Nevada Docs Medical Risk Retention Group, Inc.

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATES & OTHER ORGANIZATIONS

Please type or print responses legibly in full. Any responses which require additional space may be included at the end of the application.

1. **Name of entity:** _____

2. **Entity business address:** _____
Street

_____
City State Zip County

a. **Mailing address:** _____

b. **Office telephone: ( )** _____ **Fax number: ( )** _____

c. **Office manager or contact person:** _____

d. **Tax ID number:** _____

3. **Type of practice:** (please check one)

☐ Professional Corporation ☐ Partnership ☐ Professional Associates
☐ Corporation ☐ LLC ☐ Other

4. **Limits of liability requested: $1,000,000/$3,000,000**

5. **Requested effective date of insurance: _____12:01 am.**
(All policies are written for one year unless otherwise requested and approved.)

6. **If last coverage is claims-made, will you obtain a tail from previous carrier?** ☐ Yes ☐ No
If yes, please forward a copy of the tail when available.
a. If no, are you applying for prior acts coverage with NDMRRG? ☐ Yes ☐ No
b. Retroactive date requested: _____

7. **Beginning with your most recent, or current insurer, please list all professional liability insurers. Please explain any gaps in the continuity of your professional liability coverage**.

Name & address of insurer	Coverage type & policy # covered (occurrence or claims-made)	Dates covered

8. Number of owners:_____ Number of partners:_____

a. Are all owners and partners insured with ND MRRG? ☐ Yes ☐ No

9. Employed or contracted physicians/surgeons of your organization:

Name	Specialty	Current Carrier	Retroactive Date

10. Furnish a list of all other professional employees of our organization (i.e., RN,LPN, PA, etc.)

Name & Professional Occupation	Name & Professional Occupation

11. Do you wish to include these employees as additional insured's? ☐ Yes ☐ No

12. Are there any subsidiaries that provide health care related services? ☐ Yes ☐ No

(If any, list subsidiary name, description of operations, % of ownership, and date acquired, below):

Subsidiary name	Description of operations	Date	%

13. Are these subsidiaries to be included in this coverage? ☐ Yes ☐ No

14. Please list all office and facility locations. (Please use Supplemental Sheet for Additional Locations)

Office Title	Address	Dates Occupied	% of Operations

15. Does this organization perform utilization review for a fee for others? ☐ Yes ☐ No

(If yes, please describe) _____

16. Is this organization currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program?

☐ Yes ☐ No (if yes, please describe) _____

17. Have you ever been involved in any disciplinary actions? ☐ Yes ☐ No

(If yes, please describe) _____

18. Has this organization's license ever been suspended, restricted, revoked or surrendered or has probation ever invoked? (If yes, please explain)_____ ☐ Yes ☐ No

19. Have any claims or suits ever been made or brought against your organization? ☐ Yes ☐ No

(If yes, you must complete a supplemental claim form for each claim regardless of its outcome.)
(Please copy the form first if you need more than one.)

20. Do you have any knowledge of any claims which might be made against you or activities that might give rise to a claim or suit in the future? (Include any request for medical records.) ☐Yes ☐No

_____

_____

I certify that the information provided in this application is true and accurate to the best of my knowledge, and that I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I understand that any misrepresentation or concealment in this application will render requested coverage completely void. I further authorize the release of any underwriting or claims information from all prior and current insurers, professional societies or associations, or hospitals, to **Nevada Docs Medical Risk Retention Group, Inc.** and release from liability all individuals and organizations who provide information in good faith and without malice.

_____ _____

Signature Date

No coverage will be bound until the company has received the completed application and expressed its intention to provide coverage. Acceptance of payment in advance of review of the application is not an expression of the company's intent to provide coverage. If the company refuses coverage, any advance payment will be returned.

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Supplemental Information Form