



**Group Policy**

# APPLICATION

**For Members of  
Large Groups**

For Claims Made Professional  
Liability Insurance

 **NORCAL**  
Mutual Insurance Company

# APPLICATION CHECKLIST

- Type or print clearly in ink.
- Please ensure that you sign and date the application on page 5 for California and Rhode Island applicants or page 6 for Alaska applicants.
- Please submit a copy of your curriculum vitae.
- You may be required to complete and submit a supplemental questionnaire(s) with this application. A supplemental questionnaire is required if you practice a certain medical specialty or are involved with a certain exposure. Please contact NORCAL or your broker for the supplemental questionnaire(s).
- Please make a copy of the completed application and supporting documents for your records.

## SECTION I IDENTIFYING INFORMATION

I wish to apply for professional liability insurance coverage under the policy of:

\_\_\_\_\_ (referred to as "group" throughout the remainder of this application).  
 (Name of Group)

**NOTE: If your application is approved, you will be added to the group's policy via endorsement. Coverage will be extended only while you are acting within the course and scope of your duties for the group and will be subject to the terms, conditions and limitations of the policy. A copy of the policy will be made available to you.**

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

## SECTION II MISCELLANEOUS

**NOTE:** Please complete this section only if this is an application to join an existing NORCAL-insured group.

1. Please identify the desired effective date of coverage:

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

2. Please identify the following:

The average number of hours that you will work on behalf of the group per week: \_\_\_\_\_

The average number of hospital admissions that you will have per week: \_\_\_\_\_

3. 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.
4. 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
5. To your knowledge, within the past ten (10) years has a malpractice claim been brought against any organization (e.g., medical group, hospital, etc. ) as a result of your rendering or failing to render professional health care services?  Yes  No
6. 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 4, 5, or 6, please complete a Claim Information Form on page 7 for the following:**

- Each claim or suit in which \$100,000 or more indemnity payment was made
- Each claim or suit that remains "open"
- Each medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim

## SECTION III 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 (e.g., nonrenewal or declination notice, medical board documents, letters from hospital, diversion program, treating physician, etc.).

1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) your insurance, declined to offer you coverage or notified you of its intent to pursue such action?  Yes  No
2. Has your license to practice medicine, dentistry or nursing 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
3. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you?  Yes  No
4. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (e.g., 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
5. 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 (e.g., 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
6. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations?  Yes  No
7. Have you **ever** been charged with, been convicted of or admitted to committing a felony?  Yes  No
8. Have you **ever** been accused of sexual misconduct?  Yes  No
9. Have you **ever** had any contact of a sexual nature with a patient or former patient?  Yes  No
10. Do you know if any individual who works on your behalf has a prior history or propensity for sexual misconduct?  Yes  No
11. 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
12. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?  Yes  No



**FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY**

**Warranties and Authorization To Release Information**

I understand that this application and any supplemental information supplied by me or on my group’s behalf is incorporated into and made a part of any policy of insurance that may be issued to my group 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 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 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 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 or others trading under my group’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 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 and its members that is done in good faith and without malice.*

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Name (Print)

If you are completing this application with a broker and/or brokerage firm, please state the name(s) and Broker License Number(s).

Name	Broker License Number
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

If you are completing this application with a NORCAL Account Executive, please state the name:

If you were referred to NORCAL by someone, please state the name:

## FOR ALASKA APPLICANTS ONLY

### Representations and Authorization To Release 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 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 group'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 (i.e., the payer).

I understand that I (or the group'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, medical 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 group's policy, coverage would be extended only while I am acting within the course and scope of my duties for the group, subject to the terms, conditions and limitations of the policy.

I understand that the Authorized Representative selected by the group 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.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

If you are completing this application with a broker and/or brokerage firm, please state the name(s) and Broker License Number(s).

Name

Broker License Number

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

If you are completing this application with a NORCAL Account Executive, please state the name:

If you were referred to NORCAL by someone, please state the name:

## 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 (e.g., attending physician, primary surgeon, assistant surgeon, consultant, etc.):  
\_\_\_\_\_

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





560 Davis Street, Suite 200  
San Francisco, CA 94111-1966

(800) 652-1051  
[www.norcalmutual.com](http://www.norcalmutual.com)