

## ENTITY-GROUP 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.
- Please ensure that you sign and date the application on page 16.
- In addition to a completed application, please provide the following items:
  - A completed application for each employed physician and each employed health care extender.
  - A copy of the group's/entity's letterhead(s).
  - Loss runs for the previous seven years for the group/entity and each member. The loss runs must include paid and reserved amounts and be less than 90 days old.
  - A copy of the Declarations Page and any endorsements from the group's/entity's most recent insurance policy, if applicable. If each physician was issued a Declarations Page, please provide each Declarations Page. If each physician was not issued a Declarations Page, please provide the endorsement to the policy that identifies all insureds and their Retroactive Dates.
  - A list of all the group/entity members, officers, directors, and managing agents.
- If the group/entity engages in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, the group/entity is considered a *Covered Entity* under HIPAA and thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at [www.norcalmutual.com](http://www.norcalmutual.com).
- Please make a copy of the completed application and supporting documents for your records.

**SECTION I****IDENTIFYING INFORMATION**

Group/Entity Name

Primary Practice Address

*(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)*Mailing Address *(Location where all mailings except invoices will be sent)**(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)*Billing Address *(Location where invoices will be sent)**(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)*

Website Address

**Coverage Structure**

Please identify the desired coverage structure:

**NOTE:** NORCAL offers two options under which groups/entities may apply for coverage — the single policy format and the multi-policy format. Please discuss the options with your broker or call NORCAL before identifying the desired structure.

The group/entity wishes to apply for coverage under the single policy format. Under this format the Named Insured is issued a policy and all health care professionals are endorsed onto that policy with individual or shared limits of liability. Coverage for an insured is provided only while he or she is acting within the course and scope of his or her duties for the Named Insured.

The group/entity wishes to apply for coverage under the multi-policy format. Under this format the entity and each physician with individual limits of liability are issued separate policies.

**Authorized Representative**

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

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

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

Name: Title: E-Mail Address: Telephone Number: 

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

Name: Title: E-Mail Address: Telephone Number:

**SECTION I (cont)**

**IDENTIFYING INFORMATION**

**Authorized Representative (cont)**

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

Name:  Title:   
 E-Mail Address:  Telephone Number:

**SECTION II**

**COVERAGE/INSURANCE INFORMATION**

**Requested Retroactive Date** (the date you wish coverage to begin)

12:01 a.m. Local Time  
(mm/dd/yyyy)

**Professional Liability Insurance – Claims Made**

**Prior Acts Coverage** *(check one)*

Prior Acts Coverage (also known as “nose coverage”) would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. Do not forfeit your right to purchase Extended Reporting Coverage (also known as “tail coverage) from your current carrier.

- The group/entity wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. (Please identify the Requested Retroactive Date below, which must be the same as the Retroactive Date of your current policy):
- The group/entity does not wish to apply for Prior Acts Coverage. It is understood that if the group/entity does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the Effective Date of the NORCAL policy, if issued.

**Requested Retroactive Date**

12:01 a.m. Local Time  
(mm/dd/yyyy)

**NOTE:** If the group/entity is not applying for Prior Acts Coverage, please skip questions 1 through 5.

1. Since the Requested Retroactive Date has there been a change in the legal structure (e.g., entities dissolved, legal associations ended, etc.)?  **Yes**  **No**

**If yes,** please explain and identify the appropriate dates of the change in structure, etc:

2. Since the Requested Retroactive Date has the group/entity rendered professional health care services at any location other than the current Practice Locations listed in this application?  **Yes**  **No**

**If yes,** please complete the following:

Location <i>(name and address)</i>	Type of Location <i>(e.g., outpatient office)</i>	From <i>(mm/yyyy)</i>	To <i>(mm/yyyy)</i>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>
<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>	<input style="width: 100%; height: 40px;" type="text"/>

**Requested Retroactive Date (cont)**

3. Since the Requested Retroactive Date have any physicians or dentists other than those identified in Section V (Personnel) rendered professional health care services on behalf of the group/entity?  Yes  No
4. Since the Requested Retroactive Date have any nurse midwives, certified registered nurse anesthetists, nurse practitioners, physician assistants, podiatrists or perfusionists other than those identified in Section V (Personnel) rendered professional health care services on behalf of the group/entity?  Yes  No

**If you answered yes to question 3 or 4,** please attach a roster of all such personnel, including each individual's name, designation, medical specialty (if a physician) and type of relationship with the group/entity (e.g., employee), and the dates that he or she provided services on behalf of the group/entity.

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

**If yes,** please provide a detailed written narrative in the Remarks Section on page 15.

**Health Care General Liability Insurance – Occurrence**

**NOTE:** This coverage is available only to qualified groups/entities insured under the single policy format.

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

1. Does the group/entity wish to apply for Health Care General Liability Insurance coverage?  Yes  No

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

**Requested Limits of Liability**

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

## Alaska Physicians

- \$500,000/\$1,000,000  
 \$1,000,000/\$2,000,000  
 \$1,000,000/\$3,000,000  
 \$2,000,000/\$4,000,000

## California Physicians

- \$500,000/\$1,500,000  
 \$1,000,000/\$3,000,000  
 \$2,000,000/\$4,000,000  
 \$2,000,000/\$5,000,000

## Rhode Island Physicians

- \$500,000/\$1,500,000  
 \$1,000,000/\$1,000,000  
 \$1,000,000/\$3,000,000

**NOTE:** The group/entity may be eligible for a higher annual aggregate limit of liability for an additional charge. If this option is not chosen, the limits of liability for the group/entity will be the same as the limits of liability for the group/entity members.

2. Do you wish to request a higher annual aggregate limit of liability for the group/entity?  Yes  No

**If you are applying for a higher annual aggregate limit of liability for the group/entity,** please indicate the desired limits of liability below.

## Alaska Physicians

- \$1,000,000/\$10,000,000  
 \$2,000,000/\$10,000,000

## California Physicians

- \$1,000,000/\$10,000,000  
 \$2,000,000/\$10,000,000

## Rhode Island Physicians

- \$1,000,000/\$10,000,000  
 \$2,000,000/\$10,000,000

**Deductible**

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

**Deductible (cont)**

1. Does the group/entity wish to have a deductible on the policy?  Yes  No

**If yes,** please complete the following:

Type:  Indemnity only  Indemnity and Expense

Per Claim Amount:

Annual Aggregate:  Yes  No

**If yes,** Annual Aggregate Amount:

**Scope of Coverage (check one)**

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

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

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

**Professional Liability Insurance History**

Please complete the following regarding all professional liability insurance you have maintained during the past ten years, beginning with the most current. Please use the Remarks Section if additional space is needed.

Name of Insurer	Coverage Dates (mm/dd/yyyy)	Policy Type	If Claims Made (check one)
<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased <input type="checkbox"/> Other: <input type="text"/>
<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased <input type="checkbox"/> Other: <input type="text"/>
<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased <input type="checkbox"/> Other: <input type="text"/>
<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased <input type="checkbox"/> Other: <input type="text"/>

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

Name of Group/Entity	Legal Structure	Names(s) of Owner(s) and the Percentage of Ownership Interest
	<input type="checkbox"/> Professional Corporation <input type="checkbox"/> Association <input type="checkbox"/> Foundation <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: <input type="text"/>	

2. Does the entity identified in question 1 own, operate, manage, or have any governing or financial interest in any other organization or entity?  Yes  No

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

Name of Group/Entity	Legal Structure – Is it a:	Name(s) of Other Owner(s) and the Type of Ownership Interest in That Entity	Is NORCAL Coverage Desired for the Organization/Entity?*
	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Other: <input type="text"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Other: <input type="text"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If NORCAL coverage is not desired for the organization or entity, please explain in the Remarks section on page 15.

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

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

4. Is the group/entity owned, operated or managed by another organization or entity not already specified above?

Yes  No

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

5. Is the group/entity involved in any joint ventures or partnerships?  Yes  No

**If yes,** please explain:

**SECTION III (cont)**

**LEGAL STRUCTURE**

6. Please provide a chart of the organizational structure of the group/entity applying for coverage listing subsidiaries, joint ventures, and include a description of how they interact.

7. Does the group/entity or any of its members do business under a fictitious name(s) or dba(s)?  Yes  No

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

**SECTION IV**

**PRACTICE LOCATIONS**

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

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

- |                                       |                                                                       |
|---------------------------------------|-----------------------------------------------------------------------|
| <b>A.</b> Outpatient Office           | <b>G.</b> Ambulatory Surgery Center                                   |
| <b>B.</b> Blood Bank                  | <b>H.</b> Community Clinic                                            |
| <b>C.</b> Dialysis Center             | <b>I.</b> Endoscopy Center                                            |
| <b>D.</b> Office-based Surgical Suite | <b>J.</b> Laboratory                                                  |
| <b>E.</b> Nursing Home                | <b>K.</b> Imaging Center                                              |
| <b>F.</b> Urgent Care Clinic          | <b>L.</b> Other (specify): <input style="width: 150px;" type="text"/> |

Location <i>(name and address)</i>	Type of Location <i>(use code)</i>	Date Group/Entity Began Rendering Services at at Location <i>(mm/dd/yyyy)</i>	Accreditation	Is NORCAL Coverage Desired for the Services Rendered at This Location?*
<div style="border: 1px solid black; height: 80px;"></div>	<div style="border: 1px solid black; width: 50px; height: 80px;"></div>	<div style="border: 1px solid black; width: 150px; height: 80px;"></div>	<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; height: 80px;"></div>	<div style="border: 1px solid black; width: 50px; height: 80px;"></div>	<div style="border: 1px solid black; width: 150px; height: 80px;"></div>	<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; height: 80px;"></div>	<div style="border: 1px solid black; width: 50px; height: 80px;"></div>	<div style="border: 1px solid black; width: 150px; height: 80px;"></div>	<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; height: 80px;"></div>	<div style="border: 1px solid black; width: 50px; height: 80px;"></div>	<div style="border: 1px solid black; width: 150px; height: 80px;"></div>	<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; height: 80px;"></div>	<div style="border: 1px solid black; width: 50px; height: 80px;"></div>	<div style="border: 1px solid black; width: 150px; height: 80px;"></div>	<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If NORCAL coverage is not desired for the services rendered at any location, please explain in the Remarks section on page 15.

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

If no, please identify the location and explain:

3 Does the group/entity allow non-members to render services at any location(s) that the group/entity owns or rents?  
 Yes  No

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

**Administration**

1. Please identify the following individuals:

Title	Name	Number of Years with Group/Entity
Chief Executive Officer		
President		
Medical Director		
Administrator		
Other (specify): <div style="border: 1px solid black; width: 150px; height: 15px; margin-top: 5px;"></div>		

**Physicians and Dentists**

1. Please attach a roster of all physicians and dentists (employees and independent contractors) who provide services on behalf of the group/entity, including the following information for each individual:

- Name and designation
- Specialty
- Date of birth
- Average number of hours worked on behalf of the group/entity per week
- Average number of hospital admissions per week
- Whether the individual is an employee or an independent contractor
- Date of employment, if an employee
- Retroactive Date

2. Please identify the average number of physicians and dentists who provided services on behalf of the group/entity during each of the past five years:

	Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year
Physicians					
Dentists					

**Departed Physicians and Dentists**

3. Does the group/entity desire coverage with NORCAL for those physicians and dentists who left the group/entity before the desired Effective Date with NORCAL?  Yes  No

If yes, please answer question 4.

4. Please attach a roster of all departed physicians and dentists, including the following information for each individual:

- Name and designation
- Specialty
- Whether the individual was an employee independent contractor
- Dates individual rendered services on behalf of the group/entity
- Retroactive Date
- Whether the individual was insured with shared or separate or an limits of liability

**Health Care Extenders and Ancillary Personnel**

1. Do any of the following provide services on behalf of the group/entity?  Yes  No

- Nurse Midwife
- Certified Registered Nurse Anesthetist
- Nurse Practitioner
- Physician Assistant
- Podiatrist
- Perfusionist
- Chiropractor
- Optometrist

If yes, please attach a roster of all such persons, including the following information for each individual:

- Name and designation
- Date of birth
- Average number of hours worked on behalf of the group/entity per week
- Whether the individual is an employee or an independent contractor
- Date of employment if an employee

2. Please identify the number of individuals in each of the following categories and any other ancillary personnel who render professional health care services on behalf of the group/entity:

Designation	Association	Designation	Association
Licensed Practical/ Vocational Nurse	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>	Medical Assistant	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>
Optometrist	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>	Psychologist	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>
Registered Nurse	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>	Registered Nurse First Assistant	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>
Other (specify): <input type="text"/>	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>	Other (specify): <input type="text"/>	Number Employed: <input type="text"/> Number Independently Contracted: <input type="text"/> Other (specify): <input type="text"/>

**Health Care Extenders and Ancillary Personnel (cont)**

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

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

**Independent Contractors**

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

1. Are all independent contractors required to maintain Professional Liability Insurance with limits of liability of at least \$1 million per claim/\$3 million annual aggregate?  Yes  No
2. Are all independent contractors required to provide the group/entity with proof of Professional Liability Insurance at least annually?  Yes  No

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

**Work Outside of Group/Entity Employment**

1. Does the group/entity permit its employees to render services unrelated to its practice?  Yes  No

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

If yes:

- a. Is the employee required to obtain separate insurance to cover the outside exposure?  Yes  No
- b. Is the employee required to notify the group/entity of any outside exposure(s)?  Yes  No

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

**Managed Care**

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

If yes:

- a. Please identify the organization(s):

- b. Does the group/entity maintain managed care errors and omissions coverage?  Yes  No

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

If yes, does the group/entity maintain separate coverage for such exposures?  Yes  No

**Managed Care (cont)**

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

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

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

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

**Cosmetic Procedures**

1. Does any group/entity member who is not a plastic surgeon, dermatologist, ophthalmologist, or otolaryngologist perform any cosmetic procedures?  Yes  No

**If Yes,** please provide the name of each individual, the cosmetic procedures performed.

**Drugs, Devices and Clinical Studies**

1. Do any group/entity members 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 part of a clinical study, please provide the following information for each clinical study.

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

2. Do any group/entity members use, administer, distribute or prescribe any FDA-approved drug, pharmaceuticals, devices or equipment in a manner not approved by the FDA (i.e., off-label use)?  Yes  No

**If yes,** are all such uses supported by appropriate precedent for effectiveness and safety? Please explain:

**Telemedicine, E-mail, and Advertising**

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine."

1. Do any group/entity members provide telemedicine services?  Yes  No

**If yes,** please contact NORCAL or your broker for a supplemental questionnaire.

## Miscellaneous

1. Do any group members render professional health care services not considered usual and customary to their medical specialties?  
 Yes  No

If yes, please explain:

2. Do any group members perform assisted reproductive technology procedures, or are any involved in the treatment of infertility?  
 Yes  No

If yes, please explain:

3. Do any group members perform surgery for obesity or weight control (i.e., bariatric surgery)?  Yes  No

If yes, please contact NORCAL or your broker for a supplemental questionnaire in order to apply for such coverage.

4. Do any group members function as a hospitalist?  Yes  No

If yes, please contact NORCAL or your broker for a supplemental questionnaire.

5. Do any group members perform any of the procedures listed below?  Yes  No

If yes, please check all that apply:

- |                                                                 |                                                                                                                  |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Mesotherapy                            | <input type="checkbox"/> Silicone Injection                                                                      |
| <input type="checkbox"/> Prolotherapy                           | <input type="checkbox"/> Sex-Reassignment/Sex Change Surgery                                                     |
| <input type="checkbox"/> Fat Injection into the Breast or Penis | <input type="checkbox"/> Chelation Therapy (other than for the treatment of patients with heavy metal poisoning) |

6. Do any of the group's health care extenders or ancillary personnel ever take call on behalf of a physician?  Yes  No

If yes, please explain:

7. Do any group members render services in or on behalf of an emergency room other than as required by hospital bylaws for mandatory call rotation?  Yes  No

If yes, please explain:

8. Does the group or any of its members contract with any facilities to be involved with the training/supervision of medical students, residents, fellows, etc.?  Yes  No

If yes:

- a. Please describe and identify where the training takes place and provide a copy of the contract(s):

- b. Who provides Professional Liability Insurance coverage to the students, residents, fellows, etc?

1. Does the group/entity have a formal risk management program?  Yes  No

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

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

### Credentialing

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

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

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

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

Claim History  Yes  No If yes, source(s) used:

Hospital Privileges  Yes  No

Employment History  Yes  No If yes, source(s) used:

Education History  Yes  No If yes, source(s) used:

Felony/Misdemeanor History  Yes  No If yes, source(s) used:

Medical/Dental/Nursing and Narcotic Licenses  Yes  No If yes, source(s) used:

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

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

**If no**, please describe the credentialing process used:

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

### Quality Assurance

1. Does the group/entity have a formal process to evaluate and address concerns of unexpected patient outcomes?

Yes  No

**Quality Assurance** (cont)

2. Does the group/entity have a formal process to evaluate patient complaints?  Yes  No
3. Does the group/entity conduct patient satisfaction surveys?  Yes  No

If yes, how often:

**Utilization Review**

1. Does the group/entity have its own utilization review committee?  Yes  No

If yes:

- a. Does the group/entity have written policies and procedures for appeals of denied procedures?  Yes  No

b. Who performs the utilization reviews?

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

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

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

**Medical Records**

1. Does the group/entity currently use electronic medical records?  Yes  No

If yes:

a. Who is the vendor?

b. How often are the electronic files backed up?

c. Who backs up the files?

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

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

- e. Do all group/entity locations use electronic medical records?  Yes  No

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

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

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

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

## SECTION VIII

## SUPPLEMENTAL QUESTIONS

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

1. Has any professional liability insurance company **ever** canceled, non-renewed, modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) the group's/entities insurance, declined to offer the group/entity coverage or notified the group/entity of its intent to pursue such action?  Yes  No
2. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the group/entity?  Yes  No
3. Have the group's/entities clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group/entity, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending?  Yes  No
4. Has the group/entity **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group/entity, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?  Yes  No
5. Has any group/entity member **ever** been accused of sexual misconduct?  Yes  No
6. Do you know if any individual who works on the group's/entities behalf has a prior history or propensity for sexual misconduct?  Yes  No

## SECTION IX

## CLAIMS HISTORY

1. Within the past seven (7) years, has a malpractice claim or suit been brought against the group entity(ies), or has a group/entity been notified of its involvement in a malpractice claim or suit, either directly or indirectly?  Yes  No
2. Is the group/entity aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against a group entity, directly or indirectly, even if you believe the claim or suit would be without merit?  Yes  No

**If you answered yes to question 1 or 2**, please complete a Claim Information Form on page 17 for each applicable claim, suit, incident, conduct, etc.



## REPRESENTATIONS, WARRANTIES, AND AUTHORIZATION TO RELEASE INFORMATION

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

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

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

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

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

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

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

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

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

Signature of Authorized Representative

Date

  
(mm/dd/yyyy)

Name (Print)

# CLAIM INFORMATION FORM

Name of Patient:

Gender:  Male  Female

Age of Patient (at time of treatment):

Name of Claimant (if different than patient):

Location of Incident:

Allegation Against the Entity:

Group/Entity Member Defendants:

Non Group/Entity Member Defendants:

Date (mm/dd/yyyy) Incident or Claim Was Reported to the Insurance Company:

Name of Insurance Company:

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

**Open**

- Incident has been reported but claim or suit has not been filed  
Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

**Closed**

**Date Closed** (mm/dd/yyyy):

- 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

Total loss payment amount (if payment made):

Amount paid on the entity's behalf:

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

## CLAIM INFORMATION NARRATIVE

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

- Condition and diagnosis at time of treatment
- Dates and a description of treatment rendered
- Condition of patient subsequent to treatment

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

Signature of Authorized Representative

Date

(mm/dd/yyyy)

Name *(Print)*