



Clinic Purchasing Group
APPLICATION
For Health Care Providers

For Claims Made Professional Liability
Insurance and Prior Acts Coverage

 **NORCAL**
Mutual Insurance Company

IMPORTANT INFORMATION

If your application is approved, you will be added to the clinic's/organization's policy via endorsement and will share in the clinic's/organization's limits of liability. With the exception of the optional Prior Acts Coverage, coverage will be extended only while you are acting within the course and scope of your duties for the clinic/organization and will be subject to the terms, conditions and limitations of the policy.

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

If you engage in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, you may be considered a *Covered Entity* under HIPAA and thus may be 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.

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 15. If you need more space, please attach additional pages.
- If a table in the application does not have a sufficient number of rows to provide the requested information, please photocopy the applicable page.
- Please ensure that you sign and date the application on page 16.
- Please provide loss runs for the previous ten years, or since the date you began practicing medicine, whichever is more recent. The loss runs must be less than 90 days old.
- Please make a copy of the completed application and supporting documents for your records.

SECTION I GENERAL INFORMATION

Applicant Name (Last, First Middle)		Professional Designation		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	
Primary Practice Address	City	County	State	Zip Code	Telephone # (with area code)	Fax # (with area code)
Home Address	City		State	Zip Code	Telephone # (with area code)	Fax # (with area code)
E-Mail Address						

SECTION II COVERAGE INFORMATION

1. Please identify the name of the clinic/organization under whose professional liability insurance coverage you wish to apply:

(Name of Clinic/Organization)

NOTE: If your application is approved, you will be added to the clinic's/organization's policy via endorsement and will share in the clinic's/organization's limits of liability. With the exception of the optional Prior Acts Coverage period, coverage will be extended only while you are acting within the course and scope of your duties for the clinic/organization and will be subject to the terms, conditions and limitations of the policy.

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 (30) days before the Requested Effective Date.

Prior Acts Coverage

NOTE: Prior Acts Coverage is available only for physicians. Please skip this section if you are not a physician.

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims or administrative proceedings that 1) are first made against you and reported to NORCAL after your coverage 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 coverage.

The Retroactive Date is the earliest date on which a medical incident or administrative proceeding 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 insurer, if applicable. However, the limits of liability available to you under the Prior Acts Coverage will in most instances be less than the limits of liability available to you if you purchase Tail Coverage from your current insurer. **NORCAL does not automatically provide Prior Acts Coverage.** Please discuss with your broker before completing the following.

Check one of the following:

- I wish 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 insurer. Please identify the Retroactive Date below and complete the Prior Acts Coverage section on page 13. **NOTE:** The Retroactive Date must be the same as the Retroactive Date of your current policy.

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

- I do not wish to apply for Prior Acts Coverage.** I understand that if I do not obtain Prior Acts Coverage, I will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the effective date of my coverage with NORCAL.

SECTION III PROFESSIONAL LIABILITY INSURANCE HISTORY

1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (for example, involuntarily reduced limits, restricted coverage or added a deductible and/or surcharge) your insurance, declined to offer you coverage or notified you of its intent to pursue such action? **Yes** **No**

If yes, please provide a detailed written narrative and copies of all pertinent documentation (for example, 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 you during the past ten years, beginning with the most current.

Name of Insurer	Coverage Dates (Month/Day/Year)	Policy Type	If Claims Made, Check One
	From: To:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From: To:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From: To:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From: To:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage
	From: To:	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage obtained <input type="checkbox"/> Prior Acts Coverage obtained from subsequent insurer <input type="checkbox"/> Did not obtain Tail Coverage or Prior Acts Coverage

3. If any one of the insurance coverages identified above was claims made coverage, and you did not obtain Tail Coverage or Prior Acts Coverage, please explain:

SECTION IV PRACTICE LOCATIONS

1. Please identify all non-hospital locations at which you will render professional health care services on behalf of the clinic/organization.

Name of Location/Entity	Address	Location Type (for example, office, surgery center or nursing home)

2. Please list all hospitals at which you currently maintain or will be applying for staff privileges. You may submit your curriculum vitae (CV) in lieu of providing the information in the table below, as long as the CV is current and provides all of the information requested in the table.

Name of Facility	Address (City and State)	Type of Privileges
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____

3. If you checked "provisional" or "other," please explain:

4. If you do not have hospital privileges, please explain why you do not have them and identify the means you use to admit your patients should the need arise:

SECTION V LICENSES

1. Please complete the following regarding *all* states where you are or have been licensed to practice as a health care professional.

State	License Type (for example, Physician, PA or RN)	License Number	Current Status	If Inactive, Reason for Inactive Status
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	

2. Federal DEA License: Number: _____ Status: _____ Expiration Date: _____

SECTION VI GENERAL PRACTICE INFORMATION

1. Please identify the status that you will maintain with the clinic/organization:

Employee
 Independent Contractor
 Volunteer
 Other (specify): _____

2. If you are a physician, please identify each medical specialty/field of medicine in which you will practice and the percentage of your practice that will be devoted to each. **NOTE:** The percentage total must equal 100%.

Primary specialty/field of medicine: _____ %

Additional specialty/field of medicine: _____ %

Additional specialty/field of medicine: _____ %

3. Please provide the following based on your work on behalf of the clinic/organization:

Average number of hours that you will work per week: _____

Average number of patients that you will care for per week: _____

Average number of hospital admissions that you will have per week: _____

SECTION VII EDUCATION, TRAINING AND CERTIFICATION

1. List all training programs you have entered, whether or not you graduated or completed the training. You may submit your curriculum vitae (CV) in lieu of completing the table below, as long as the CV is current and provides all of the information requested in the table.

- Medical/Osteopathic School**
 Dental School
 Perfusionist Program
 Physician Assistant Program
 Podiatric School
 Registered Nursing Program

Name of School	City, State	Dates (from – to)
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- Nurse Midwife Program**
 Direct-Entry Midwife Program
 Nurse Anesthesia Program
 Nurse Practitioner Program

Type (for example, adult nurse practitioner)		
Name of School	City, State	Dates (from – to)

Internship:

Type		
Name of Location	City, State	Dates (from – to)

Residency:

Type		
Name of Location	City, State	Dates (from – to)

Residency:

Type		
Name of Location	City, State	Dates (from – to)

Other Training:

Type		
Name of Location	City, State	Dates (from – to)

2. If you are a physician, and are a graduate of a non-U.S. medical school, please attach a copy of your Educational Council for Foreign Medical School Graduates (ECFMG) or Fifth Pathway certificate.

3. Did you successfully complete each training program that you started? Yes No

If no, please explain in the Remarks section on page 15.

4. Please explain any gaps in your training, if applicable, in the Remarks section on page 15.

5. If you are a physician, are you *currently* certified by or eligible for a member board of the American Board of Medical Specialties or the American Osteopathic Association or any other health care organization? Yes No

If yes, please complete the following:

Name of Organization	Name of Board	Status
		<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible
		<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible
		<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible

6. If you are a midwife, are you *currently* certified by the American Midwifery Certification Board or the North American Registry of Midwives? Yes No

If yes, please identify the organization and attach a copy of your certificate:

- American Midwifery Certification Board
- North American Registry of Midwives

7. If you are a nurse practitioner and *currently* hold a national *nurse practitioner* certification, please identify the certifying organization and specialty/subspecialty area and attach a copy of your certificate:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- Pediatric Nursing Certification Board
- National Certification Corporation
- Other (specify): _____

Specialty Certificate: _____ Subspecialty Certificate: _____

8. If you are a perfusionist, are you certified by the American Board of Cardiovascular Perfusion? Yes No

9. If you are a physician assistant, are you certified by the National Commission on Certification of Physician Assistants? Yes No

10. If you are a podiatrist, are you *currently* board certified or board qualified by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or the American Board of Podiatric Surgery? Yes No

Note: Board qualified refers to one who has passed the written examination but not the oral examination.

If yes, please submit proof of your certification/qualification and identify which of the following apply:

- American Board of Podiatric Orthopedics and Primary Podiatric Medicine: Certified Qualified
- American Board of Podiatric Surgery in foot surgery: Certified Qualified
- American Board of Podiatric Surgery in reconstructive rearfoot/ankle surgery: Certified Qualified

11. If you are a CRNA, please provide proof of your certification by the American Association of Nurse Anesthetists Council on Certification (or Recertification) of Nurse Anesthetists.

SECTION VIII PROCEDURES AND SERVICES

NOTE: Please complete the questions in this section only as they relate to the course and scope of your duties for the clinic/organization.

1. Please complete the following tables regarding the procedures that you will perform:

If you do not perform any of the procedures listed below, please check here.

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Acupuncture		<input type="checkbox"/> Fracture Repairs	
<input type="checkbox"/> Adenoidectomy		<input type="checkbox"/> Closed Reduction of Simple	
<input type="checkbox"/> Amniocentesis		<input type="checkbox"/> Closed Other than Simple	
<input type="checkbox"/> Amputation Surgery (specify types): _____		<input type="checkbox"/> Surgical	
<input type="checkbox"/> Angiography – Coronary		<input type="checkbox"/> Hemorrhoid Treatment (specify procedures): _____	
<input type="checkbox"/> Angiography – Noncoronary		<input type="checkbox"/> Hernia Repairs	
<input type="checkbox"/> Angioplasty – Coronary		<input type="checkbox"/> Hypnosis	
<input type="checkbox"/> Angioplasty – Noncoronary or Carotid		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Hysteroscopy	
<input type="checkbox"/> Atherectomy		<input type="checkbox"/> Lumbar Puncture/Spinal Tap	
<input type="checkbox"/> Bariatric Surgery		<input type="checkbox"/> Mammography – Diagnostic	
<input type="checkbox"/> Biopsy – Needle or Incisional (specify types): _____		<input type="checkbox"/> Mammography – Screening	
<input type="checkbox"/> Biopsy – Excisional (specify types): _____		<input type="checkbox"/> Manipulation Under Anesthesia	
<input type="checkbox"/> Cardioversion		<input type="checkbox"/> Mesotherapy	
<input type="checkbox"/> Carpal Tunnel Release		<input type="checkbox"/> MRI Interpretation	
<input type="checkbox"/> Catheterization – Right Heart		<input type="checkbox"/> Myofascial Trigger Point Injection	
<input type="checkbox"/> Catheterization – Left Heart		<input type="checkbox"/> Nerve Repair	
<input type="checkbox"/> Catheterization – Noncoronary		<input type="checkbox"/> Oophorectomy	
<input type="checkbox"/> Chelation Therapy		<input type="checkbox"/> Oral Surgery (specify): _____	
<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> Pacemaker Insertion – Temporary	
<input type="checkbox"/> Circumcision		<input type="checkbox"/> Pacemaker Insertion – Permanent	
<input type="checkbox"/> Conization of the Cervix		<input type="checkbox"/> Paracentesis	
<input type="checkbox"/> Cystoscopy		<input type="checkbox"/> Prolotherapy	
<input type="checkbox"/> CT Scan Interpretation		<input type="checkbox"/> Silicone Injection	
<input type="checkbox"/> Dilation & Curettage of the Uterus		<input type="checkbox"/> Spinal Surgery	
<input type="checkbox"/> Endoscopy		<input type="checkbox"/> Stenting (specify): _____	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Tendon Repairs	
<input type="checkbox"/> Esophagogastroduodenoscopy		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Thoracentesis/Paracentesis	
<input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> Episiotomy Repair – 1 st and 2 nd Degree		<input type="checkbox"/> Ultrasound Interpretation	
<input type="checkbox"/> Episiotomy Repair – 3 rd and 4 th Degree		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Fluoroscopic Examinations			

2. Do you, or do you intend to, perform any cosmetic procedures? Yes No

If yes, please identify the procedures and the number of each that you will perform per year:

3. Do you, or do you intend to, perform ophthalmic surgery? Yes No

If yes, please identify the procedures and the number of each that you will perform per year:

4. Do you, or do you intend to, perform any interventional chronic pain management procedures? Yes No

If yes, please identify the procedures and the number of each that you will perform per year:

5. Do you, or do you intend to, perform any interventional radiology procedures? Yes No

If yes, please identify the procedures and the number of each that you will perform per year:

6. Do you, or do you intend to, perform abortions? Yes No

If yes:

a. Do you, or do you intend to, perform abortions at a location owned or operated by the clinic/organization? Yes No

If yes, please identify the locations:

b. Do you, or do you intend to, perform abortions after 15 weeks post-last menstrual period? Yes No

If yes, please explain under what circumstances you perform abortions after 15 weeks post-last menstrual period:

7. Do you, or do you intend to, practice obstetrics? Yes No

NOTE: Obstetrics is defined as the care and treatment of pregnancy including, but not limited to, prenatal care, labor, delivery, cesarean section and/or postnatal care.

If yes, please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> First Trimester Prenatal Care | <input type="checkbox"/> Deliveries (specify estimated number per year): _____ |
| <input type="checkbox"/> Second Trimester Prenatal Care | <input type="checkbox"/> Cesarean Section (specify estimated number per year): _____ |
| <input type="checkbox"/> Third Trimester Prenatal Care | <input type="checkbox"/> Other (specify): _____ |

8. Do you, or do you intend to, perform any procedures other than those that you have specified in the above table and questions? Yes No

If yes, please identify the procedures and the number of each that you will perform per year:

8. Do you maintain hospital privileges for all of the procedures that you will perform? Yes No

If no, please identify the procedures for which you do not maintain hospital privileges and explain why you do not maintain hospital privileges for them:

9. Do you, or do you intend to, administer anesthesia other than topical or by means of local infiltration? Yes No

If yes:

a. Please identify the types of anesthesia and the locations where you administer or intend to administer the anesthesia:

	Hospital/Hospital Surgery Center	Accredited* Freestanding Surgery Center	Accredited* Office-Based Surgery Suite	Other (specify): _____
Spinal/Epidural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major Nerve Block (for example, brachial plexus or femoral nerve)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Accredited refers to a location currently accredited by the Joint Commission, AAAASF, AAAHC or IMQ.

b. Do you maintain hospital privileges for the types of anesthesia that you will administer? Yes No

If no, please explain:

10. Do you, or do you intend to, perform procedures on patients who have been administered anesthesia other than topical or by means of local infiltration? Yes No

If yes, please identify the types of anesthesia used and the locations where you perform or will perform these procedures:

	Hospital/Hospital Surgery Center	Accredited* Freestanding Surgery Center	Accredited* Office-Based Surgery Suite	Other (specify): _____
Spinal/Epidural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major Nerve Block (for example, brachial plexus or femoral nerve)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Accredited refers to a location currently accredited by the Joint Commission, AAAASF, AAAHC or IMQ.

11. Do you, or do you intend to, provide professional health care services during delivery (including the immediate labor, puerperium and/or neonatal period) in any facility or any place other than a licensed acute care hospital or licensed alternative birthing center? **Yes** **No**

If yes, please explain and identify the facility(ies) and place(s):

12. Do you, or do you intend to, use, administer, distribute or prescribe any drugs, pharmaceuticals, devices or equipment disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings? **Yes** **No**

If yes:

- a. Please describe:

- b. If the applicable use(s) is/are part of a clinical study, please provide the following information for each clinical study:

- A copy of the clinical study's protocol
- Proof of its FDA or IRB approval, if not stamped on the protocol
- A copy of the consent form, if it is not FDA or IRB approved

13. Do you, or do you intend to, use, administer, distribute or prescribe any FDA-approved drugs, pharmaceuticals, devices or equipment in a manner not approved by the FDA (that is, off-label use)? **Yes** **No**

If yes, are all of your off-label uses supported by appropriate precedent for effectiveness and safety (that is, within the standard of care)? **Yes** **No**

If no:

- a. Identify each drug, pharmaceutical, device and/or equipment, its FDA-approved use and your off-label use:

- b. Provide a copy of the informed consent form that you use for each such off-label use.

14. As it relates to your duties on behalf of the clinic/organization:

- a. Are you, or will you be, employed by the U.S. government or any other governmental or public entity? **Yes** **No**
- b. Do you function, or intend to function, as a hospitalist? **Yes** **No**
- c. Do you have, or intend to have, any medical director, laboratory director, management or similar responsibilities at or on behalf of an entity or organization not wholly owned by the clinic/organization? **Yes** **No**
- d. Do you provide, or intend to provide, telemedicine services? **Yes** **No**

If you answered yes to any one of the above, please explain:

SECTION IX HEALTH CARE EXTENDERS

NOTE: Please complete the questions in this section only if you are a midwife, nurse practitioner or physician assistant and complete them only as they relate to the course and scope of your duties for the clinic/organization.

1. Please identify all of your supervising/collaborating physicians and provide their medical specialties:

2. Please attach a copy of any written agreement(s) (for example, delegation of services/collaboration agreements, protocols or guidelines) you maintain with your supervising/collaborating physician(s).
3. Have any tasks been, or will any tasks be, delegated to you by your supervising/collaborating physician(s) that are not consistent with the physician(s) own expertise and competence? **Yes** **No**

If yes, identify the tasks and explain:

4. Do you perform/provide, or intend to perform/provide, any procedures or services that have not been or will not be delegated to you by a supervising/collaborating physician(s)? **Yes** **No**

If you answered yes to question 2 or 3, please identify the procedures or services and explain:

SECTION X 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 resolution) and pertinent documentation (for example, nonrenewal or declination notice, medical board documents, or letters from the hospital, diversion program or treating physician).

1. Has your license to practice as a health care professional in any jurisdiction, your DEA registration, or any applicable controlled substance license or registration in any jurisdiction **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way? Yes No
2. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you? Yes No
3. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (for example, hospital medical staff, medical 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 contract, or is any such action pending? Yes No
4. Have you **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges with; terminated contractual participation or employment in; or resigned from any medical organization (for example, hospital medical staff, medical 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, 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
5. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations? Yes No
6. Have you **ever** been charged with, been convicted of or admitted to committing a felony? Yes No
7. Have you **ever** been accused of sexual misconduct? Yes No
8. Have you **ever** had any contact of a sexual nature with a patient or former patient? Yes No
9. Do you know if any individual who works on your behalf has a prior history or propensity for sexual misconduct? Yes No
10. Have you **ever** had a problem with, been evaluated for, been diagnosed with, been treated for or are currently being treated for alcohol, narcotic or any other substance addiction, sexual addiction or mental illness? Yes No
11. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice? Yes No

SECTION XI CLAIMS HISTORY

1. Within the past ten (10) years has a malpractice claim or suit been brought against you, or have you been notified of your involvement in a malpractice claim or suit, either directly or indirectly? Yes No
2. To your knowledge, within the past ten (10) years has a malpractice claim been brought against any organization (for example, medical group or hospital) as a result of your rendering or failing to render professional health care services? Yes No
3. Are you 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 you, directly or indirectly, even if you believe the claim or suit would be without merit? Yes No

If you answered yes to questions 1, 2 or 3, please complete the attached Claim Information Form and Claim Information Narrative Form for each applicable claim, suit, incident, conduct, etc.

SECTION XII PRIOR ACTS COVERAGE

NOTE: Please complete the questions in this section only if you are applying for Prior Acts Coverage.

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

1. Please attach a copy of the declarations page and any endorsements from your most recent insurance policy.
2. Please complete the following regarding the locations where you practiced during the Prior Acts Period. Please provide your complete history since the Requested Retroactive Date.

Name of Practice	Address (city and state)	Type of Location (for example, office or surgery center)	Type of Practice	From (Month/Year)	To (Month/Year)
			<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Other		
			<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Other		
			<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Other		
			<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Other		
			<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Other		

3. If you indicated that any one of the practices identified in the question 2 table was not a solo practice, please describe the practice arrangement:

4. Since the Requested Retroactive Date, have there been any changes from what was specified on this application in terms of the procedures that you performed and/or the services that you provided (for example, you performed deliveries but no longer perform them). Yes No

If yes, please explain, identify the procedures and/or services and provide the date when you stopped performing the procedures and/or providing the services.

5. 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, please provide a detailed description of that practice, including the start and end dates. Please also identify the name of the insurance company that provided you with professional liability insurance coverage for that practice:

REPRESENTATIONS, WARRANTIES, AUTHORIZATION TO RELEASE INFORMATION AND FRAUD STATEMENTS

NOTE: "Warrant" in the following statement is not applicable to Arizona or New Mexico health care providers. By statute, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

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

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

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 me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the clinic's/organization's policy (including my coverage), if issued, can be canceled for failure to pay the premium by the due date stated on the invoice. If that happens, I may not have the right to purchase Tail Coverage.

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

I understand that I (or the clinic's/organization's Authorized Representative) 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 my behalf, including changes in my partners or associates, license, 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 I assume 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 me or others trading under my name.

I understand that if my application is approved and I am added to the clinic's/organization's policy, coverage would be extended only while I am acting within the course and scope of my duties for the clinic/organization, subject to the terms, conditions and limitations of the policy.

I understand that the Authorized Representative selected by the clinic/organization will act on behalf of the Named Insured or other insureds for all purposes relating to the policy, if issued, except consent decisions. With respect to consent decisions, the Authorized Representative will act on behalf of the Named Insured.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am 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 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 me.

Notice to 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.

Signature

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): _____

Your Relationship to Patient (for example, health care provider or consultant):

Allegation: _____

Location of Incident: _____

Additional 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:

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 your favor

Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on your behalf (if different): _____

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



THIS AGREEMENT and commitment is executed this 20th day of April 2005, by NORCAL Mutual Insurance Company, hereinafter referred to as “NORCAL.” This agreement supersedes inconsistent provisions of existing agreements between the parties.

NORCAL and the insured or applicant have an insurer/insured relationship by virtue of a professional liability policy requested from or issued by NORCAL. NORCAL and its insureds and applicants are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Regulations”) and Security Regulations under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Under the Privacy Regulations, the NORCAL insured or applicant may be a “Covered Entity,” and, as defined by 45 C.F.R. §164.502(e) and 45 C.F.R. §164.504(e), NORCAL may be a “Business Associate” of the insured or applicant. This Agreement sets forth the manner in which NORCAL will handle “Protected Health Information” that is provided by or received from or on behalf of the insured or applicant. NORCAL agrees as follows:

SECTION 1

Definitions

1.1 Business Associate: “Business Associate” shall mean a “Business Associate” as defined in 45 C.F.R. §164.501. Unless otherwise specified, the term Business Associate in this Agreement shall refer to NORCAL.

1.2 Covered Entity: “Covered Entity” shall mean the insured or applicant.

1.3 Designated Record Set: “Designated Record Set” means “Designated Record Set” as defined in 45 C.F.R. §164.501.

1.4 Electronic Protected Health Information: “Electronic Protected Health Information” shall mean Protected Health Information that is transmitted or maintained in electronic format or by electronic media.

1.5 Insurance Policy: “Insurance Policy” shall mean the policy of professional liability insurance requested by an applicant or now in effect between NORCAL and the insured, and any subsequent or replacement policy between NORCAL and the insured.

1.6 Privacy Rule: “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts §160 and §164, subparts A and E, as amended from time to time.

1.7 Protected Health Information (PHI): “Protected Health Information” or “PHI” shall have the same meaning as the term “Protected Health Information” in 45 C.F.R.



§164.501, limited to the information received by NORCAL from, or on behalf of, Covered Entity.

1.8 Secretary: “Secretary” shall mean the Secretary of the Department of Health and Human Services of his/her designee.

1.9 Security Incident: “Security Incident” shall have the same meaning as the term “Security Incident” in 45 C.F.R. §164.304.

1.10 Security Rule: “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. §160 and §164, subparts A and C.

SECTION 2

Obligations and Activities of NORCAL

In consideration of the Covered Entity’s continuing obligation to assist and cooperate with NORCAL’s efforts in providing services under the Insurance Policy, NORCAL hereby agrees to the following:

2.1 Not to Use or Disclose PHI Unless Permitted. NORCAL agrees not to use, or further disclose, Protected Health Information other than as permitted or required by the Agreement or as required or allowed by law.

2.2 Use Safeguards. NORCAL agrees to use reasonable safeguards to prevent use or disclosure of Protected Health Information other than as allowed by this Agreement or as otherwise required or allowed by law. NORCAL will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic Protected Health Information NORCAL creates, receives, maintains or transmits on behalf of Covered Entity.

2.3 Mitigation of Harmful Effects. NORCAL agrees to mitigate, to the extent practicable, any harmful effect that is known to NORCAL of a use or disclosure of Protected Health Information by NORCAL in violation of the requirements of this Agreement.

2.4 Report Inappropriate Disclosure of PHI. NORCAL agrees to report to Covered Entity any use or disclosure of the Protected Health Information not permitted or required by this Agreement of which NORCAL becomes aware. NORCAL also agrees to report to Covered Entity any Security Incident related to Electronic Protected Health Information of which NORCAL becomes aware.

2.5 Compliance of Agents. NORCAL agrees to require any agents, including subcontractors, to agree to the same restrictions and conditions that apply to NORCAL through



this Agreement provided that such agents perform a service that NORCAL agreed to perform for, or on behalf of, the Covered Entity under the Insurance Policy and to whom NORCAL provides Protected Health Information. NORCAL also agrees to ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it.

2.6 Access. To the extent that NORCAL possesses a Designated Record Set, NORCAL agrees to provide access to the Protected Health Information in that Designated Record Set, during normal business hours, provided the Covered Entity delivers prior written notice to NORCAL, at least five business days in advance, requesting such access but only to the extent required by 45 C.F.R. §164.524.

2.7 Amendments. To the extent that NORCAL possesses a Designated Record Set, NORCAL agrees to incorporate any amendment(s) to Protected Health Information in that Designated Record Set that the Covered Entity directs, pursuant to 45 C.F.R. §164.526.

2.8 Disclosure of Practices, Books, and Records. Unless otherwise protected from discovery or disclosure by law or unless otherwise prohibited from discovery or disclosure by law, NORCAL agrees to make internal practices, books, and records available to the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. NORCAL shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after NORCAL's receipt of such request.

2.9 Accounting. NORCAL agrees to maintain sufficient documentation to allow it to provide to Covered Entity a list of any disclosures of Protected Health Information by NORCAL or its agents so as to allow the Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. §164.528.

SECTION 3

Permitted Uses and Disclosures by NORCAL

3.1 Use of PHI for Specified Purposes. Under the Insurance Policy, NORCAL provides the Covered Entity with insurance products and services (hereinafter "Services") that involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, the acceptance, declination, or acceptance with revisions of professional liability insurance; receiving and evaluating incidents, claims, and lawsuits; quality assessment; quality improvement; loss prevention tools; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance;



conducting training programs to improve the skills of health care practitioners and providers; credentialing, conducting, or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing insurance or reinsurance, including but not limited to pro rata, stop-loss, and excess of loss insurance, and other functions necessary to perform these Services. NORCAL may make any uses of Protected Health Information necessary to perform its obligations under this Agreement and under the Insurance Policy. Moreover, NORCAL may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section 3.2 through 3.4 of this Section below; or (ii) as otherwise permitted by the terms of this Agreement. All other uses not authorized by this Agreement are prohibited.

3.2 Use of PHI for NORCAL Management and Administration. NORCAL may use Protected Health Information for the proper management and administration of NORCAL or to carry out the legal responsibilities of NORCAL.

3.3 Disclosure Required by Law or With Reasonable Assurance. NORCAL may disclose Protected Health Information for the proper management and administration of NORCAL and to carry out its legal responsibilities, provided that disclosures are required by law, or provided that NORCAL obtains the following reasonable assurances from the person or entity to whom the Protected Health Information is disclosed: 1) the PHI will remain confidential; 2) the PHI will be used or further disclosed only as required by law or for the purposes for which it was disclosed; and 3) the person or entity will notify NORCAL of any instances of which the person or entity is aware in which the confidentiality of the information has been breached.

3.4 Data Aggregation Services. NORCAL may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B).

3.5 De-identified Information. NORCAL may de-identify any and all Protected Health Information in accord with the requirements of applicable law as provided in 42 C.F.R. §164.514(b), and use or disclose all such de-identified information for its own managerial and administrative activities as it sees fit. NORCAL agrees to maintain such documentation regarding de-identified information as required by 42 C.F.R. §164.514(b). Covered Entity understands and acknowledges that de-identified information is not Protected Health Information under the terms of this Agreement.



SECTION 4

Impermissible Requests by Covered Entity

NORCAL shall not use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except that, despite this Section 4, NORCAL may use or disclose Protected Health Information for data aggregation or management and administrative activities of NORCAL as provided in sections 3.2, 3.3, and 3.4 above, or as otherwise permitted by this Agreement.

SECTION 5

Term and Termination

5.1 Term. This Agreement shall remain effective during the time that NORCAL provides the Covered Entity with Services, as defined in section 3.1 above, pursuant to the terms of the Insurance Policy, and shall terminate when all such Services under the Insurance Policy are terminated and all of the Protected Health Information created or received by NORCAL on behalf of Covered Entity is destroyed or returned to Covered Entity; provided, however, certain provisions and requirements of this Agreement shall survive such termination in accord with subsection 5.3, below.

5.2 Termination by Covered Entity. Upon Covered Entity's determination that NORCAL has breached a material term of this Agreement, Covered Entity shall immediately notify NORCAL and provide NORCAL a reasonable opportunity to cure the breach. Covered Entity may terminate this Agreement, and NORCAL agrees to such immediate termination, if NORCAL has breached a material term of this Agreement and cure is not possible. **Covered Entity and NORCAL hereby acknowledge and agree that the termination of this Agreement by Covered Entity shall have no effect on the terms and conditions of the Insurance Policy between them unless NORCAL determines, in its sole discretion, that the termination of this Agreement by Covered Entity constitutes a breach of Covered Entity's duty of cooperation under the Insurance Policy.**

5.3 Effect of Termination. Upon termination of NORCAL's provision of Services under the Insurance Policy, the protection of this Agreement will remain in force and NORCAL shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of its business or to carry out its legal responsibilities or as required by law. To the extent that it is feasible to do so, NORCAL agrees to return or destroy all PHI, pursuant to 45 C.F.R. §164(e)(2)(ii)(I), and to require any and all of its subcontractors or agents to return or destroy any PHI in their possession. However, NORCAL and Covered Entity hereby acknowledge and agree that, because of the nature of the Services provided by NORCAL and its business obligations, it is not feasible to return or destroy all



Protected Health Information immediately on the termination of this Agreement, or for some time thereafter. Therefore, NORCAL agrees to extend, and require its subcontractor and agents to extend, and all protections, limitations, and restrictions contained in this Agreement to such PHI as may be retained after the termination of this Agreement. **This section 5 shall survive the termination of this Agreement and NORCAL's provision of Services under the Insurance Policy.**

SECTION 6

Miscellaneous Provisions

6.1 Regulatory References. A reference in this Agreement to a section in the Privacy or Security Rule means the Section in effect or as amended, and for which compliance is required.

6.2 Amendment. NORCAL agrees to take such action as is necessary to amend this Agreement from time to time as is necessary, as determined by NORCAL, for compliance with the requirements of the Privacy Rule, the Security Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191 as determined by NORCAL.

A handwritten signature in black ink that reads "David R. Holley, MD." The signature is fluid and cursive.

David R. Holley, MD
Secretary, Board of Directors

A handwritten signature in black ink that reads "James Sunseri". The signature is fluid and cursive.

James Sunseri
President & Chief Executive Officer