss run for the past five (5) years.

Additional information may be requested.

COPIC
7351 E Lowry Boulevard, Ste. 400 ■ Denver, CO 80230
phone 720/858-6000 ■ *fax* 720/858-6004 ■ *toll free* 800/421-1834 ■ www.callcopic.com

APPLICANT DATA

1. Last name _____ First name _____ M.I. _____ Gender ☐ M ☐ F

2. DOB _____ 3. SSN _____ 4. NPI # _____

5. Legal Residence (Physical Street/Home Address) _____

City _____ State _____ ZIP _____ Cell phone # _____

Rural Mailing Address/P.O. Box (if applicable) _____ City _____ State _____ ZIP _____

Home phone # _____ Personal/Confidential E-mail address _____

6. Primary practice location _____

Address _____ City _____ County _____ State _____ ZIP _____

Office # _____ Primary fax # _____

Website address _____

Primary contact name _____ E-mail address _____

Phone # _____

7. Office/Practice Post Office Box (if preferred mailing address) _____

City _____ County _____ State _____ ZIP _____

8. Billing Address (if statements should be sent to a different location than practice location):

Firm Name _____ Address _____

City _____ County _____ State _____ ZIP _____ Phone # _____

9. Please select the mailing address you prefer for each of the following:

Confidential documents (acknowledgement of incident report, claim correspondence, etc.):

☐ Office ☐ Office P.O. Box ☐ Residence ☐ Residence P.O. Box

Policy related documents (application, policy, endorsements, etc.):

☐ Office ☐ Office P.O. Box ☐ Residence ☐ Residence P.O. Box

If you are approved for coverage under a group policy, policy related documents will be sent to the address selected by the policyholder.

COVERAGE REQUESTED

10. Requested Effective Date _____ Requested Retroactive Date _____

Note: If you are requesting prior acts coverage, a separate Supplemental Prior Acts Application will be required.

11. Liability limits ☐ $500,000/$1 million ☐ $1 million/$3 million ☐ $1.5 million/$3 million ☐ $2 million/$4 million
☐ Other: _____

12. Practicing as (check one): ☐ Individual ☐ Joining Group ☐ Forming Group ☐ Joining Hospital

Name of Group or Employer: _____

☐ Other: _____

13. List each professional corporation in which you have an ownership and need coverage under the policy:

Name	Description of Interest	% of Practice

An additional entity application may be needed for the organization(s) listed above.

IF YOU PRACTICE IN A STATE WITH A PATIENT COMPENSATION FUND

14. If approved for COPIC coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under a patient compensation fund? ☐ Yes ☐ No ☐ N/A*

15. Have you been a qualified health care provider under the Fund at all times subsequent to the retroactive date requested above and as shown on the insurance declarations page(s) attached to the application? ☐ Yes ☐ No ☐ N/A*

**"N/A" means that you do not practice within a Fund state and, therefore, this question is not applicable.*

PROFESSIONAL LIABILITY INSURANCE HISTORY

16. Name of Company (current)	Policy Limits $_____/$_____	Period of Coverage: _____ to _____ (mm/yy) (mm/yy) Retroactive Date: _____	☐ Claims-Made ☐ Occurrence
Name of Company	Policy Limits $_____/$_____	Period of Coverage: _____ to _____ (mm/yy) (mm/yy) Retroactive Date: _____	☐ Claims-Made ☐ Occurrence
Name of Company	Policy Limits $_____/$_____	Period of Coverage: _____ to _____ (mm/yy) (mm/yy) Retroactive Date: _____	☐ Claims-Made ☐ Occurrence

17. If your current insurance is claims-made, will "tail" coverage be purchased? ☐ Yes ☐ No ☐ N/A

18. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate, required that you accept a deductible, or issued coverage with any restrictions or exclusions? * ☐ Yes ☐ No
*Missouri applicants do not answer this question.

19. Have you ever practiced without professional liability insurance? ☐ Yes ☐ No

LICENSES

20. List all states in which you have ever been licensed to practice medicine, the license number for that state, the date the license was issued and the number of hours you will work in each state as of the requested effective date of coverage. (If extra space is needed, please attach additional sheets.)

State_____ License # _____ Date issued_____ # hours/week _____

State_____ License # _____ Date issued_____ # hours/week _____

State_____ License # _____ Date issued_____ # hours/week _____

21. Are you ABMS or AOA Board Certified? ☐ Yes ☐ No
If "no," have you ever failed any licensing or Board Certification Examinations? ☐ Yes ☐ No

22. Have you ever been denied a medical license or certification by a specialty board? ☐ Yes ☐ No

23. If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No ☐ N/A

PRACTICE HISTORY/TRAINING/EDUCATION

24. You must provide a current C.V. If you have any gaps in practice over 90 days, an explanation must be included.

PRACTICE CHARACTERISTICS

25. What is your Specialty? _____ Percentage of your practice devoted to your Specialty _____ %

26. What is your Subspecialty? _____ Percentage of your practice devoted to your Subspecialty _____%

27. Average number of hours worked per week ☐ 1-15 ☐ 16-20 ☐ 21-25 ☐ ≥ 26

When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds.

28. Do you maintain any other medical professional liability coverage? ☐ Yes ☐ No

If "yes," please explain. _____

29. After the Requested Effective Date, do you plan to practice/consult outside your principal state of practice in the next 12 months? ☐ Yes ☐ No

If "yes," do you or will you maintain professional liability insurance for this exposure? ☐ Yes ☐ No

Please describe the nature of your out-of-state practice and indicate the number of hours per week devoted to it. _____

_____

_____

30. Do you provide telemedicine services outside of your principle state of practice? ☐ Yes ☐ No

If "yes," please provide additional information. _____

31. Are you employed or contracted as a medical director for an agency, business, or organization outside of your trained specialty? ☐ Yes ☐ No

32. Do you practice "Concierge Medicine?" ☐ Yes ☐ No

Note: *For purposes of this question, "Concierge Medicine," also known as direct care, is a relationship between a patient and a healthcare provider in which the patient pays monthly or annual fees.*

If "no," please skip to question #33.

If "yes," what percentage of your practice is based on this model?_____ %

What is your current total patient count? _____

33. Do you work in an Urgent Care? ☐ Yes ☐ No

If "yes," percentage of practice _____%

If "yes," do you hold a current ATLS and ACLS certification? ☐ Yes ☐ No

34. Do you provide services at a correctional facility? ☐ Yes ☐ No

35. Please describe your practice (choose only one): ☐ Hospitalist ☐ Intensivist/Critical Care Specialist ☐ N/A

If you answered "N/A" to question #35, please skip the next question and proceed to question #36.

Please indicate the percentage of your total practice devoted to in-patient care of hospitalized patients. _____ %

36. Do you practice in an Emergency Department (ED)? ☐ Yes ☐ No

For the purpose of this question, answer "no" if you only provide backup/consult call or work in the ED only for the purpose of maintaining privileges.

PROCEDURES PERFORMED

All <u>"yes" answers</u> require explanation. Please attach additional sheets, if necessary.

37. Do you perform or supervise anyone who performs aesthetic or cosmetic procedures? ☐ Yes ☐ No

38. Do you perform Sclerotherapy (the injection of sclerosing agents) into the vertebral column? ☐ Yes ☐ No

39. Do you participate in non-IRB clinical trials? ☐ Yes ☐ No

40. Do you use any non-FDA approved devices, drugs, or procedures? ☐ Yes ☐ No

41. Do or will any of your employees practice at a location geographically separate from you? ☐ Yes ☐ No

If "yes," please provide details on an additional sheet. Please include in your explanation the distance of the employee's separate practice location from your practice location and a summary of the employee's duties and responsibilities while practicing there. In addition, please explain how these employees are supervised consistent with their duties and the frequency of and methods by which that supervision occurs.

42. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? ☐ Yes ☐ No

43. Do you perform surgery or obstetrical procedures at a location **more than 50 miles or one hour** from your office location(s)? ☐ Yes ☐ No

44. Do you perform surgery or obstetrical procedures in a surgical suite **more than 50 miles or one hour** from a hospital? ☐ Yes ☐ No

45. Do you perform procedures or use equipment not used by a majority of physicians in your specialty or perform "invasive" procedures for which you were not resident trained or for which you do not hold hospital privileges? ☐ Yes ☐ No

"Invasive" refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation.

If applicable, please list all such procedures:

Procedure	**Do you maintain Hospital Privileges?**
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No

FAMILY PRACTICE PHYSICIANS ONLY

46. **Do you perform:**

Prenatal care beyond the first trimester? ☐ Yes ☐ No
Second-trimester abortions? ☐ Yes ☐ No
Obstetrical procedures? ☐ Yes ☐ No
VBAC's? ☐ Yes ☐ No

FAMILY PRACTICE WITH OB & OB/GYN PHYSICIANS ONLY

47. Do you offer obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"? ☐ Yes ☐ No

Do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)? ☐ Yes ☐ No

Do you perform elective home delivery? ☐ Yes ☐ No

Do you supervise or employ Nurse Midwives who manage the active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC)? ☐ Yes ☐ No

If yes, is a physician physically on premises and immediately available for the entire course of care? ☐ Yes ☐ No

Average number of deliveries performed per year _____

Average number of C-sections performed per year_____

OTHER PERSONNEL TO BE COVERED

48. Will you/your entity employ or contract with any allied health practitioners who will work at any of your office locations? ☐ Yes ☐ No

If "yes," please provide the census information requested below. If you are practicing as part of a group practice, one person may complete this section if the information applies to all physicians in the group.

	# to be insured		**# to be insured**		**# to be insured**
Advanced Practice Nurses		Embryologists		Psychologists	
Anesthesiologist Assistants		Nurse Midwives		Psychotherapists	
Aestheticians		Nurse Practitioners		Optometrists	
*CRNA/Nurse Anesthetists		Pharmacists		Surgical Assistants	
Cytotechnologists		Physician Assistants			

***Nebraska Applicants Only:** Nurse Anesthetists are required to complete a special application form; please contact your agent or the COPIC Underwriting Department for the appropriate application form.

The COPIC policy provides no individual coverage to any employee or independent contractor in any of these classifications working in your office unless he/she is specifically named on the Declarations Page. Please contact your underwriter for more information.

OTHER INFORMATION

All "yes" answers require an explanation. Please attach additional sheets, if necessary.

49.	Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure and any allegations which are currently pending.)	☐ Yes	☐ No
50.	Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way?	☐ Yes	☐ No
51.	Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified?	☐ Yes	☐ No
52.	Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? **Note**: You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.	☐ Yes	☐ No
53.	Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity?	☐ Yes	☐ No
54.	Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry?	☐ Yes	☐ No
55.	Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action?	☐ Yes	☐ No
56.	Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, health plan, managed care organization or other medical review committee?	☐ Yes	☐ No
57.	Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness?	☐ Yes	☐ No
58.	Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee or an employee of a hospital or surgery center; or have you been accused by a patient or been investigated by any state regulatory authority for boundary violations of a sexual nature?	☐ Yes	☐ No
59.	Have you ever been reported to the National Practitioners Data Bank?	☐ Yes	☐ No

CERTIFICATES:

60. Please record below all organizations you would like listed as a certificate holder on your policy (e.g., hospitals, HMOs, IPAs, etc.).

Name	Address (including city, state and zip code)

By adding a certificate holder's name and address to the above list, you give COPIC your permission to allow the certificate holder to obtain your certificate of insurance.

CLAIMS INFORMATION

Important information regarding questions 61 and 62 (including sub-questions):

1. The word "claim" as used in questions 61 and 62 below refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to question 61 and 62 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 8).

61.	Have you ever been involved in a malpractice claim or suit, either directly or indirectly?	☐ Yes	☐ No
62.	Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:		
	a. A request for records from a patient and/or attorney related to an adverse outcome?	☐ Yes	☐ No
	b. A letter from an attorney regarding your medical treatment of a patient?	☐ Yes	☐ No
	c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	☐ Yes	☐ No
	d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	☐ Yes	☐ No
	e. Any other circumstances that might reasonably lead to a claim or suit?	☐ Yes	☐ No
	f. If yes, to any of the above, have they been reported to your current or prior professional liability insurance carrier?	☐ Yes	☐ No

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____

   _____

   _____

6. What is the present condition of the patient? _____

   _____

   _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ☐ Yes ☐ No

8. Status of claim (check applicable answer):

   ☐ Suit threatened, no action taken
   ☐ Suit filed but dropped by claimant
   ☐ Summary judgment in your favor
   ☐ Court outcome in your favor
   ☐ Court outcome in favor of plaintiff:
   Amount of Loss payment:
   $_____
   ☐ Awaiting mediation
   ☐ Awaiting court action:
   Reserve Amount:
   $_____
   ☐ Suit settled out of court
   a. Date claim paid: _____
   b. Amount paid: $_____
   c. Did you want to settle this claim? ☐ Yes ☐ No

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No
   If "yes," amount was $_____

Signature: _____ **Date**: _____

Name (Printed): _____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! As a condition of being insured, I understand and agree to the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare that all answers and statements in this application are true and complete and that no material fact or circumstance has been omitted or withheld. I understand that these answers and statements are material and, as such, will be relied upon by the company to determine whether to issue my liability insurance. If I or any other person making application or providing information on my behalf misstate(s) or fail(s) to disclose any material information, my application may be declined. If my application is approved and it includes any material misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the material misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and in consideration for issuing this liability insurance, COPIC and/or its assigns may conduct a professional/peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by the COPIC Practice Quality personnel, as COPIC may request or direct. I agree to abide by any recommendations arising from that review.

I authorize any state board of medical examiners or medical board, or any licensure, hospital board or committee, hospital records department, insurance company, professional society or association, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC or its assigns. This authorization applies regardless of whether I am currently affiliated with the above persons or entities, or have been in the past. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC policy, I hereby consent to COPIC's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations (including professional societies or associations), professional liability insurance carriers, and state and federal regulatory entities, including but not limited to medical boards and boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. This release applies to the following information: my name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank. To the fullest extent permitted by law, I hereby release all providers of such information, including COPIC, its employees and agents, from any and all liability therefore.

Physician signature _____ Date _____

Please PRINT your name _____

RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

INSURANCE FRAUD WARNINGS

The following Insurance Fraud Warnings are required to be provided with all applications.

ALABAMA

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 restitution fines or confinement in prison, or any combination thereof.

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for 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 in formation 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.

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 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

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.

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 subject to civil fines and criminal penalties.

NEW YORK

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.

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.

OREGON

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.

RHODE ISLAND

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.

TENNESSEE

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.

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 and civil damages.

WASHINGTON

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.

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.

HOSPITAL EMPLOYED/CONTRACTED PHYSICIAN/SURGEON STATEMENT OF UNDERSTANDING SHARED LIMIT OF LIABILITY

I hereby understand and agree that the attached application is not an application for an individual policy of insurance. I understand that I will not be extended any individual limits of insurance, but rather I will share in the limit of insurance available to the hospital, who is the named insured on the policy.

I further understand that the insurance available under this policy only applies to me as an employed or contracted physician of the hospital while I am acting within the course and scope of duties for the hospital.

Physician signature _____ **Date** _____

Please PRINT your name _____