Medical Director Application

1.1 Applicant Name: _____

Email Address: _____ Phone Number: _____

Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Business Address (1): _____

City: _____ State: _____ Zip Code: _____

Type of Facility:_____

Business Address (2): _____

City: _____ State: _____ Zip Code: _____

Type of Facility:_____

1.2 Your Degree Type: _____ Specialty/Area of Practice: _____

1.3 Annual Gross Receipts from Medical Director operations only: _____

2.1 Please indicate percentage of patients among the following that you are a medical director for:

Urgent Care:	%	Alternative Medicine:	%	Emergency Care:	%
Sleep Studies:	%	Dialysis:	%	Psychiatric:	%
Occupational Health:	%	Weight Loss:	%	Students:	%
Crisis Stabilization:	%	Home Health:	%	Assisted Living:	%
Medical Spas:	%	Orthopedics:	%	Pain Management:	%
Clinical Trials:	%	Pediatrics:	%	Long Term Care:	%
Women's Health:	%	Marijuana Dispensary:	%	General/Family Practice:	%
Other: (Describe)					%

2.2 Name ALL businesses for which you are a medical director for:

1. _____
2. _____
3. _____

2.3 Do you have any ownership of any the facility that you are overseeing? ☐ Yes ☐ No

2.4 Do you do any Direct Patient Care as a Medical Director? ☐ Yes ☐ No

If Yes, what percentage of your medical director time is direct patient care? _____%

Describe: _____

2.5 Do you want coverage for License Action Reimbursement at limits of $25,000? ☐ Yes ☐ No

2.6 Do you currently have Medical Malpractice insurance? If yes, indicate below ☐ Yes ☐ No

Insurer: *Liability Limits:* *Exp. Date :*

2.7 Do you currently have insurance for Medical Director Oversight? If yes, indicate below ☐ Yes ☐ No

Insurer: *Liability Limits:* *Premium:* *Exp. Date :* *Retro Date (If applicable)*

2.8 Do ALL locations use consent forms for each client? ☐ Yes ☐ No

2.9 Do ALL locations use medical forms for each client? ☐ Yes ☐ No

3.0 ALL Locations and Medical Professionals must have a professional liability (malpractice) insurance for all services provided. Do you agree to make this a contractual requirement for being a medical director? ☐ Yes ☐ No

3.1 Have you signed a contract making you responsible for their acts? If Yes, send copy ☐ Yes ☐ No

3.2 Do you provide any general administration including financial and/or employment duties for these facilities? ☐ Yes ☐ No

3.3 List type of medical professionals you oversee:

Medical Doctors: ☐ Yes ☐ No #: _____ PAs: ☐ Yes ☐ No #: _____

Nurse Practitioners: ☐ Yes ☐ No #: _____ RNs: ☐ Yes ☐ No #: _____

Other: (Describe) _____ #: _____

HISTORY Note: ALL questions must be answered. Failure to disclosure claims history could invalidate coverage

4.1 Have you ever had professional liability insured refused, declined, cancelled or accepted on special terms? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

4.2 Has any liability suit, arbitration or other claim proceeding been brought against you, your business or any applicant for any alleged malpractice? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

4.3 Do you, or any applicant, have knowledge of an event, circumstance or occurrence prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? *If yes, describe details on a separate sheet* ☐ Yes ☐ No

4.4 Has any applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by, or to, any state or federal licensing board or regulatory agency? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

4.5 Have you ever or any applicant ever been charged or convicted of a criminal offense? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

4.6 Have you ever been treated for substance abuse or chemical dependency? *If yes, provide details on a separate sheet* ☐ Yes ☐ No

4.7 Are you aware of any incidents that could arise in claims to any facility *If yes, provide details on a separate sheet* ☐ Yes ☐ No

---

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release all Lloyd's of London participating syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy. I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY

I understand:

1. No medical director coverage will be offered for any service unless specifically approved by underwriters.
2. If I am aware of any claim or incident that could arise from any of the locations where I will be working, that occurred while I was the medical director there, I have indicated it on this application.
3. Claims from "Failure to Diagnose" will be EXCLUDED

_____	_____
APPLICANT SIGNATURE	**TITLE**
_____	_____
DATE	**REQUESTED EFFECTIVE DATE**
_____	
LIABILITY LIMIT REQUESTED	