HALLMARK Pro
PROFESSIONAL LIABILITY
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Entity Application

Physicians & Surgeons Medical Professional Liability Insurance Claims Made & Reported Coverage

NOTE: This Application is for Entity and Corporate Risks Only

Please answer all questions that apply. State "not applicable" to those question that do not apply.

General Information:

Entity/Corporation Name: *(Include Legal Designation)*

FEIN #:

Address:

County: PO Box: State: Zip Code:

Phone: Fax: Email:

Website: Is this the Entity's Only Practice Location? ☐ Yes ☐ No *If "No," Add All Locations on a Separate Sheet.*

Coverage Information:

Proposed Inception Date: Retroactive Date:

Proposed Entity Limits of Liability: Per Claim: Annual Aggregate

Is the entity a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996? ☐ Yes ☐ No

If "Yes", is the entity in full compliance with the HIPAA privacy rule? ☐ Yes ☐ No

Please indicate the name and title of your HIPAA Privacy Officer:

Past Coverage and Experience:

Please provide the following information regarding the entity's professional liability coverage history:

Policy Period	Insurer	Policy Limits	Deductible	Policy Type	Premium	Total# of Claims*
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		

** Total # of claims by carrier regardless of payment, no payment, dismissed or open.*

Has any insurance company ever declined, canceled, rescinded or non-renewed any Professional Liability policy for the entity? *(Response not required in the State of Missouri)* ☐ Yes ☐ No

If Yes, please provide explanation:

Has the entity been involved now or ever in a professional liability claim or suit? If "Yes", please complete the *Supplemental Claim Information* form for each. ☐ Yes ☐ No

Has the entity had any losses or claims that have not been reported to a prior insurance carrier or any other source from which payment could be made? ☐ Yes ☐ No

Are you aware of any specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim that has not been reported to a prior insurance carrier? ☐ Yes ☐ No

Has the entity received any requests for medical records by a patient or attorney which might result in a claim? ☐ Yes ☐ No

Has the entity had any prior professional liability carrier refuse coverage for, or decline to accept a report of a specific act, omission or circumstance involving a particular and specific professional service(s) that may result in a claim, threat of a claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No

If Yes to any of the above, please provide explanation:

Employee and Group Members:

Please list all *physician members* of the group, the *date* each member joined the group, and *liability insurance carrier* information. Please include owners, partners, employees and independent contractors. (A*ttach additional pages if necessary)*

Name:		Effective Date:		Carrier:	
Name:		Effective Date:		Carrier:	
Name:		Effective Date:		Carrier:	
Name:		Effective Date:		Carrier:	
Name:		Effective Date:		Carrier:	

Total number of employed, contractor and partner physicians:

(Note: all active physician members must complete separate applications)

Please list any physicians whose employment or association with the group has terminated in the past 5 years and indicate the effective and termination dates. *(Attach additional pages if necessary)*

Name:		Effective Date:		Termination Date:	
Name:		Effective Date:		Termination Date:	
Name:		Effective Date:		Termination Date:	
Name:		Effective Date:		Termination Date:	

If the group requires prior acts coverage for any terminated physician, please provide details:

Please list all current non-physician employees and contractors and include any professional designation:

Name:		Professional Designation:	
Name:		Professional Designation:	
Name:		Professional Designation:	
Name:		Professional Designation:	

Total number of non-physician employees:

Risk Management and Credentialing:

Has your entity established a formal risk management program? ☐ Yes ☐ No

If "Yes, do you have a dedicated risk manager either on staff or under contract? ☐ Yes ☐ No

Please describe your risk management program and attach documentation, including the Risk Manager's job description and CV if applicable.

Has your entity established specific criteria for physician credentialing? ☐ Yes ☐ No

If "Yes", please describe and attach any applicable documentation.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy.

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom, shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is assigned and the effective date of the policy, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

The policy for which application is made applies only to "Claims" first made during the "Policy Period".

Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy.

Unless amended by endorsement, "Claim Expenses" shall be applied against the "Deductible".

WARRANTY:

I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy, I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.

Must be signed by an authorized representative of the group or entity within 60 days of the proposed effective date.

Signature: _____ Date: _____

Corporate Officer/Authorized Representative: _____ Title: _____

Signing this form does not bind the Applicant or the Company to complete the Insurance.

Notice to 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 the person to criminal and civil penalties.