



# CPG SPECIALTY HEALTH CARE PROVIDER APPLICATION

## 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.

## 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 11. 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 12.
- Please provide loss runs, if requesting prior acts coverage, for the previous seven 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)	E-Mail Address			

## SECTION II COVERAGE INFORMATION

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 an insured and reported to NORCAL, after the policy effective date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the expiration date of the policy.

The Retroactive Date is the earliest date on which a medical incident, benefit error or administrative proceeding can occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage for your current insurer, if applicable. **NORCAL does not automatically provide Prior Acts Coverage.**

Please 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.

**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"/> Solo <input type="checkbox"/> Group		

## SECTION III PROFESSIONAL LIABILITY INSURANCE HISTORY

Please complete the following regarding all professional liability insurance maintained by you during the past seven 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

## SECTION IV HOSPITAL PRIVILEGES

- Do you maintain hospital privileges for all of the procedures that you will perform?  Yes  No
- 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: _____

- If you checked "provisional" or "other," please explain in the Remarks section page 11.

## SECTION V LICENSES

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 NP)	License Number

## SECTION VI GENERAL PRACTICE INFORMATION

- 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: \_\_\_\_\_ %

## 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    Podiatric School    Nursing Program

Name of School	City, State	Dates (from – to)
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**Internship:**

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

Type
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Name of Location	City, State	Dates (from – to)
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2. Did you successfully complete each training program that you started?  Yes    No

If no, please explain in the Remarks section on page 11.

3. Please explain any gaps in your training, if applicable, in the Remarks section on page 11.

4. 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 name of the organization: \_\_\_\_\_

## SECTION VIII PROCEDURES AND SERVICES

1. Please complete the following table by providing the estimated number of procedures and surgeries to be performed or services to be provided on behalf of the clinic/organization for the current (and complete) calendar year, regardless of where they are performed or provided.

<b>Procedure/Surgery/Service</b>	<b># of visits</b>
Family Practice and General Visits (excluding general podiatric visits):	
General Podiatric Visits:	
Prenatal and Postnatal Visits:	
General Dental Visits (excluding oral surgery):	
Mental Health Counseling Visits:	
Deliveries (including cesarean delivery):	
Abortions:	
Administration of Anesthesia other than topical or by means of local infiltration:	

**Oral Surgery:**

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Cleft lip and palate surgery	
Dental implants	
Orthognathic surgery	
Tempromandibular joint surgery	
Wisdom tooth extraction (By Dentist or Oral Surgeon)	
Other oral surgery (specify procedures): ----- -----	

<b>Procedure/Surgery/Service</b>	<b># of visits</b>
Minor Procedures and Surgeries (optional):	-----
Biopsy of lesions limited to the mucous membranes of the nose, mouth, throat, vagina, uterine cervix or rectum	
Surgical treatment of cysts, abscesses or superficial or and traumatic wounds using local infiltration anesthesia	
Other oral surgery (specify procedures): -----	

<b>Intermediate Procedures and Surgeries:</b>	<b># of visits</b>
Amniocentesis	
Carpal tunnel release	
Catheterization	
Circumcision	
Cystoscopy	
Dilation and curettage of the uterus (other than for the termination of a pregnancy)	
Endoscopy procedures	
Herniorrhaphy (inguinal or femoral only)	
Hemorrhoidectomy and other procedures limited to the anal ring	
Hysteroscopy	
Injection treatment of varicose veins	
Lithotripsy	
Myringotomy	
Orthopedic operations of the interphalangeal joints	
Tonsillectomy and adenoidectomy	
Transurethral procedures on the kidney, ureter, bladder or urethra	
Vasectomy and other procedures involving cutting of the scrotal sac	
Other intermediate procedures and surgeries (specify): ----- -----	

<b>Procedure/Surgery/Service</b>	<b># of visits</b>
<b>Major Surgery:</b>	-----
Amputations	
Angiography	
Angioplasty	
Episiotomy repair	
Fracture repair – plating, pinning or open reduction	
Mastectomy	
Reconstructive vascular surgery, thromboembolectomy and thrombectomy of the arteries and veins and arterial-venous fistula creation/revision	

Procedure/Surgery/Service	# of visits
<b>Major Surgery:</b>	-----
Neurological surgery	
Ooporectomy	
Ophthalmic surgery	
Operations within the middle inner ear	
Orthopedic surgery (other than orthopedic operations on the interphalangeal joints)	
Plastic (cosmetic or reconstructive) surgery	
Prostatectomy	
Submucous nasal resection and other sinus surgery	
Stenting – coronary and noncoronary	
Thyroidectomy	
Any surgical procedure on malignant lesions (other than for diagnostic purposes)	
Any cutting into or on the kidney, urethra or bladder or appendix	
General Surgery – any surgical procedure involving cutting into or within the abdominal cavity, cranial cavity, orbital cavity, spine or facial sinuses (not already identified in the major surgery section)	
Other major surgery (specify): ----- -----	

## SECTION IX HEALTH CARE EXTENDERS

**NOTE:** If you are a nurse midwife or a nurse practitioner, please identify the name of all of your supervising/collaborating physicians and provide their Medical Specialties:

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## SECTION X CLAIMS HISTORY

1. Within the past seven (7) 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 seven (7) 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 XI 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. Have you **ever** had a problem with, been evaluated for, been diagnosed with, been treated for, or are you currently being treated for: alcohol, narcotic or any other substance addiction, sexual addiction or mental illness?  Yes  No
10. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice?  Yes  No
11. Has any professional liability insurance company **ever** canceled, non-renewed 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



# 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): \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Allegation Against the Physician/Syrgeon: \_\_\_\_\_

Clinic/Organization Member Defendants: \_\_\_\_\_

Non-Clinic/Organization Member Defendants: \_\_\_\_\_

Date Incident or Claim Was Reported to the Insurance Company: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Disposition or Current Status of the Incident, Claim or Suit Against the Clinic/Organization:

Open

Incident has been reported but claim or suit has not been filed

Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.

Claim or suit is currently in arbitration or mediation or is being tried in court

Settlement has been made or judgment returned but remains open

Closed      Date Closed (month/day/year): \_\_\_\_\_

Incident was reported but claim or suit was not filed

Claim or suit was filed but was dismissed or dropped before trial

Claim or suit was filed but settlement was made

Verdict or judgment was made in the entity's favor

Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): \_\_\_\_\_

Amount paid on the clinic's/organization's behalf: \_\_\_\_\_

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

