



WVMIC Professional Liability Insurance

How to Apply

Complete, sign and submit the enclosed application for insurance 30 days prior to the requested effective date of coverage. The application should be received as early as possible since insurance coverage is subject to underwriting review and approval. Please be certain that the following items are included with your completed application.

- A copy of your current Curriculum Vitae
- A copy of your current Medical License
- A copy of your current DEA License
- A copy of your practice letterhead
- A copy of your current medical professional liability insurance Declarations Page
- Copies of your loss history from prior carriers, if any
- A claim narrative from the physician for any open claims
- A claim narrative from the defense attorney for any open claims
- A copy of any Board complaint
- A copy of any Board action

Additional information may be requested by the WVMIC Underwriting Department.

Thank you for your interest in the West Virginia Mutual Insurance Company.

Mailing address:

West Virginia Mutual Insurance Company
P.O. Box 3697
Charleston, WV 25336-3697

Physical address:

West Virginia Mutual Insurance Company
Attn: Underwriting Department
500 Virginia Street, East, Suite 1200
Charleston, WV 25301

For questions call: 304-343-3000
888-998-7642



500 Virginia St. E. Ste 1200
 Charleston, WV 25301
 P.O. Box 3697
 Charleston, WV 25336-3697

Tel: 304.343.3000
 Toll-Free: 888.998.7642
 Fax: 304.342.0985
www.wvmic.com

| Agent Information | |
|-------------------|-------|
| Agency | _____ |
| Address | _____ |
| Producer | _____ |

APPLICATION FOR PHYSICIAN AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

Please complete the entire application. Indicate not applicable (n/a) where appropriate. Incomplete applications cannot be processed.

PART I - NAME AND ADDRESS

| | | | | |
|---------------------------------------|------------------------------|-------------------------------|-------------------------------|---------------------------------|
| First Name _____ | Middle Name _____ | Last Name _____ | <input type="checkbox"/> M.D. | <input type="checkbox"/> D.O. |
| Home Address _____ | City _____ | State _____ | Zip _____ | Gender |
| County _____ | Social Security Number _____ | Date and Place of Birth _____ | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| FEIN _____ | D.E.A. License Number _____ | | | |
| Specialty _____ | % of Practice _____ | Sub-specialty _____ | % of Practice _____ | |
| Office Telephone: _____ | Home Telephone: _____ | Fax: _____ | | |
| Business Manager/Administrator: _____ | | | | |
| E-Mail Address: _____ | | Website: _____ | | |

PART II - COVERAGE INFORMATION

A Name of current or immediate past carrier: _____ Expiration date, 12:01am _____ (M/D/Y)
 Attach a copy of the expiring declarations page from your most recent policy

B Requested effective date, 12:01am _____ (M/D/Y)

C Coverage is available on a claims-made basis only. Do you want prior acts coverage? Yes No Retroactive Date _____

D Coverage limit sought: \$1,000,000 / \$3,000,000 \$2,000,000 / \$4,000,000

E List the insurance carrier, limits of liability, effective and expiration dates, type of coverage and whether tail coverage was purchased for all previous insurance. Include periods covered by a self insurance program, military service coverage or no coverage:

| | INSURANCE CARRIER | LIMITS OF LIABILITY | EFFECTIVE | EXPIRATION | CLAIMS MADE OR OCCURRENCE | TAIL PURCHASED* |
|---|-------------------|---------------------|-----------|------------|---------------------------|--|
| 1 | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4 | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*Attach copy of Reporting Endorsement If **No**, provide explanation.

F If you changed your medical practice or specialty after the requested retroactive date, list each change and the effective date of each change:

| | CHANGED FROM | CHANGED TO | DATE OF CHANGE |
|---|--------------|------------|----------------|
| 1 | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ |

PART IV - MEDICAL EDUCATION/BACKGROUND (continued)

G Locations (other than present) where you have practiced to date since completion of formal training (include military or public service organization)

| | | | |
|---|--|------|----|
| 1 | | From | To |
| 2 | | From | To |
| 3 | | From | To |

H States in which you hold a license to practice medicine: Please check the box to indicate the status of your license

| | | | Active | Inactive | Temporary | Pending |
|---|-----------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1 | State _____ License # _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | State _____ License # _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | State _____ License # _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | State _____ License # _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PART V - PRACTICE ORGANIZATION

- | | |
|--|---|
| <input type="checkbox"/> 1. Solo Unincorporated <input type="checkbox"/> 2. Solo Corporation <input type="checkbox"/> 3. Employee of Individual/Group (not a shareholder/partner) <input type="checkbox"/> 4. Partner in Partnership <input type="checkbox"/> 5. Corporate Shareholder | <input type="checkbox"/> 6. Hospital Employee <input type="checkbox"/> 7. Government Employee <input type="checkbox"/> 8. Industrial Employee <input type="checkbox"/> 9. Independent Contractor <input type="checkbox"/> 10. Other |
|--|---|

A Name of Corporation, Partnership or Employer _____

B Do you wish coverage for your Professional Corporation or Partnership? Yes No Separate or Shared? _____
 If separate limits are requested, a separate corporation/partnership application is needed. Separate limits are not available for a solo practice.

C Do you use an unincorporated trade name (DBA)? Yes No
 If **Yes**, please provide the name: _____

D Do you **employ** other Physicians/Surgeons (non-shareholders/partners)? Yes No
 If **Yes**, please complete the following:

| PHYSICIAN NAME | INSURED BY | SPECIALTY |
|----------------|------------|-----------|
| | | |

E If you employ or contract medical professionals – complete the following.
 Number and desired coverage for employed or contracted. If individual coverage has been obtained with another carrier, please provide verification of current coverage:

| | | | |
|---|--|--|--|
| _____ Physician assistant/Surgeon assistant | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Nurse midwives | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Nurse anesthetists | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Nurse practitioner | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Psychologist | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Perfusionist | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Chiropractor | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Certified nurse anesthetists | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Cytotechnologist | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |
| _____ Optometrist | <input type="checkbox"/> Shared Limits | <input type="checkbox"/> Separate Limits | <input type="checkbox"/> Individual Coverage |

F Are you currently a party to a Collaborative Agreement with another medical professional? Yes No
 If **Yes**, please provide a copy of the Agreement.

PART V - PRACTICE ORGANIZATION (continued)

G If you, as an individual, employ or contract other medical professionals to provide services, list them and their professional occupations (i.e., R.N., L.P.N., etc) [Use additional sheets as necessary]

PART VI - CLASSIFICATION INFORMATION

Indicate percentage of time devoted to the following medical and/or surgical activities:
(Total should equal 100%)

| % Medical Procedure | | % Surgery Procedure | |
|-------------------------------------|--|----------------------------|--|
| _____ Aerospace Medicine | _____ Nephrology | _____ Abdominal | |
| _____ Allergy | _____ Neurology | _____ Bariatric | |
| _____ Anesthesiology | _____ Nuclear Medicine | _____ Cardiac | |
| _____ Broncho-Esophagology | _____ Nutrition | _____ Cardiovascular | |
| _____ Cardiovascular Disease | _____ Obstetrics/Pre-Natal | _____ Colon & Rectal | |
| _____ Dermatology | _____ Occupational Medicine | _____ Dermatology | |
| _____ Diabetes | _____ Oncology | _____ General | |
| _____ Emergency Medicine | _____ Ophthalmology | _____ Geriatrics | |
| _____ Endocrinology | _____ Orthopedic | _____ Gynecology | |
| _____ Family or General Practice | _____ Otology | _____ Hand | |
| _____ Forensic Medicine | _____ Otorhinolaryngology | _____ Head & Neck | |
| _____ Gastroenterology | _____ Pathology | _____ Neonatal | |
| _____ General Preventative Medicine | _____ Pain Medicine | _____ Neurology | |
| _____ Genetic Counseling | _____ Pediatrics | _____ Obstetrics | |
| _____ Geriatrics | _____ Pharmacology-Clinical | _____ OB/GYN | |
| _____ Gynecology | _____ Physiatry | _____ Ophthalmology | |
| _____ Hematology | _____ Physical Medicine & Rehabilitation | _____ Orthopedic | |
| _____ Hypnosis | _____ Psychiatry | _____ Otorhinolaryngology | |
| _____ Infectious Diseases | _____ Psychoanalysis | _____ Pain Management | |
| _____ Intensive Care Medicine | _____ Psychosomatic Medicine | _____ Pediatric | |
| _____ Internal Medicine | _____ Public Health | _____ Plastic | |
| _____ Laryngology | _____ Pulmonary Diseases | _____ Plastic-ENT | |
| _____ Legal Medicine | _____ Radiology | _____ Thoracic | |
| _____ Neonatology | _____ Rheumatology | _____ Traumatic | |
| _____ Neoplastic Diseases | _____ Rhinology | _____ Urology | |
| | | _____ Vascular | |
| | | _____ Other _____ | |

PART VI - CLASSIFICATION INFORMATION (continued)

Do you perform: *(Please check all boxes that apply)*

- Category 1** No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia or circumcision.
- Category 2** Perform minor surgery or assist in surgery on your own patients.
- Category 3** All other types of surgery and procedures performed under general anesthesia or assisting on surgery on other than your own patients.
- Category 4** Obstetrics including normal deliveries and c-sections.

Please check any of the following procedures that you perform:

- | | |
|---|--|
| <input type="checkbox"/> Abdominoplasty – Tummy Tuck | <input type="checkbox"/> Endoscopy |
| <input type="checkbox"/> Abortions - Elective | <input type="checkbox"/> ERCP |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Fluoroscopy |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Face Lifts |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal | <input type="checkbox"/> Face Lifts – Mini (done with laser) _____ % of Practice |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Fracture Reductions |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Open |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Closed |
| <input type="checkbox"/> Assisting in major surgery – own patients only | <input type="checkbox"/> Gastrointestinal Endoscopy |
| <input type="checkbox"/> Assisting in major surgery – own & other than own patients | <input type="checkbox"/> Hip Nailings |
| <input type="checkbox"/> Bariatric Surgery – Laparoscopic | <input type="checkbox"/> Hyperbaric Medicine |
| <input type="checkbox"/> Bariatric Surgery – Non-Laparoscopic | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Biopsy – Endoscopic | <input type="checkbox"/> Laser Surgery |
| <input type="checkbox"/> Blepharoplasty – Cosmetic _____ % of Practice | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Blepharoplasty - Reconstruction _____ % of Practice | <input type="checkbox"/> Lithotripsy |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Mammograms |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Cosmetic _____ % of Practice | <input type="checkbox"/> Norplant Insertion/Extraction |
| <input type="checkbox"/> Reconstructive _____ % of Practice | <input type="checkbox"/> Obstetrics |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Prenatal |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Postnatal |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Deliveries |
| <input type="checkbox"/> Catheterization | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Arterial | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Medicine Only |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Nerve Block |
| <input type="checkbox"/> Left Heart | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Chelation Therapy | <input type="checkbox"/> Radiofrequency Procedures |
| <input type="checkbox"/> Chemonucleolysis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Pedicle Screws for Spinal Surgery |
| <input type="checkbox"/> Cholecystectomy / Laparoscopic | <input type="checkbox"/> Permanent Pacemaker |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Cryosurgery (other than external lesions) | <input type="checkbox"/> Radiation/ X-Ray Therapy |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Radiopaque Dye Injection |
| <input type="checkbox"/> Dermatological Surgery: | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Chemabrasion | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Spinal Surgery |
| <input type="checkbox"/> Hair Transplants | <input type="checkbox"/> Teleradiology _____ % of Practice |
| <input type="checkbox"/> Silicone Injections | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Tumescent Liposuction | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Elective Plastic Surgery | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Encephalography | <input type="checkbox"/> Weight Control Medication _____ % of Practice |
| <input type="checkbox"/> Endoscopic Laser Therapy | <input type="checkbox"/> Other Procedures: _____ |

PART VII - ADDITIONAL PROFESSIONAL INFORMATION

How many scheduled patients do you see per week? _____

How many walk-in patients do you see per week? _____

How many hours do you work per week? _____

Are you subject to the Federal Tort Claims Act? Yes No

Please provide a narrative and any applicable documentation explaining any "Yes" answer to the following questions:

Do you normally staff an emergency room? Yes No

If Yes, is coverage being requested for this ER work? Yes No

Do you practice in or staff an urgent-center or similar minor emergency clinic? Yes No

Are you employed full time by the Federal Government or are you in the military service? Yes No

Do you treat Federal or Non-Federal Inmates? Yes No

Are you engaged in any "moonlighting" activities? Yes No

Number of hours per month spent moonlighting _____

Is coverage being requested for moonlighting activities? Yes No

Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? Yes No

Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? Yes No

Has any hospital ever denied, restricted, suspended or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked? Yes No

Has your narcotics or medical license ever been suspended, restricted, revoked or voluntarily surrendered; has probation ever been invoked? Yes No

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 health? Yes No

Have you ever been asked to participate in or have you volunteered to participate in an impaired physician program? Yes No
(if Yes, please attach a copy of your recovery plan)

If Yes, was your participation: Mandatory Voluntary

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

Do you do outside peer reviews or medical exams, or have a contract with an insurance company to do reviews? Yes No

If Yes, % of practice: _____

Are you currently under contract to supervise or administer any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program? Yes No

Do you provide any diagnostic, consulting or other professional services to patients in states other than those in which you are currently licensed? Yes No

Have you ever had any claims of sexual misconduct made against you? Yes No

Have you ever had your request for coverage denied, your policy cancelled or non-renewed or had a policy issued to you that contained restrictions or special exclusions? Yes No

Has a patient or his representative ever filed a complaint or grievance against you with a hospital committee, state licensing or regulatory agency or other medical review committee? Yes No
(If Yes, please attach a copy of the board complaint and/or board order)

Other than a minor traffic offense, have you ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance? Yes No

Have you performed and/or do you currently perform silicone breast implants? Yes No

(If Yes, describe the types and time frames in which they were performed. Confirm compliance with FDA recommendations regarding silicone breast implants.)

Have you had any injury, illness or other event occur that may impair, lessen or diminish your physical or mental ability to practice medicine? Yes No

Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes No

(If Yes, please attach a copy of the board complaint and/or board order.)

SPECIFIC CONSENT TO CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release WV Mutual Insurance Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company’s insurance program is not a right of every licensed physician who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company’s Underwriting Committee.

Applicant’s Signature _____ **Date** _____

AGREEMENTS & NOTICES

Notice to 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 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 on misleading , information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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 Virginia 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, denial of insurance benefits, and civil damages.

Applicant’s Signature: _____ **Date:** _____

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. Below is an Authorization to Release Information form which requires your signature. Please read carefully.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by WV Mutual Insurance Company (the "Company") hereby authorizes his/her present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his/her acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he/she is or has been a member; all hospitals in which he/she now holds, had held or has applied for staff privilege; the State Board of Medicine or Board of Osteopathy for the state in which he/she is licensed; any other state in which he/she has practiced or resided; and any and all physicians having information regarding the undersigned to release to the Company upon its request for information any such person or entity may have which, in the judgment of any such person, or entity of the Company, may have a bearing upon his/her acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, the Company, its directors, officers, employees and agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing the information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the undersigned original.

Name: _____

Signature: _____

Date: _____

SUPPLEMENTAL CLAIMS INFORMATION FORM

Please complete a Supplemental Claims Information Form for each case indicated on the application. You may photocopy this form if needed. All requested information must be provided 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. 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

7. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed but dropped by claimant Date _____
- Summary judgment in your favor Date _____

Court outcome in your favor: Jury verdict Directed verdict Date _____

Court outcome in favor of plaintiff: Jury verdict Directed verdict Date _____

Verdict Amount _____

Suit settled out of court

A. Date claim paid: _____

B. Amount paid on your behalf: \$ _____

C. Did **you** want to settle this claim? Yes No

Claim is currently pending

Reserve Amount _____

Signature _____ Date _____

Name (printed) _____