WVMIC Corporation 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.

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:

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

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

Agent Information	
Agency	
Address	
Producer	

CORPORATION PROFESSIONAL LIABILITY APPLICATION

PART I – NAME AND ADDRESS

Entity Name _____ FEIN _____

Address _____ City _____ State _____ Zip _____ County _____

Entity Phone Number _____ Fax Number _____ Website _____

Office Manager/Business Administrator _____ Phone _____ E-mail Address _____

PART II – OFFICE LOCATIONS

Primary Office Location – Street _____ City _____ State _____ Zip _____ County _____

Primary Phone _____ Primary Fax _____ % of Practice _____

Other Locations

1. Address _____ City _____ State _____ Zip _____ County _____

   Phone _____ Fax _____ % of Practice _____

2. Address _____ City _____ State _____ Zip _____ County _____

   Phone _____ Fax _____ % of Practice _____

3. Address _____ City _____ State _____ Zip _____ County _____

   Phone _____ Fax _____ % of Practice _____

Preferred Address: ☐ Entity Address ☐ Primary Office Address ☐ Other _____

PART III – 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 IV – COVERAGE HISTORY

Current Insurance Carrier _____ Policy Number _____ Policy Term _____

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

PART IV – COVERAGE HISTORY (continued)

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

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, governmental program coverage or no coverage:

INSURANCE CARRIER	LIMITS OF LIABILITY	EFFECTIVE	EXPIRATION	CLAIMS MADE OR OCCURRENCE	TAIL PURCHASED*
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

*Attach copy of reporting Endorsement If **NO**, provide explanation.

PART V – ENTITY INFORMATION

Your entity is: ☐ Partnership ☐ Professional Corporation ☐ Joint Venture ☐ Other _____

1. When was this entity established/incorporated? _____

2. Do you use an unincorporated trade name (DBA)? If **Yes,** please provide the name(s) _____

3. Is this entity involved in the delivery of healthcare or professional medical services to patients within a direct professional provider-patient relationship? ☐ Yes ☐ No

   If **No**, thoroughly describe the entity's purpose below.

4. List below the name of all owners, stockholders and/or partners of this entity:

Name	Description and % of Interest	Profession	% of Practice (if applicable)

5. Does the entity employ or contract any other healthcare professionals? ☐ Yes ☐ No

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

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

PART V – ENTITY INFORMATION (continued)

6. Are there any subsidiaries of this entity that are involved in the delivery of healthcare or professional medical services to patients with a direct professional provider relationship? If **Yes**, list below: ☐ Yes ☐ No

Name of Subsidiary	Type of service provided	Include in Coverage
		☐ Yes ☐ No
		☐ Yes ☐ No

If subsidiary is not to be included in coverage, please attach declarations page from current carrier.

PART VI – ADDITIONAL INFORMATION

1. Does this entity own, operate, or staff any hospital, sanitarium or clinic with regular bed and board facilities? ☐ Yes ☐ No
2. Does this entity own, operate or staff any surgi-center, emergency service facility, minor emergency care facility, or laboratory? ☐ Yes ☐ No
3. Does this entity own, operate or staff any outpatient facility or provide out patient services at any location owned or operated by this entity? ☐ Yes ☐ No
4. Does this entity own, operate or staff any drug or alcohol rehabilitation facility or provide drug or alcohol rehabilitation services at any location owned or operated by this entity? ☐ Yes ☐ No
5. Does this entity allow other healthcare providers not employed or contracted by this entity to provide medical professional services at any office locations owned or operated by this entity? ☐ Yes ☐ No
6. Has this entity's license ever been suspended, restricted, revoked or surrendered or has probation been invoked? ☐ Yes ☐ No
7. Has this entity ever had a request for coverage denied, cancelled or non-renewed or had a policy issued to it that contained restrictions or special exclusions? ☐ Yes ☐ No

PART VII –CLAIMS INFORMATION

Have any claims or suits ever been made or brought against this entity? ☐ 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 VI and VII (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)