For Claims Made Professional Liability
Insurance and Prior Acts Coverage

COVERAGE HIGHLIGHTS

Feature	Benefit
Physicians Administrative Defense Reimbursement Coverage	Provides defense cost reimbursement and practice interruption expense reimbursement for administrative proceedings and employment-related civil actions
Free Tail Coverage for a Retiring Group Member (certain qualifications required)	Reduces the group's/physician's expenses after retirement
Limited Professional Office Premises Liability Coverage	Provides limited coverage for slips and falls and property damage
Optional Health Care General Liability Insurance for Qualified Groups (additional charge applies)	Replaces and provides broader coverage than Limited Professional Office Premises Liability Coverage and includes coverage for personal injury and advertising injury
Prior Acts/Nose Coverage (Over Current Retroactive Date)	Conveniently provides coverage from one insurer
Right to Consent to Settle	Places the Insured in control of whether to settle a claim

The following benefits are provided in addition to the Limits of Liability of the policy:

- Defense Costs
- Attendance at Trial: *$500 maximum per half day per Insured*
- Fire and Water Damage Legal Liability: *$500,000/$500,000 for the Named Insured*
- Medical Payments: *$10,000 per person*
- Pre-judgment and Post-judgment Interest on that part of any judgment we pay

Additional Highlights

Aggressive Claims Handling	Represents the Insured's interests and helps protect the Insured's reputation
On-Site Clinical and Administrative Assessment	Helps the group to identify risks and evaluate and improve its practice systems
Award-winning CME Material	Assists the group in enhancing patient safety and improving communication
Monthly *Claims Rx* Newsletter	Helps the group stay on top of current administrative and clinical issues
Risk Management 24/7 Phone Consultations	Offers peace of mind and allows an Insured to call NORCAL 24/7 for Risk Management advice

The above information is intended only to highlight the NORCAL policy features and benefits. The conditions of coverage are specifically explained in the NORCAL policy. Please read the policy for complete coverage information.

If you have questions regarding this application or would like a copy of the NORCAL policy, please contact your broker or NORCAL's Policyholder Services Unit at (877) 443-7232.

IMPORTANT INFORMATION

The coverage of any policy, if issued, is limited generally to liability only for those claims that are first made against an Insured and reported to NORCAL while the policy is in force. The coverage provided under the optional Health Care General Liability Insurance, if purchased, is limited to bodily injury, property damage, fire damage, personal injury or advertising injury that occurred during the policy period.

Please review the policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker. Please note that no coverage exists until written verification of coverage by NORCAL Mutual Insurance Company is issued in the group's/entity's name.

The application asks that you provide information regarding affiliations, practice associations, etc. This information is requested to provide us with an understanding of the group's practice but does not mean that a policy, if issued, would cover such entities and persons.

APPLICATION CHECKLIST

❏ Type or print clearly in ink.

❏ Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.

❏ If you wish to explain any of your answers, please use the Remarks section on page 18. If you need more space, please attach additional pages.

❏ Please ensure that you sign and date the application on page 19 for California and Rhode Island applicants or page 20 for Alaska applicants.

❏ In addition to a completed application, please provide the following items:

- A completed application for each employed physician and each employed health care extender.
- A copy of the group's letterhead(s).
- Loss runs for the previous ten years for the group and each group member. The loss runs must include paid and reserved amounts and be less than 90 days old.
- A copy of the Declarations Page and any endorsements from the group's/entity's most recent insurance policy, if applicable. If each physician was issued a Declarations Page, please provide each Declarations Page. If each physician was not issued a Declarations Page, please provide the endorsement to the policy that identifies all insureds and their Retroactive Dates.

❏ If the group engages in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, the group is considered a *Covered Entity* under HIPAA and is thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at www.norcalmutual.com.

❏ Please make a copy of the completed application and supporting documentation for your records.

SECTION I IDENTIFYING INFORMATION

Group Name					Tax ID Number	
Primary Practice Address	City	County	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Mailing Address (Location where all mailings except invoices will be sent)		City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Billing Address (Location where invoices will be sent)		City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -

Coverage Structure

Please identify the desired coverage structure:

NOTE: NORCAL offers two options under which groups may apply for coverage—the **single group policy format** and the **multi-policy format**. Please review the attached document that highlights the main differences between these options and discuss the options with your broker or call NORCAL before identifying the desired structure.

❏ The group wishes to apply for coverage under the **single group policy format**. Under this format the group's entity is the Named Insured and is issued a policy. All health care professionals are endorsed onto that policy as Insureds with individual or shared limits of liability. Individual insured physicians do not have their own policies. Coverage for an Insured is provided only while he or she is acting within the course and scope of his or her duties for the Named Insured.

❏ The group wishes to apply for coverage under the **multi-policy format**. Under this format the entity and each physician with individual limits of liability are issued separate policies and each is a Named Insured under the applicable policy.

Authorized Representative

1. If you are applying for coverage under the **single group policy format**, please complete the following:

   The Authorized Representative is the person responsible for providing consent decisions on behalf of the Named Insured and the person who will act on behalf of the Named Insured or other Insureds for all other purposes relating to the policy. One person may be designated for both purposes or a separate person may be designated for each purpose.

   Please provide the name and title of the person authorized to provide consent decisions on behalf of the Named Insured:

   Name: ______________________ **Title:** ______________________

   E-Mail Address: ______________________ **Telephone Number:** ______________________

   Please provide the name and title of the person authorized to act on behalf of the Named Insured and all other Insureds for all other (nonconsent) purposes relating to the policy:

   Name: ______________________ **Title:** ______________________

   E-Mail Address: ______________________ **Telephone Number:** ______________________

2. If you are applying for coverage under the **multi-policy format**, please identify the Authorized Representative to act on behalf of the Named Insured entity for all purposes relating to the policy:

   Name: ______________________ **Title:** ______________________

   E-Mail Address: ______________________ **Telephone Number:** ______________________

SECTION II COVERAGE/INSURANCE INFORMATION

Requested Effective Date (the date you wish coverage to begin)

____ 12:01 a.m. Local Time
Month Day Year

NOTE: NORCAL should receive the application at least thirty days before the Requested Effective Date.

Prior Acts Coverage (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. **This coverage does not apply to the optional Health Care General Liability Insurance. NORCAL does not automatically provide Prior Acts Coverage.**

❏ The group wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current carrier. (Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 17.):

❏ The group does not wish to apply for Prior Acts Coverage. It is understood that if the group does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the Effective Date of the NORCAL policy, if issued.

Requested Retroactive Date

____ 12:01 a.m. Local Time
Month Day Year

NOTE: The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

Health Care General Liability Insurance – Occurrence

NOTE: This coverage is available only to qualified groups insured under the **single group policy format**. Please discuss with your broker or contact NORCAL before completing the remaining questions.

Health Care General Liability Insurance is an optional, occurrence-based coverage. Additional premium will be charged if this coverage is approved. **NORCAL does not automatically provide Health Care General Liability Insurance coverage**.

Does the group wish to apply for Health Care General Liability Insurance coverage? ❏ **Yes** ❏ **No**

If yes, please contact NORCAL or your broker for an application in order to apply for such coverage.

Requested Limits of Liability

1. If you are applying for coverage under the **single group policy format**, please complete the following:

   a. Please indicate the desired limits of liability for the group members. All insured group members will have the same limits of liability.

   $ _______________ each claim/$ _______________ annual aggregate

   NOTE: The entity may be eligible for a higher annual aggregate limit of liability for an additional charge. Please contact your broker or NORCAL for the eligibility requirements and available limits of liability if the group is interested. If this option is not chosen, the limits of liability for the entity will be the same as the limits of liability for the group members.

   b. If the group qualifies, do you wish to request a higher annual aggregate limit of liability for the entity? ❑ **Yes** ❑ **No**

2. If you are applying for coverage under the **multi-policy format**, please indicate the desired limits of liability for the entity:

   $ _______________ each claim/$ _______________ annual aggregate

Deductible

NOTE: NORCAL offers deductibles in specified amounts and only to qualified groups. Please discuss with your broker or contact NORCAL before completing the remaining questions if you are interested in a deductible. Deductibles apply to both Professional Liability Insurance and Health Care General Liability Insurance, if applicable.

Does the group wish to have a deductible on the policy? ❑ **Yes** ❑ **No**

If yes, please complete the following:

Type: ❑ Indemnity only ❑ Indemnity and Expense

Per Claim Amount: $ _____________________________

Annual Aggregate: ❑ **Yes** ❑ **No** **If yes,** Annual Aggregate Amount: $ _____________________________

Scope of Coverage (check one)

❑ NORCAL coverage is being requested for the group's entire medical practice as described in this application.

❑ NORCAL coverage **is not** needed for part of the group's medical practice (e.g., services rendered at certain locations).

If the group does not need NORCAL coverage for a particular part of its practice, please provide a detailed description of that part of the group's practice, including the start date, below. Please also identify the name of the insurance carrier that is providing the group with professional liability coverage for that part of its practice, as well as the limits of liability of that coverage.

____

____

____

____

Professional Liability Insurance History

1. Has any professional liability insurance company **ever** canceled, nonrenewed, modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) the group's insurance, declined to offer the group coverage or notified the group of its intent to pursue such action? ❏ **Yes** ❏ **No**

   If yes, please provide a detailed, written narrative below and copies of all pertinent documentation (e.g., a copy of the nonrenewal or declination notice). At a minimum, the narrative must include the name of the insurance company, the date(s) of the action(s) and a detailed description of the reason(s) for the action(s).

   ____

   ____

   ____

   ____

2. Please complete the following regarding all Professional Liability Insurance maintained by the group during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	**Coverage Dates** (month/day/year)	**Deductible or Self-insured Retention?**	**Policy Type**	**If Claims Made, Check One**
	From: To:	❏ **Yes** ❏ **No** If yes, specify type: ________ ________________________ Amount: $ ______________	❏ Claims Made ❏ Occurrence ❏ Other: ________ ______________	❏ Tail Coverage purchased ❏ Prior Acts Coverage purchased from subsequent insurer ❏ Other: __________________
	From: To:	❏ **Yes** ❏ **No** If yes, specify type: ________ ________________________ Amount: $ ______________	❏ Claims Made ❏ Occurrence ❏ Other: ________ ______________	❏ Tail Coverage purchased ❏ Prior Acts Coverage purchased from subsequent insurer ❏ Other: __________________
	From: To:	❏ **Yes** ❏ **No** If yes, specify type: ________ ________________________ Amount: $ ______________	❏ Claims Made ❏ Occurrence ❏ Other: ________ ______________	❏ Tail Coverage purchased ❏ Prior Acts Coverage purchased from subsequent insurer ❏ Other: __________________
	From: To:	❏ **Yes** ❏ **No** If yes, specify type: ________ ________________________ Amount: $ ______________	❏ Claims Made ❏ Occurrence ❏ Other: ________ ______________	❏ Tail Coverage purchased ❏ Prior Acts Coverage purchased from subsequent insurer ❏ Other: __________________

3. If any one of the insurance coverages identified above was Claims Made Coverage, and the group did not purchase Tail Coverage *or* Prior Acts Coverage, please explain:

   ____

   ____

   ____

   ____

SECTION III LEGAL STRUCTURE

1. Please complete the following regarding the primary legal entity applying for coverage and provide a copy of the entity's partnership agreement, articles of incorporation, etc:

Name of Entity	Legal Structure	Name(s) of Owner(s) and the Percentage of Ownership Interest
	❏ Corporation ❏ Limited Liability Company ❏ Partnership ❏ Limited Liability Partnership ❏ Other: _______________	

2. Does the entity identified in question 1 own, operate or manage any other organization or entity? ❏ **Yes** ❏ **No**

   If yes, please complete the following for each organization or entity and provide a copy of each entity's partnership agreement, articles of incorporation, etc. Please photocopy this page if additional space is needed.

Name of Entity	Legal Structure	Name(s) of Owner(s) and the Percentage of Ownership Interest	Is NORCAL Coverage Desired for the Organization/Entity?*
	❏ Corporation ❏ Limited Liability Company ❏ Partnership ❏ Limited Liability Partnership ❏ Other: _______________		❏ **Yes** ❏ **No**
	❏ Corporation ❏ Limited Liability Company ❏ Partnership ❏ Limited Liability Partnership ❏ Other: _______________		❏ **Yes** ❏ **No**

* If NORCAL coverage is not desired for the organization or entity, please explain in the Remarks section on page 18.

3. Does the group desire coverage for any entity(ies) not already identified in question 1 or 2? ❏ **Yes** ❏ **No**

   If yes, please identify each entity and its owner(s) and explain:

   ____

   ____

4. Is the group owned, operated or managed by another organization or entity not already specified above? ❏ **Yes** ❏ **No**

   If yes, please explain and provide the name(s) of the organization(s):

   ____

   ____

5. Is the group involved in any joint ventures or partnerships? ❑ **Yes** ❑ **No**

   If yes, please explain:

   ____

   ____

6. If you answered yes to question 2, 3, 4 or 5, please provide a chart of the organizational structure on a separate sheet of paper.

7. Does the group or any of its members use any fictitious name(s) or dba(s)? ❑ **Yes** ❑ **No**

   If yes, please identify each fictitious name or dba and explain:

   ____

   ____

SECTION IV PRACTICE LOCATIONS

1. Please identify all non-hospital locations at which the group's members render professional health care services. Please photocopy this page if additional space is needed.

   Use the following codes for the location type when completing the table:

   A. Outpatient Office
   B. Blood Bank
   C. Dialysis Center
   D. Office-based Surgical Suite
   E. Nursing Home
   F. Urgent Care Clinic
   G. Ambulatory Surgery Center
   H. Community Clinic
   I. Endoscopy Center
   J. Laboratory
   K. Imaging Center
   L. Other (specify): ____

Location (name and address)	**Type of Location** (use code)	**Date Group Began Rendering Services at Location**	**Accreditation**	**Is NORCAL Coverage Desired for the Services Rendered at This Location?***
			❏ JCAHO ❏ AAAHC/AAAASF ❏ Other: ___________	❏ **Yes** ❏ **No**
			❏ JCAHO ❏ AAAHC/AAAASF ❏ Other: ___________	❏ **Yes** ❏ **No**
			❏ JCAHO ❏ AAAHC/AAAASF ❏ Other: ___________	❏ **Yes** ❏ **No**
			❏ JCAHO ❏ AAAHC/AAAASF ❏ Other: ___________	❏ **Yes** ❏ **No**

* If NORCAL coverage is not desired for the services rendered at any location, please explain in the Remarks section on page 18.

2. Does the group own or rent each location identified in question 1? ❏ **Yes** ❏ **No**

   If no, please identify the location and explain:

   ____

   ____

3. Does the group allow nongroup members to render services at any location(s) that the group owns or rents? ❏ **Yes** ❏ **No**

   If yes, please identify the location(s), provide the name(s) and designation(s) of the person(s), and explain:

   ____

   ____

SECTION V PERSONNEL

NOTE: Due to the potential for shared liability, NORCAL requires that all health care practitioners practicing in an employer-employee relationship, partnership or medical corporation be insured with NORCAL.

Administration

1. Please identify the following individuals:

Title	Name	Number of Years with Group
Chief Executive Officer:		
President:		
Medical Director:		
Administrator:		
Other:		

Physicians and Dentists

1. Please attach a roster of all physicians and dentists who provide services on behalf of the group, including the following information for each individual:
   - Name and designation
   - Whether the individual is a partner/shareholder, an employee or an independent contractor
   - Date of employment, if an employee

Departed Physicians and Dentists

1. Does the group desire coverage with NORCAL for those physicians and dentists who left the group before the group's desired Effective Date with NORCAL? ❑ **Yes** ❑ **No**

   If yes, please answer question 2.

   If no, please answer questions 3 and 4.

2. Please attach a roster of all departed physicians and dentists, including the following information for each individual:
   - Name and designation
   - Specialty
   - Whether the individual was a partner/shareholder, an employee or an independent contractor
   - Dates individual rendered services on behalf of the group
   - Retroactive Date
   - Whether the individual was insured with shared or separate limits of liability

3. Is there a written agreement between the group and each of its employed and independently contracted physicians and dentists which specifies who is responsible for purchasing Tail Coverage if the physician or dentist leaves the group? ❑ **Yes** ❑ **No**

   If yes, who is responsible for purchasing Tail Coverage? ❑ Group ❑ Physician/Dentist

   If no, please explain:

   ____

   ____

4. Has Tail Coverage been purchased for all departed physicians and dentists? ❑ **Yes** ❑ **No**

If no, please explain:

____

____

Health Care Extenders and Ancillary Personnel

1. Other than physicians and dentists, please identify all individuals who render professional health care services on behalf of the group:

Designation	Association	Designation	Association
Certified Nurse Midwife*	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Medical Assistant	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Certified Registered Nurse Anesthetist*	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Optometrist	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Nurse Practitioner*	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Psychologist	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Physician Assistant*	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Registered Nurse	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Podiatrist*	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Registered Nurse First Assistant	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Perfusionist*	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Other (specify): ________ ________	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Emergency Medical Technician	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Other (specify): ________ ________	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________
Licensed Practical/ Vocational Nurse	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________	Other (specify): ________ ________	Number Employed: ________ Number Independently Contracted: ________ Other (specify): ________

***A separate application is required**

2. Does the group lease any health care personnel from other organizations or individuals (e.g., temporary employment agencies)?
❑ **Yes** ❑ **No**

If yes, please provide a copy of the contract(s).

3. Do any persons identified in question 1 perform cosmetic procedures? ❑ **Yes** ❑ **No**

If yes, please provide the name of each person and the cosmetic procedures he or she performs:

____

____

Independent Contractors

NOTE: Please complete the questions in this section only if you indicated that the group independently contracts with physicians, dentists, health care extenders or ancillary personnel. **No coverage is provided to independent contractors unless they are endorsed onto the policy.**

1. Are all independent contractors required to maintain Professional Liability Insurance with limits of liability of at least $1 million per claim/$3 million annual aggregate? ❑ **Yes** ❑ **No**

2. Are all independent contractors required to provide the group with proof of Professional Liability Insurance at least annually?
❑ **Yes** ❑ **No**

If you answered no to question 1 or 2, please explain:

____

____

3. Are the independent contractors permitted to do any of the following:

Share in the group's or a group member's profits and/or overhead expenses? ❑ **Yes** ❑ **No**

Share medical professional personnel with a group member? ❑ **Yes** ❑ **No**

Use the group's or a group member's letterhead? ❑ **Yes** ❑ **No**

Use the group's or a group member's advertisements? ❑ **Yes** ❑ **No**

Bill under the group's or a group member's name? ❑ **Yes** ❑ **No**

If you answered yes to any one of the above, please identify each individual and the applicable common action(s) pertinent to him or her:

____

____

Work Outside of Group Employment

1. Does the group permit its employees to render services unrelated to the group's practice? ❑ **Yes** ❑ **No**

NOTE: If you are applying for coverage under the single group policy format, the NORCAL group policy provides coverage to an Insured only while he or she is acting within the course and scope of his or her duties for the Named Insured.

If yes:

a. Is the employee required to obtain separate insurance to cover the outside exposure? ❑ **Yes** ❑ **No**

b. Is the employee required to notify the group of any outside exposure(s)? ❑ **Yes** ❑ **No**

If you answered no to question 1a or 1b, please explain:

____

____

SECTION VI GENERAL PRACTICE INFORMATION

1. Does the group specialize in any particular field of medicine and/or particular procedure(s)? ❑ **Yes** ❑ **No**

   If yes, please explain:

   ____

   ____

2. Within the next 12 months, are there any planned material changes for the group (e.g., the addition of a new location(s), establishment of another entity, changes in the type of procedures performed and/or services provided)? ❑ **Yes** ❑ **No**

   If yes, please explain:

   ____

   ____

Managed Care

1. Does the group have an ownership interest in any managed care organizations? ❑ **Yes** ❑ **No**

   If yes:

   a. Please identify the organization(s):

   ____

   ____

   b. Does the group maintain managed care errors and omissions coverage? ❑ **Yes** ❑ **No**

2. Do any group members perform utilization review activities on behalf of any managed care organizations? ❑ **Yes** ❑ **No**

   If yes, does the group maintain separate coverage for such exposures? ❑ **Yes** ❑ **No**

3. Does the group assume "capitated risk" under any of the managed care contracts? ❑ **Yes** ❑ **No**

   If yes, does the group maintain provider "stop loss" insurance coverage for its capitated risk? ❑ **Yes** ❑ **No**

4. If you answered yes to question 1, 2 and/or 3, but indicated that the group does not maintain insurance coverage for the exposure(s), please explain:

   ____

   ____

NOTE: NORCAL does **not** provide coverage for the exposures identified in questions 1, 2 and 3 above.

Advertising

1. Does the group advertise in any way other than listing the name, address and telephone number in the telephone book? ❑ **Yes** ❑ **No**

   If yes, please submit copies of all of the advertisements (excluding those that appear on the website, if applicable) and/or the script of any voice, film or TV media.

2. Is there a website related to the group's medical practice? ❑ **Yes** ❑ **No**

   If yes, please provide the website address (if more than one, please identify each):

   ____

   ____

Miscellaneous

1. Has the group entered into any contracts to provide professional health care services (excluding those with managed care organizations)? ❑ **Yes** ❑ **No**

   If yes, please explain and provide a copy of the contract(s):

   ____

   ____

2. Does the group comply with all federal, state and local laws and regulations regarding the disposal of hazardous waste material? ❑ **Yes** ❑ **No**

   If no, please explain:

   ____

   ____

SECTION VII RISK MANAGEMENT

1. Does the group have a formal risk management program? ❑ **Yes** ❑ **No**

   a. **If yes,** who (name and title) is responsible for the risk management program?

   ____

   b. **If no,** please explain:

   ____

   ____

Credentialing

1. Does the group have a formal process to credential its health care providers? ❑ **Yes** ❑ **No**

   a. **If yes,** please identify who performs the initial credentialing (e.g., employee, hospital, outside company):

   ____

   ____

   b. **If no,** please explain:

   ____

   ____

2. Does the group evaluate the following when credentialing its health care providers?

Claim History	❑ **Yes**	❑ **No**	**If yes,** source(s) used: ____________________
Hospital Privileges	❑ **Yes**	❑ **No**	
Employment History	❑ **Yes**	❑ **No**	**If yes,** source(s) used: ____________________
Education History	❑ **Yes**	❑ **No**	**If yes,** source(s) used: ____________________
Felony/Misdemeanor History	❑ **Yes**	❑ **No**	**If yes,** source(s) used: ____________________
Medical/Dental/Nursing and Narcotic Licenses	❑ **Yes**	❑ **No**	**If yes,** source(s) used: ____________________

   If you answered no to any one of the above, please explain:

   ____

   ____

3. Does the group use the same credentialing procedures to credential independent contractors and locum tenens health care providers? ❑ **Yes** ❑ **No**

   If no, please describe the credentialing process used:

   ____

   ____

4. How often are the group's health care providers recredentialed?

   ____

   ____

Quality Assurance

1. Does the group have a formal process to evaluate and address concerns of unexpected patient outcomes? ❑ **Yes** ❑ **No**
2. Does the group have a formal process to evaluate patient complaints? ❑ **Yes** ❑ **No**
3. Does the group conduct patient satisfaction surveys? ❑ **Yes** ❑ **No**

   If yes, how often: ____

Utilization Review

1. Does the group have its own utilization review committee? ❑ **Yes** ❑ **No**

   If yes:

   a. Does the group have written policies and procedures for appeals of denied procedures? ❑ **Yes** ❑ **No**

   b. Who performs the utilization reviews? ____

   ____

   c. Are claim denial procedures explained in writing to patients? ❑ **Yes** ❑ **No**

   d. Does a physician review all proposed denials of benefits? ❑ **Yes** ❑ **No**

   e. Is there a fast track appeal system for denied procedures that may severely impair the quality of life for a patient if not performed? ❑ **Yes** ❑ **No**

Medical Records

1. Does the group currently use electronic medical records? ❑ **Yes** ❑ **No**

   If yes:

   a. Who is the vendor? ____

   b. How often are the electronic files backed up? ____

   c. Who backs up the files? ____

   d. Are the backed-up files stored at an off-site location? ❑ **Yes** ❑ **No**

   If you answered no to question 2d, please explain:

   ____

   ____

   e. Do all group locations use electronic medical records? ❑ **Yes** ❑ **No**

   f. Are all systems (e.g., inpatient, outpatient, billing, scheduling) electronic? ❑ **Yes** ❑ **No**

   If you answered no to question 2f, how are the different systems coordinated?

   ____

   ____

2. If the group does not use electronic medical records, or uses them but not at all locations, how are records made available to group members who are not at the location where the medical record is stored?

   ____

   ____

3. How are record-keeping deficiencies identified and handled?

   ____

   ____

SECTION VIII SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the group? ❑ **Yes** ❑ **No**

2. Have the group's clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending? ❑ **Yes** ❑ **No**

3. Has the group **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ❑ **Yes** ❑ **No**

4. Has any group member **ever** been accused of sexual misconduct? ❑ **Yes** ❑ **No**

5. Do you know if any individual who works on the group's behalf has a prior history or propensity for sexual misconduct? ❑ **Yes** ❑ **No**

SECTION IX CLAIMS HISTORY

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the group entity(ies), or has a group entity been notified of its involvement in a malpractice claim or suit, either directly or indirectly? ❑ **Yes** ❑ **No**

2. Is the group aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against a group entity, directly or indirectly, even if you believe the claim or suit would be without merit?
❑ **Yes** ❑ **No**

If you answered yes to question 1 or 2, please complete a Claim Information Form on page 21 for each applicable claim, suit, incident, conduct, etc.

SECTION X PRIOR ACTS COVERAGE

NOTE: If the group is not applying for Prior Acts Coverage, please skip this section.

Please ensure that your answers to the following questions reflect the group's practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date:

   a. Has there been a change in the information provided in Section III (Legal Structure) (i.e., entities dissolved, legal associations ended, etc.)? ❑ **Yes** ❑ **No**

   If yes, please explain and identify the entities, associations, etc. and the corresponding dates:

   ____

   ____

   b. Has the group rendered professional health care services at any location other than a location identified in Section IV (Practice Locations)? ❑ **Yes** ❑ **No**

   If yes, please complete the following:

Location (name and address)	**Type of Location** (e.g., outpatient office)	**From** (month/year):	**To** (month/year):

   c. Have any physicians or dentists other than those identified in Section V (Personnel) rendered professional health care services on behalf of the group? ❑ **Yes** ❑ **No**

   d. Have any certified nurse midwifes, certified registered nurse anesthetists, nurse practitioners, physician assistants, podiatrists or perfusionists other than those identified in Section V (Personnel) rendered professional health care services on behalf of the group? ❑ **Yes** ❑ **No**

   If you answered yes to question 1c or 1d, please attach a roster of all such personnel, including each individual's name, designation, medical specialty (if a physician) and type of relationship with the group (e.g., employee), and the dates that he or she provided services on behalf of the group.

2. Since the Requested Retroactive Date, have there been any material changes in the group's practice other than as specified above? ❑ Yes ❑ No

   If yes, please provide a detailed written narrative in the Remarks section on page 18.

Scope of Coverage (Prior Acts Period)

1. Other than any exposure that you might have identified under Scope of Coverage in Section II (Coverage/Insurance Information), is there any aspect of your practice since the Requested Retroactive Date for which you do not need NORCAL Prior Acts Coverage? ❑ Yes ❑ No

   If yes, in the Remarks section on page 18 please provide a detailed description of that practice, including the start and end dates. Please also identify the name of the insurance carrier that provided you with professional liability coverage for that practice.

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (e.g., 2, 3b). Please photocopy this page if additional space is needed:

Page Number	Section Number	Question Number	Remarks

Please provide any additional information material to the risk that has not otherwise been addressed in this application:

FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

Warranties and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on my group's behalf is incorporated into and made a part of any policy of insurance that may be issued to my group by NORCAL ("the Company").

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the group and NORCAL, the dispute will be submitted to binding arbitration.

I understand that this policy, if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that in the event this coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payer).

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on the group's behalf, including changes in its partners or associates, medical licenses, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that is assumed under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by my group or others trading under my group's name.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where any members presently hold, are applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my group's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about my group and its members that is done in good faith and without malice.

____ ___________________________

Signature of Authorized Representative Date

____

Name (Print)

FOR ALASKA APPLICANTS ONLY

Representations and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on my group's behalf is incorporated into and made a part of any policy of insurance that may be issued to my group by NORCAL ("the Company").

I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the group and NORCAL, the dispute will be submitted to binding arbitration.

I understand that this policy, if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that in the event this coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payer).

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on the group's behalf, including changes in its partners or associates, medical licenses, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that is assumed under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by my group or others trading under my group's name.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where any members presently hold, are applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my group's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about my group and its members that is done in good faith and without malice.

____________________________________ ____________________

Signature of Authorized Representative Date

____

Name (Print)

CLAIM INFORMATION FORM

Name of Patient: ____________________ Gender: ❏ Male ❏ Female

Age of Patient (at time of treatment): ____________________

Name of Claimant (if different than patient): ____________________

Location of Incident: ____________________

Allegation Against the Entity: ____________________

____

Group Member Defendants: ____________________

____

Non-Group Member Defendants: ____________________

Date Incident or Claim Was Reported to the Insurance Company: ____________________

Name of Insurance Company: ____________________

Disposition or Current Status of the Incident, Claim or Suit Against the Entity:

- ❏ **Open**
  - ❏ Incident has been reported but claim or suit has not been filed
  - ❏ Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
  - ❏ Claim or suit is currently in arbitration or mediation or is being tried in court
  - ❏ Settlement has been made or judgment returned but remains open
- ❏ **Closed** Date Closed (month/day/year): ____________________
  - ❏ Incident was reported but claim or suit was not filed
  - ❏ Claim or suit was filed but was dismissed or dropped before trial
  - ❏ Claim or suit was filed but settlement was made
  - ❏ Verdict or judgment was made in the entity's favor
  - ❏ Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): ____________________

Amount paid on the entity's behalf: ____________________

Total verdict amount (if different than total loss payment amount): ____________________

CLAIM INFORMATION NARRATIVE

Please describe the care and treatment of the patient. Attach additional pages as needed. Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and must include the following information:

- Condition and diagnosis at time of treatment
- Dates and a description of treatment rendered
- Condition of patient subsequent to treatment
- Copies of patient(s) chart(s) and operative report(s) as appropriate

I understand the information submitted herein becomes part of my group's insurance application as submitted.

Signature of Authorized Representative

Date

Name (Print)

Highlights of Differences between the Single Group Policy and Multi-Policy Formats

Note: This document highlights some of the major differences between the single group policy and multi-policy formats and is not meant to be all inclusive. For additional information, you may request copies of the policies for review with your attorney and/or insurance representative.

TOPIC	SINGLE GROUP POLICY FORMAT	MULTI-POLICY FORMAT
Policy Structure	The group entity is issued a policy and is the Named Insured of that policy. All physicians are endorsed onto the group's policy with separate or shared limits of liability.	The group entity and each physician with separate limits of liability are issued separate policies and each is the Named Insured of the applicable policy.
Policy Documents (Declarations Pages, endorsements, etc.)	Policy documents are issued in the name of and mailed to the Named Insured group. The group is responsible for distributing the policy documents to the Insureds.	Policy documents for each applicable policy are issued in the name of and mailed to each Named Insured entity and physician.
Policy Administration (e.g., policy changes)	The Named Insured group's Authorized Representative is the only one who may act on behalf of all Insureds as respects matters of policy administration.	Each Named Insured physician or his or her Authorized Representative may act on behalf of all Insureds covered under that policy as respects matters of policy administration.
Invoicing	The group is issued a single invoice for the policy.	Each Named Insured is issued an invoice. The group may choose to have the invoicing setup as a plan bill in which the invoices from each policy are sent together to one location.
Coverage Limitation/Moonlighting Activities	Coverage for any Insured is limited to those services rendered on behalf of the Named Insured group. If an Insured desires coverage for services rendered outside of the group's practice, a separate policy must be issued for the outside exposure.	Coverage is provided to the Named Insured physician for all services rendered, subject to the terms, conditions and limitations of the policy. Underwriting must review and approve any new exposures.
Extended Reporting Period Endorsement Coverage (Tail Coverage) – Right to Purchase	Tail Coverage may be available to the Named Insured group entity and physicians with separate limits of liability when their coverage or the policy is canceled or non-renewed.	Tail Coverage may be available to the Named Insured group entity and all physicians upon policy cancellation or non-renewal.
Extended Reporting Period Endorsement Coverage (Tail Coverage) – Payment Options	Payment is 100% due at termination.	Eligible physicians have the option of purchasing Tail Coverage in one lump sum or in three payments over two years—50%, 25% and 25%. Payment for the entity's Tail Coverage is 100% due at termination.
Health Care General Liability Insurance	Qualified groups have the option of purchasing this coverage for an additional charge. If this optional coverage is not purchased, the policy provides Limited Professional Office Premises Liability Coverage.	This coverage is not available. However, each policy provides Limited Professional Office Premises Liability Coverage.
Physicians Who Leave the Group and Want to Continue Coverage with NORCAL	Generally, the physician is canceled from the group's policy and must purchase Tail Coverage and is then issued a separate policy with no prior acts coverage.	Generally, the physician's policy will extend to cover the new exposure, and the physician does not need to purchase Tail Coverage.
Voting Rights	The Named Insured group has the right to one vote at any general or special meeting of members of NORCAL, subject to the terms and conditions of the policy and in accordance with the bylaws of NORCAL. Insureds other than the Named Insured do not have the right to a vote.	Each Named Insured entity and physician has the right to one vote at any general or special meeting of members of NORCAL, subject to the terms and conditions of the policy and in accordance with the bylaws of NORCAL.

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