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.

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	

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 _____ ☐ M.D. ☐ D.O.

Home Address _____ City _____ State _____ Zip _____

County _____ Social Security Number _____ Date and Place of Birth _____ Gender ☐ Male ☐ 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						☐ Yes ☐ No
2						☐ Yes ☐ No
3						☐ Yes ☐ No
4						☐ Yes ☐ No
5						☐ Yes ☐ 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 III - PRACTICE AND HOSPITAL LOCATIONS

List LOCATIONS where you will practice subsequent to the requested date of coverage.
Note: please base percentage of practice on the number of patients treated.
PRACTICE AND HOSPITAL LOCATION PERCENTAGES MUST TOTAL 100% COMBINED.

A PRACTICE LOCATIONS – LIST PRINCIPAL LOCATION FIRST

1 _____
Suite | Address Number & Street | City | State | Zip | County | % of Practice

2 _____
Suite | Address Number & Street | City | State | Zip | County | % of Practice

3 _____
Suite | Address Number & Street | City | State | Zip | County | % of Practice

B HOSPITAL LOCATIONS

1 _____
Hospital Name | City | State | County | Type of Privileges | % of Practice

2 _____
Hospital Name | City | State | County | Type of Privileges | % of Practice

3 _____
Hospital Name | City | State | County | Type of Privileges | % of Practice

4 _____
Hospital Name | City | State | County | Type of Privileges | % of Practice

C PREFERRED MAILING ADDRESS

☐ Home ☐ Principal Office ☐ Other _____

PART- IV MEDICAL EDUCATION/BACKGROUND

A Medical School: _____ (Name of School) Year Graduated _____

City _____ State _____ Country _____ Degree _____

B Internship: _____ (Name of Hospital) City _____ State _____

From _____ (Month/Year) To _____ (Month/Year) Type of Internship _____

C-1 Residency: _____ (Name of Hospital) City _____ State _____

From _____ (Month/Year) To _____ (Month/Year) Type of Internship _____

C-2 Residency: _____ (Name of Hospital) City _____ State _____

From _____ (Month/Year) To _____ (Month/Year) Type of Internship _____

D Additional Training/Fellowship: _____ (Name of Hospital or Facility) City _____ State _____

From _____ (Month/Year) To _____ (Month/Year) Type of Training Completed _____

E Are you board certified? ☐ Yes ☐ No If **No**, are you Board Eligible? ☐ Yes ☐ No

If **Yes**, list board certifications _____ Certified _____ month/year

F If a foreign medical school graduate, have you obtained an ECFMG Certificate or a Fifth Pathway Certificate? ☐ Yes ☐ No

Indicate the year the certification was obtained: _____ ECFMG _____ Fifth Pathway

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 #	_____	☐	☐	☐	☐
2	State _____	License #	_____	☐	☐	☐	☐
3	State _____	License #	_____	☐	☐	☐	☐
4	State _____	License #	_____	☐	☐	☐	☐

PART V - PRACTICE ORGANIZATION

☐ 1. Solo Unincorporated
☐ 2. Solo Corporation
☐ 3. Employee of Individual/Group (not a shareholder/partner)
☐ 4. Partner in Partnership
☐ 5. Corporate Shareholder
☐ 6. Hospital Employee
☐ 7. Government Employee
☐ 8. Industrial Employee
☐ 9. Independent Contractor
☐ 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	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Nurse midwives	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Nurse anesthetists	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Nurse practitioner	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Psychologist	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Perfusionist	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Chiropractor	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Certified nurse anesthetists	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Cytotechnologist	☐ Shared Limits	☐ Separate Limits	☐ Individual Coverage
_____	Optometrist	☐ Shared Limits	☐ Separate Limits	☐ 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 - CLASSICIFATION 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:

- ☐ Abdominoplasty – Tummy Tuck
- ☐ Abortions - Elective
- ☐ Acupuncture
- ☐ Adenoidectomy
- ☐ Anesthesia General/Spinal/Caudal
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Assisting in major surgery – own patients only
- ☐ Assisting in major surgery – own & other than own patients
- ☐ Bariatric Surgery – Laparoscopic
- ☐ Bariatric Surgery – Non-Laparoscopic
- ☐ Biopsy – Endoscopic
- ☐ Blepharoplasty – Cosmetic _____ % of Practice
- ☐ Blepharoplasty - Reconstruction _____ % of Practice
- ☐ Botox
- ☐ Breast Implants
  - ☐ Cosmetic _____ % of Practice
  - ☐ Reconstructive _____ % of Practice
- ☐ Breast Reduction
- ☐ Bronchoscopy
- ☐ Cataract Surgery
- ☐ Catheterization
  - ☐ Arterial
  - ☐ Cardiac
  - ☐ Diagnostic
  - ☐ Left Heart
- ☐ Chelation Therapy
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy / Laparoscopic
- ☐ Colonoscopy
- ☐ Cryosurgery (other than external lesions)
- ☐ D&C
- ☐ Dermatological Surgery:
  - ☐ Chemical Peels
  - ☐ Chemobrasion
  - ☐ Dermabrasion
  - ☐ Hair Transplants
  - ☐ Silicone Injections
  - ☐ Tumescent Liposuction
  - ☐ Other: _____
- ☐ Elective Plastic Surgery
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy
- ☐ ERCP
- ☐ Fluoroscopy
- ☐ Face Lifts
- ☐ Face Lifts – Mini (done with laser) _____ % of Practice
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastrointestinal Endoscopy
- ☐ Hip Nailings
- ☐ Hyperbaric Medicine
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Mammograms
- ☐ Myelography
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrics
  - ☐ Prenatal
  - ☐ Postnatal
  - ☐ Deliveries
- ☐ Organ Transplant
- ☐ Pain Management
  - ☐ Medicine Only
  - ☐ Nerve Block
  - ☐ Implants
  - ☐ Radiofrequency Procedures
  - ☐ Other: _____
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Permanent Pacemaker
- ☐ Polypectomy
- ☐ Radiation/ X-Ray Therapy
- ☐ Radiopaque Dye Injection
- ☐ Renal Dialysis
- ☐ Sclerotherapy
- ☐ Shock Therapy
- ☐ Spinal Surgery
- ☐ Teleradiology _____ % of Practice
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Weight Control Medication _____ % of Practice
- ☐ 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 urgi-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? **(if Yes, please attach a copy of your recovery plan)**	☐ Yes	☐ No
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? **(If Yes, please attach a copy of the board complaint and/or board order)**	☐ Yes	☐ No
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? **(If Yes, please attach a copy of the board complaint and/or board order.)**	☐ Yes	☐ No

PART VIII –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 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 VII and VIII (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)