



HEALTHCARE PROVIDERS INSURANCE EXCHANGE

ENTITY LIABILITY APPLICATION

Legal Name of Entity _____

Entity Business Address (include city, state, zip) _____

Phone: _____

Fax: _____

E-mail Address: _____

Attach Copy of Date Stamped Articles of Incorporation or Partnership Agreement

Desired coverage effective date: _____ 12:01 a.m.

Desired coverage type:

CLAIMS-MADE **With Prior Acts Coverage.** Retroactive date used by your existing carrier: _____ 12:01 a.m.
A copy of your current declarations page verifying retroactive date must be attached.

CLAIMS-MADE **Without Prior Acts Coverage** (decline or do not need retroactive coverage). The retroactive date on the policy applied for will be the same as the effective date of coverage.
Under the *claims-made policy type*, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force. A reporting endorsement or equivalent coverage must be secured upon policy termination or nonrenewal.

OCCURRENCE
Under the *occurrence policy type*, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is reported.

Entity Type

- | | |
|--|---|
| <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Business Corporation | <input type="checkbox"/> Professional Association |
| <input type="checkbox"/> Limited Liability Corporation | <input type="checkbox"/> Joint Venture |

Description of Operations

- | | |
|--|---|
| <input type="checkbox"/> Private doctor's office | <input type="checkbox"/> Physician owned and operated lab –owner use only |
| <input type="checkbox"/> Doctor's office with diagnostic equipment | <input type="checkbox"/> Physician owned and operated lab –used by other than doctor/owner patients |
| <input type="checkbox"/> Outpatient Surgery Urgent Care Facility | <input type="checkbox"/> Other |

Are there any services or business operations conducted outside of Pennsylvania? Yes No
If yes, describe: _____

How many physicians and/or surgeons are in your group? _____ How many are applying to HPIX? _____

List the names of all physicians in the entity

<i>Name and Specialty</i>	<i>Current Insurer</i>	<i>Retroactive Date</i>	<i>Shareholder(SH) Employed Physician(EP) or Independent Contractor(IC)</i>

If additional space is required, use a separate sheet.

DESIGNATED EMPLOYEE COVERAGE

Does your entity employ any paraprofessionals?

Yes No

If yes, complete Section 1 below.

If you wish to purchase a separate set of basic limits of liability for any of these employees (referred to as Designated Employee Coverage), complete Section 2 below and attach a copy of employee's license and/or certification.

SECTION 1	
Specialty	Number
Nurses (RN and LPN)	
CRNAs	
Nurse Practitioners	
Nurse Midwives	
Physician Assistants	
Surgical Assistants	
Physical Therapists	
Medical or Lab Technicians	
Medical Assistants	
Other (specify)	

SECTION 2		
Name and Specialty	Current Insurer	Retroactive Date

Have any of your paraprofessional employees ever been named in a claim or suit?

Yes No

Have any of your paraprofessional employees ever had any action taken against licensure?

Yes No

If yes to either answer, complete the following (if additional space is required, photocopy this form as needed).

Employee Name: _____

Insurer: _____

Allegation: _____

Action Taken: _____

Status: Open Reserves: Closed without Payment Closed with Payment - Amount: _____

CLAIMS HISTORY

1. In the past ten years, has any malpractice claim or suit been made against the entity?

Yes No

If yes, how many? _____

2. Do you have knowledge of any incident, adverse outcome or other circumstances that might reasonably lead to such a claim or suit?

Yes No

If yes, how many? _____ Have they been reported to your previous insurers?

Yes No

Complete a Claims Supplement Form for each claim, suit or potential claim.

CERTIFICATION, AUTHORIZATION AND SIGNATURE

The undersigned certifies that the information in this application is true and correct. The undersigned further agrees to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

Any person or entity who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature: _____ Title _____ Date: _____