



Malpractice Insurance For Nurse Practitioners

For nearly 100 years, CM&F has partnered with the country's strongest insurers for the most comprehensive coverages available. This **Occurrence Form Insurance Policy** is underwritten by America's foremost healthcare malpractice insurer - The Medical Protective Company [MedPro], a member of the Warren Buffett/Berkshire Hathaway group of businesses. MedPro enjoys an A++ financial strength rating from the A. M. Best Company. With our combined resources and expertise, we have forged a commitment to support our clients with the challenges which they might face by providing sound protection - today, tomorrow and beyond.

Coverage Summary

COVERAGES

Professional Liability	Included
Workplace/Premises Liability	Included
General Liability	Available
Good Samaritan	Included
Employment Practices Liability	Available
Assault Upon You	\$25,000
First Aid	\$15,000
Medical Payments	\$25,000/\$100,000
Deposition Fees	\$10,000
License Defense	\$25,000/\$100,000
Sexual Misconduct	\$25,000
Loss Of Earnings	\$2,500 Per Day /\$35,000 Aggregate
HIPAA Defense	\$25,000
Biomedical Defense	\$10,000



For Fastest Coverage,
Apply Online Today!

www.CMFGroup.com

Need Help? Have A Question
About Coverage? Call Us At
1-800-221-4904
Or Email Us At
info@cmfgroup.com

NURSE PRACTITIONERS PENNSYLVANIA

ANNUAL RATE TABLES

FULL TIME PRACTICE RATES (MORE THAN 10 HOURS PER WEEK)

CLASS N1	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 758.00
\$200,000 / \$600,000	\$ 817.00
\$250,000 / \$750,000	\$ 841.00
\$500,000 / \$1,000,000	\$ 912.00
\$1,000,000 / \$3,000,000	\$ 1,137.00
\$1,000,000 / \$6,000,000	\$ 1,185.00

CLASS N1	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 550.00
\$200,000 / \$600,000	\$ 593.00
\$250,000 / \$750,000	\$ 610.00
\$500,000 / \$1,000,000	\$ 662.00
\$1,000,000 / \$3,000,000	\$ 825.00
\$1,000,000 / \$6,000,000	\$ 860.00

CLASS N2	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 1,073.00
\$200,000 / \$600,000	\$ 1,157.00
\$250,000 / \$750,000	\$ 1,190.00
\$500,000 / \$1,000,000	\$ 1,291.00
\$1,000,000 / \$3,000,000	\$ 1,610.00
\$1,000,000 / \$6,000,000	\$ 1,677.00

CLASS N2	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 778.00
\$200,000 / \$600,000	\$ 839.00
\$250,000 / \$750,000	\$ 863.00
\$500,000 / \$1,000,000	\$ 936.00
\$1,000,000 / \$3,000,000	\$ 1,167.00
\$1,000,000 / \$6,000,000	\$ 1,216.00

CLASS N3	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 1,385.00
\$200,000 / \$600,000	\$ 1,493.00
\$250,000 / \$750,000	\$ 1,536.00
\$500,000 / \$1,000,000	\$ 1,666.00
\$1,000,000 / \$3,000,000	\$ 2,078.00
\$1,000,000 / \$6,000,000	\$ 2,165.00

CLASS N3	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 1,004.00
\$200,000 / \$600,000	\$ 1,082.00
\$250,000 / \$750,000	\$ 1,113.00
\$500,000 / \$1,000,000	\$ 1,208.00
\$1,000,000 / \$3,000,000	\$ 1,506.00
\$1,000,000 / \$6,000,000	\$ 1,569.00

CLASS N4	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 1,702.00
\$200,000 / \$600,000	\$ 1,835.00
\$250,000 / \$750,000	\$ 1,888.00
\$500,000 / \$1,000,000	\$ 2,048.00
\$1,000,000 / \$3,000,000	\$ 2,553.00
\$1,000,000 / \$6,000,000	\$ 2,660.00

CLASS N4	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 1,232.00
\$200,000 / \$600,000	\$ 1,328.00
\$250,000 / \$750,000	\$ 1,366.00
\$500,000 / \$1,000,000	\$ 1,482.00
\$1,000,000 / \$3,000,000	\$ 1,848.00
\$1,000,000 / \$6,000,000	\$ 1,926.00

CLASS NS	FULL TIME
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 176.00
\$200,000 / \$600,000	\$ 190.00
\$250,000 / \$750,000	\$ 195.00
\$500,000 / \$1,000,000	\$ 212.00
\$1,000,000 / \$3,000,000	\$ 264.00
\$1,000,000 / \$6,000,000	\$ 275.00

Nurse Practitioner Rating Classes

N1: Specializing in Dermatology, Geriatric,
Women's Health Care, Oncology, Gynecology, or
Correctional Facility < 10 hours/week

N2: Specializing in Psychiatric Care

N3: Specializing in Family Practice, Pediatric,
School Nurse, Neonatal Care

N4: Specializing in Acute Critical Care, OB/GYN,
Perinatal Care, Cosmetic/Aesthetic, Pain Management or
Correctional Facility > 10 hours/week

NS: Students currently attending an accredited
Nurse Practitioner Program

NURSE PRACTITIONERS PENNSYLVANIA

ANNUAL RATE TABLES

PART TIME PRACTICE RATES (10 HOURS OR LESS PER WEEK)

CLASS N1	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 379.00
\$200,000 / \$600,000	\$ 409.00
\$250,000 / \$750,000	\$ 421.00
\$500,000 / \$1,000,000	\$ 456.00
\$1,000,000 / \$3,000,000	\$ 569.00
\$1,000,000 / \$6,000,000	\$ 593.00

CLASS N1	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 275.00
\$200,000 / \$600,000	\$ 297.00
\$250,000 / \$750,000	\$ 305.00
\$500,000 / \$1,000,000	\$ 331.00
\$1,000,000 / \$3,000,000	\$ 413.00
\$1,000,000 / \$6,000,000	\$ 430.00

CLASS N2	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 537.00
\$200,000 / \$600,000	\$ 579.00
\$250,000 / \$750,000	\$ 595.00
\$500,000 / \$1,000,000	\$ 646.00
\$1,000,000 / \$3,000,000	\$ 805.00
\$1,000,000 / \$6,000,000	\$ 839.00

CLASS N2	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 389.00
\$200,000 / \$600,000	\$ 420.00
\$250,000 / \$750,000	\$ 432.00
\$500,000 / \$1,000,000	\$ 468.00
\$1,000,000 / \$3,000,000	\$ 584.00
\$1,000,000 / \$6,000,000	\$ 608.00

CLASS N3	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 693.00
\$200,000 / \$600,000	\$ 747.00
\$250,000 / \$750,000	\$ 768.00
\$500,000 / \$1,000,000	\$ 833.00
\$1,000,000 / \$3,000,000	\$ 1,039.00
\$1,000,000 / \$6,000,000	\$ 1,083.00

CLASS N3	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 502.00
\$200,000 / \$600,000	\$ 541.00
\$250,000 / \$750,000	\$ 557.00
\$500,000 / \$1,000,000	\$ 604.00
\$1,000,000 / \$3,000,000	\$ 753.00
\$1,000,000 / \$6,000,000	\$ 785.00

CLASS N4	SELF EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 851.00
\$200,000 / \$600,000	\$ 918.00
\$250,000 / \$750,000	\$ 944.00
\$500,000 / \$1,000,000	\$ 1,024.00
\$1,000,000 / \$3,000,000	\$ 1,277.00
\$1,000,000 / \$6,000,000	\$ 1,330.00

CLASS N4	EMPLOYED
<u>LIMIT</u>	<u>OCCURRENCE</u>
\$100,000 / \$300,000	\$ 616.00
\$200,000 / \$600,000	\$ 664.00
\$250,000 / \$750,000	\$ 683.00
\$500,000 / \$1,000,000	\$ 741.00
\$1,000,000 / \$3,000,000	\$ 924.00
\$1,000,000 / \$6,000,000	\$ 963.00

Nurse Practitioner Rating Classes

N1: Specializing in Dermatology, Geriatric,
Women's Health Care, Oncology, Gynecology, or
Correctional Facility < 10 hours/week

N2: Specializing in Psychiatric Care

N3: Specializing in Family Practice, Pediatric,
School Nurse, Neonatal Care

N4: Specializing in Acute Critical Care, OB/GYN,
Perinatal Care, Cosmetic/Aesthetic, Pain Management or
Correctional Facility > 10 hours/week



NPSecure®
Malpractice Insurance For
Nurse Practitioners

- 1) Please print a copy of this application to your desktop printer.
- 2) Complete this hard copy by hand, answering all questions
- 3) Sign, date and either:
 - a. Mail your completed application providing your credit card information OR with check payable to:
CM&F Group, Inc., 99 Hudson Street, 12th Floor,
New York, NY 10013
 - OR
 - b. Fax your signed and completed application providing your credit card information (per the application) to
CM&F Group, Inc. at (646) 390.5163
- 4) Once your application is processed & approved, your policy will be mailed within 5-7 business days. Your payment -- whether by check or credit card -- will NOT be processed until your coverage has been approved.

Fax or Mail Completed Application To:
CM&F Group, Inc.
99 Hudson Street, 12th Floor
New York, New York 10013-2815
(212)233-8911 (800)221-4904
Fax (646)390.5163 np@cmfgroup.com

If previously covered with Medical Protective, please enter
the policy number _____

THE MEDICAL PROTECTIVE COMPANY

(a Stock Company)

HEALTHCARE PROFESSIONAL - PROFESSIONAL LIABILITY INSURANCE APPLICATION - NP

I. General Information

Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

A. _____
First Name Middle Initial Last Name

Degree (DNP/MA) Suffix Date of Birth MM/DD/YYYY Professional License Number Graduation Year

Street Address Apartment/Suite # City

County State Zip Code State of Practice National Provider Identifier # (Optional)

Business Phone Business Fax Residence/Cell Phone

E-mail Address: _____

B. Requested Effective Date: ____ / ____ / ____
MM DD YYYY

II. Coverage Information

**Please note that requested policy types may not be available in all states.*

A. Coverage Desired:

- ☐ Occurrence coverage
☐ Claims-Made coverage without Prior Acts coverage
☐ Claims-Made coverage with Prior Acts coverage
☐ Convertible Claims-Made coverage

**PLEASE CALL FOR MORE INFORMATION
PLEASE CALL FOR MORE INFORMATION
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B. Retroactive date shown on my current Claims-Made policy is:

(This date is not a requirement for Occurrence or Claims-Made
without Prior acts policies.)

____ / ____ / ____
MM DD YYYY

C. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- ☐ An extended reporting endorsement (tail coverage) has been purchased.
☐ An extended reporting endorsement has not and will not be purchased.

* Please be advised that if you do not purchase tail coverage (an extended reporting endorsement) from your current insurer where you are insured under a Claims-Made policy, this will result in an uninsured exposure for any claims which may arise as a result of professional services rendered or which should have been rendered while insured by your current insurer's

policy. If you do not purchase tail coverage from your current insurer, understand that the policy for which you are applying with The Medical Protective Company, if offered, will not provide prior acts coverage.

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage.

D. Desired Limits:

** Please note that requested limits options may not be available in your state.*

☐ \$100,000/\$300,000 ☐ \$200,000/\$600,000 ☐ \$250,000/\$750,00
☐ \$500,000/\$1,000,000 ☐ \$1,000,000/\$3,000,000 ☐ \$1,000,000/\$6,000,00
☐ \$2,000,000/\$6,000,000

☐ **VA Only:** The limits of insurance for Insureds practicing in Virginia will equal the annual damages cap, as set out in VA Code Ann. § 8.01-581.15 as amended, based upon the expiration date of the policy to which this application may become attached.

E. Are you an Indiana resident electing to participate in the Indiana Patient Compensation Fund? ☐ Yes ☐ No

If yes, coverage provided will have limits of \$250,000/\$750,000.

F. Are you a Louisiana resident electing to participate in the Louisiana Patient Compensation Fund? ☐ Yes ☐ No

If yes, coverage provided will have limits of \$100,000/\$300,000.

G. If in Maryland, do you want to purchase administrative hearing coverage? ☐ Yes ☐ No

Administrative Hearing Expense Coverage Option: \$25,000 each limit/\$100,000 aggregate limit.

Defense arising out of Disciplinary, Licensure or similar Administrative Proceedings, arising from your professional services as a Healthcare Professional to a patient may be purchased for an additional premium.

III. Practice Information

A. Please indicate your Nurse Practitioner Rating Class: (Please select all that are applicable. At least one must be selected.)

N1: ☐ Dermatology ☐ Geriatric ☐ Women's Health Care ☐ Oncology ☐ Gynecology
☐ Correctional Facility < 10 hours/week

N2: ☐ Psychiatric Care

N3: ☐ Family Practice ☐ Pediatric ☐ School Nurse ☐ Neonatal Care

N4: ☐ Acute Critical Care ☐ OB/GYN ☐ Perinatal Care ☐ Cosmetic/Aesthetic ☐ Pain Management
☐ Correctional Facility > 10 Hours / Week

NS: Students currently attending an accredited Nurse Practitioner Program

*** I understand that if I am a Nurse Anesthetist or Certified Nurse Midwife, I am not covered by this policy.**

B. If your specialty is OB/GYN, are you responsible for the labor or delivery of a fetus? ☐ Yes ☐ No ☐ N/A

C. Do you perform any major invasive surgical procedures? ☐ Yes ☐ No

If yes, please give a general description: _____

D. As a Nurse Practitioner I practice as: ☐ Employee ☐ Self-Employed
(W2 & not owner) (File 1099 Tax Form)

E. Indicate the estimated average number of hours you practice per week. _____

F. Is your professional designation/certification currently valid? ☐ Yes ☐ No

Please provide date of most recent certification: ____ / ____ / ____
MM DD YYYY

G. Highest level of education: ☐ Masters (MS) ☐ Doctorate (DNP) ☐ Licensed Nurse Midwife

H. Have you completed training/education courses in addition to the level required for licensing/certification?

If yes, please provide details. _____

I. If you are a student, what is the anticipated date of graduation? ____ / ____ / ____
MM DD YYYY

J. Are you a member of a Professional Association(s)? ____ Yes ____ No

If yes, please list membership affiliation(s) _____

K. Have you completed a risk management education course within the last (12) months? ____ Yes ____ No

IV. Additional Practice Information

A. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses? ____ Yes ____ No

If yes, please attach a separate sheet with full particulars including date(s).

B. Have you ever had your hospital privileges, DEA license, healthcare license or reimbursement privileges, refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ____ Yes ____ No

If yes, please attach a separate sheet with full particulars including date(s).

C. Has any professional liability insurance company ever declined, refused, canceled or non-renewed your coverage? ____ Yes ____ No
NOTE: MISSOURI AND CALIFORNIA RESIDENTS DO NOT RESPOND.

If yes, please indicate the date(s) and explain: Date ____ / ____
MM YYYY

D. Have you ever been accused of sexual misconduct of any kind? ____ Yes ____ No

If yes, please indicate the date(s) and explain: Date ____ / ____
MM YYYY

E. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? ____ Yes ____ No
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics or other controlled substances, etc).

* If yes, please complete Medical Condition Supplement

V. Loss Information

Please complete the Loss Information Supplement for each written request, incident, claim or suit that has NOT been covered by a Medical Protective policy.

Report professional liability and malpractice-related matters, including but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim, or suit, received a written request for treatment records arising out of the rendering or failure to render professional services, or related to any other coverage you are requesting from Medical Protective (e.g. CGL, EPLI, etc.)? ____ Yes ____ No

If yes, how many? _____

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? ____ Yes ____ No

This includes, but it is not limited to, the following:

♦ Amputation ♦ Permanent Neurological Injury ♦ Loss of Major Organ Function ♦ Death ♦ Loss of Vision.

If yes, how many? _____

C. In the last 12 months, have you received a written request from an attorney for treatment records concerning any current or former patient(s) which might reasonably result in a claim or suit against you? ____ Yes ____ No

If yes, how many? _____

VI. Professional Liability Coverage

A. Please list your prior professional liability insurance, if any.

Insurance Carrier	Coverage Type (Occurrence or Claims-Made)	Policy Number	Limits	Effective Date(s)	Retro Date
_____	_____	_____	_____	_____	_____

VII. Important Notice – Representations, Authorizations, Releases and Notices

MANDATORY: ALL APPLICANTS must read the following unless in a state listed below:

Any person 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, which may include voiding of the policy if allowed by state law.

ALL ALABAMA APPLICANTS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALL ARKANSAS 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.

ALL COLORADO APPLICANTS:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulated Agencies.

ALL DISTRICT OF COLUMBIA APPLICANTS:

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

ALL FLORIDA APPLICANTS:

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of a claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

ALL GEORGIA 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 may include imprisonment, fines, or denial of insurance benefits.

ALL HAWAII APPLICANTS:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

ALL 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 of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ALL MAINE 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 may include imprisonment, fines, or denial of insurance benefits.

ALL MINNESOTA APPLICANTS:

No oral or written misrepresentation made by the insured, or in the insured's behalf, in the negotiation of insurance, shall be deemed material, or defeat or avoid the policy, or prevent its attaching, unless made with intent to deceive and defraud, or unless the matter misrepresented increases the risk of loss.

ALL NEW HAMPSHIRE APPLICANTS:

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in Section 638.20.

ALL NEW JERSEY APPLICANTS:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ALL NEW MEXICO 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 civil fines and criminal penalties.

ALL OHIO APPLICANTS:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

ALL OKLAHOMA APPLICANTS:

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

ALL OREGON APPLICANTS:

Any person who knowingly files an application for insurance or a statement of a claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

ALL PENNSYLVANIA APPLICANTS:

Any person 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.

ALL RHODE ISLAND 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.

ALL TENNESSEE 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 may include imprisonment, fines, or denial of insurance benefits.

ALL VERMONT APPLICANTS:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

ALL 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, or denial of insurance benefits.

ALL WASHINGTON 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, or denial of insurance benefits.

ALL 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.

VIII. Notes and Agreements

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I or any applicant agree that this application, and any **Attachments**, shall be the bases of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare provider, facility, firm or professional association.

Where allowed by state law, I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Arizona:

I understand that, to the extent permitted by law, the Company reserves the right to deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the Company as required either by this application for the policy, subsequent notice, or otherwise.

If Delaware:

Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent; or (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate or would not have issued a policy or contract in as large an amount or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

If Georgia:

I understand that any material misrepresentation or omission made by me on this application may provide the Company with the right to cancel the policy and/or deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the Company as required either by this application for the policy, subsequent notice, or otherwise. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Kansas:

An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

If Maine:

I understand that any material misrepresentation or omission made by me on this application may cause coverage to be cancelled and/or denied. However, we maintain the right to request a ruling from the Maine Courts on voidance or rescission of this policy. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If New Hampshire:

I understand that any material misrepresentation or omission made by me on this application may provide the Company with the right to cancel my policy pursuant to state law and pursue further legal action against me. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Oklahoma:

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Vermont:

Where allowed by state law, I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to cancel it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

If Washington:

I understand that any intentional concealment or material misrepresentation made by me, or someone acting on my behalf, on this application may act to render any contract of insurance null and without effect. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) my application has been accepted by the Company; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer, credit card payment or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

If Illinois:

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, my policy shall not be deemed to have been issued or delivered and shall not be applicable to any matter which may have been covered under the policy if the payment is later dishonored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

If California:

I understand that if I cancel or terminate any coverage that may be provided by the Company, earned premium shall be computed in accordance with the standard short rate tables and procedures with a maximum penalty of up to 11%. Premium adjustments shall be made within a reasonable period of time after cancellation or termination. However, payment or tender of unearned premium shall not be a condition of cancellation.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

The Delaware Civil Union & Equality Act of 2011

The Medical Protective Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 including the following:

Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

Compliance with Illinois Bulletin 2011-06 and The Religious Freedom Protection and Civil Union Act

The Medical Protective Company recognizes the rights afforded to individuals under The Religious Freedom Protection and Civil Union Act which states:

"The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA INSURANCE GUARANTY ASSOCIATION LAW

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
7600 Parklawn Ave # 460
Edina, MN 55435-5137
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Applicant's Signature

Date Signed: ____ / ____ / ____
MM DD YYYY

Print Name

Agent Name & License Number (if applicable): _____

PREMIUM PAYMENT OPTIONS

PREPAYMENT REQUIRED

☐ Check or money order enclosed. ☐ Charge premium to credit card.

I authorize CM&F Group, Inc. to charge the premium to my: ☐ VISA ☐ MASTERCARD ☐ Discover

Credit Card Account Number: _____ Expiration Month and Year: ____ / ____

Print name exactly as it appears on card: _____

THIRD PARTY CREDIT CARD AUTHORIZATION Please complete the following (if payer other than applicant):

CHARGE TO: ☐ VISA ☐ MASTERCARD ☐ Discover

Credit Card Account Number: _____ Expiration Month and Year: ____ / ____

Card Member Name (Print): _____

Signature: _____ Date Signed: _____

MAIL OR FAX COMPLETED APPLICATION & PAYMENT INFORMATION TO:

CM&F Group, Inc.

99 Hudson Street, 12th Floor, New York, NY 10013-2815

212.233.8911 1.800.221.4904 FAX: 646.390.5613 np@cmfgroup.com

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL**LOSS INFORMATION SUPPLEMENT**

Please complete the following information for each applicant involved in each claim or incident. Please make copies if additional forms are needed for multiple claims or incidents and/or each applicant.

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

A. Is the matter related to A, B or C from the Loss Information section? (Check only one.)

- ☐ **A.** Current or prior claim.
☐ **B.** Complication, incident, or adverse outcome.
☐ **C.** Written request for records.

B. Is the matter identified in the Loss Information section related to (Check only one):

- ☐ Professional Liability
☐ Other Commercial Liability, i.e. General Liability, EPLI, Cyber, etc. (please describe): _____

C. Patient/Claimant Information:

 Last Name First Name Age

D. Date of treatment and/or surgery which led, or could lead, to allegations against you: ____/____/____
 (MM/YYYY)

E. Date of notice received, if applicable: ____/____/____
 (MM/YYYY)

F. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If Yes, date reported to your current or former insurer: ____/____/____
 (MM/YYYY)

Current or former insurer name: _____

If No, please explain: _____

G. Name of all other doctor(s), hospital(s), surgery center(s) or healthcare provider(s), if any, involved: _____

H. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: \$ _____

If closed, date of closing: ____/____/____
 (MM/YYYY)

Was a payment made? ☐ Yes ☐ No

1. If Yes, did you consent to the settlement? ☐ Yes ☐ No

2. Total amount of settlement or award: \$ _____

3. Total amount of settlement or award paid on your behalf: \$ _____

I. Nature of allegations or potential allegations:

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

J. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

K. What steps or procedures have you adopted to prevent a similar claim? Please explain:

Applicant's Name: _____

HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

Assignment of Cancellation Rights and Premium Refund Supplemental Application

Would you like to assign an employer or named third party the right to cancel your policy and receive any premium refund? _____ Yes _____ No

If yes, please sign below:

By my signature, I assign to the following employer or named third party (include name and address), the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all premium refund correspondence be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to CM&F Group at 212-233-8919 or sending written notice to The Medical Protective Company Program Administrator, CM&F Group, Inc. 99 Hudson Street, 12th Floor, New York, NY 10013-2815.

Name of Employer or Third Party

Street Address

City

State

Zip Code

()

Phone #

Signature of Applicant

Date