WVMIC Ancillary Medical Professional Liability Insurance

How to Apply

Complete, sign and submit the enclosed application for insurance at least 20 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 current medical professional liability insurance Declarations Page
- ☐ Copies of your loss history from prior carriers
- ☐ A claim narrative from the physician for any open claim
- ☐ A claim narrative from the defense attorney for any open claim
- ☐ 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.

Please submit applications to:

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

West Virginia Mutual Insurance Company

500 Virginia Street, East, Suite 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	

ANCILLARY MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

PART I – NAME AND ADDRESS

Name of Applicant

Home Address | City | State | Zip

Business Address | City | State | Zip

County | Home Phone | Home Fax | Business Phone | Business Fax

Date of Birth | Social Security Number | FEIN | DEA License Number

PART II – COVERAGE REQUESTED

Requested effective date _____ Limit Type ☐ Shared ☐ Separate

Coverage Limit ☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $4,000,000

Are you applying for prior acts coverage? ☐ Yes ☐ No If **Yes,** please provide requested retroactive date _____

PART III – COVERAGE HISTORY

Current Insurance Carrier | Policy Number | Policy Term

Coverage Type ☐ Claims Made ☐ Occurrence Coverage Limit _____ Limit Type ☐ Shared ☐ Separate

If coverage type is Claims Made, what retroactive date was used by your current carrier? _____

Did you purchase an extended reporting endorsement (tail) from your current carrier? ☐ Yes ☐ No

PART IV – PRACTICE INFORMATION

Type of practice

☐ Individual ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ Other

If employed, please specify name of employer: _____

How many hours do you work per week? _____

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

Do you perform any invasive procedures? ☐ Yes ☐ No If **Yes,** please specify and provide a Statement of Competency from your supervising Physician.

Are you currently a party to a Collaborative Agreement with a physician? If **Yes,** please provide a copy of the Agreement. ☐ Yes ☐ No

A. Do you have ownership in any Professional Corporation, Professional Association, Partnership or any other healthcare services entity? ☐ Yes ☐ No

If **Yes,** please list below:

Name	Description of Interest	% of Practice

PART IV – PRACTICE INFORMATION (continued)

Do you wish to include any of the entities listed as a named insured? ☐ Yes ☐ No

If **Yes,** please complete the Corporation Professional Liability Application for each entity you wish to include as a named insured.

B. If you as an individual employ or contract medical professionals, please list each medical professional below:

	Name	Designation (MD, DO, PA, NP, RN, LPN, etc.)	Contracted or Employed?	Insurance Carrier	Policy Limits
1.					
2.					
3.					
4.					

PART V – MEDICAL AND EDUCATIONAL BACKGROUND

Professional School Attended _____ Degree _____ Month _____ Year _____

If so recognized by your profession, what is your specialty and subspecialty?

Specialty _____ Subspecialty _____

Are you certified by an approved specialty board? ☐ Yes ☐ No If **Yes,** please specify: _____

Are you a dues paying member of a professional organization? ☐ Yes ☐ No If **Yes,** please specify: _____

PART VI – PRACTICE HISTORY

List all places where you have practiced your profession.

	Location	From	To
1.			
2.			
3.			
4.			
5.			

List all states where you are licensed to practice and license numbers:

	State	License Number	% of patients seen, treated or examined in each state
1.			
2.			
3.			

Name and location of all hospitals where you hold privileges:

	Hospital	Location	Type of Privileges
1.			
2.			
3.			

PART IV – PROFESSIONAL INFORMATION

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

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

If **Yes**, location and number of hours per month spent moonlighting

Location _____ Hours _____

Has your professional license been suspended, restricted, revoked, or voluntarily surrendered, or has probation ever been invoked? ☐ Yes ☐ No

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

Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO, PPO, or any governmental agency 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 allegations of sexual misconduct made against you? ☐ Yes ☐ No

PART V – CLAIMS INFORMATION

Have any claims or suits ever been made or brought against you? ☐ Yes ☐ No

Indicate number of previous claims or suits (this includes closed, dismissed, and/or dropped cases) _____

Indicate number of pending claims or suits * _____

The attached Supplementary Claims Information Form must be completed for each case indicated above

Do you have any have any knowledge of any claims which might be made against you (other than those indicated above) or activities that might reasonably give rise to a claim or suit being brought against you even if you believe the claim or suit would be without merit? (Include any requests for medical records.) ☐ Yes ☐ No

* A narrative from the applicant and the defense attorney describing each pending claim must be attached.

Explain any "Yes" answers to questions in Part IV and V (use additional sheets as necessary)

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)