Application for Long-term Care Medical Director Liability Insurance

Program not available in CT, IA, DE and OK
Not PCF Compliant in WI & KS

AMDA-endorsed Medical Director Program is intended for Medical Directors of Long-term Care facilities who may also have a private practice and/or provide direct care to residents at Long-term Care facilities.

The program is comprised of three coverage parts. The core of the program is Medical Director Duties Liability. If you have a private practice and/or provide direct care to residents at Long-term Care facilities, you may be eligible for one or both of these medical Malpractice coverage parts.

APPLICANT NAME:_____

COVERAGE DEFINITIONS:

1. **Healthcare Services Liability:** Provides coverage for direct patient care to a "Patient" at a designated premise.
2. **Medical Director Duties Liability:** Provides coverage for administrative services at a designated premise.
3. **Resident Care Services Liability:** Provides coverage for direct resident care to a "Resident" at a designated premise.

Please check the coverage you are applying for (check all that apply):

- ☐ Healthcare Services Liability (Private Practice and/or Hospital Admitting Privileges)
- ☐ Medical Director Duties Liability
- ☐ Resident Care Services Liability (Direct Care to Residents at Long Term Care Facilities)

Please check the coverage you currently have with another policy (check all that apply):

- ☐ Healthcare Services Liability (Private Practice and/or Hospital Admitting Privileges)
- ☐ Medical Director Duties Liability
- ☐ Resident Care Services Liability (Direct Care to Residents at Long Term Care Facilities)

INSTRUCTIONS

In order to determine eligibility for the AMDA-endorsed Medical Director Program, please answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space. If additional space is needed to answer any questions, attach a separate page.

In addition to this Application, please provide the following information:

- ☐ A copy of Applicant's current license(s)
- ☐ Curriculum Vitae
- ☐ Loss Information: refer to Part V of the application to see what, if any, additional information is required
- ☐ Declaration page(s) from current Physician and/or Medical Director Policies
- ☐ A copy of your Medical Director agreement(s) may be requested by the underwriter

If you should have any questions about the application or the submission process, please contact Lockton Affinity, LLC.

PART I - GENERAL INFORMATION

1. Name of Applicant _____

   Billing Address* _____

   City _____ State _____ Zip Code _____ Email _____

   Phone # _____ Fax # _____ Licensed specialty _____

2. Has Applicant's License ever been suspended or revoked? ☐ Yes ☐ No

   If yes, please explain _____

3. Does Applicant's license have any restrictions? ☐ Yes ☐ No

   If yes, please explain _____

4. Has Applicant ever had or been treated for substance abuse or chemical dependency? ☐ Yes ☐ No

5. Is the Applicant a current AMDA member? ☐ Yes ☐ No

6. Does the Applicant have the Certified Medical Director (CMD) designation? ☐ Yes ☐ No

   Attach a separate page if the private practice address is different than the billing address above.

7. Indicate the percentage of the Applicant's work as allocated to each of the following categories:

Private Practice (Exposure A)	**Medical Director** (Exposure B)	**Resident Care Services** (Exposure C)	**Total**
%	**%**	**%**	**100 %**

PART II – EXPOSURE A – PRIVATE PRACTICE (Other Than Long-term Care Residents)

1. Does the Applicant have a Private Practice? ☐ Yes ☐ No

2. Description of Applicant's Private Practice: _____

3. Has Applicant's Private Practice ever included any of the following: ☐ Surgical ☐ Emergency Medicine

   ☐ Pediatrics ☐ None of the above ☐ Other _____ Additional details: _____

4. Please provide the Applicant's history of annual patient encounters over the past 5 years & estimate for next 12 months. **(DO NOT INCLUDE PATIENT ENCOUNTERS FOR THE TREATMENT OF RESIDENTS AT LONG-TERM CARE FACILITIES. PATIENT ENCOUNTERS FOR THE TREATMENT OF RESIDENTS AT LONG-TERM CARE FACILITIES WILL BE COLLECTED IN THE NEXT PART OF THE APPLICATION)**:

5 Years Prior	**4 Years Prior**	**3 Years Prior**	**2 Years Prior**	**Prior Year**	**Current Year (Estimate)**

5. Any change in Applicant's specialty in the past 5 years? ☐ Yes ☐ No

   If yes, please explain _____

6. Does Applicant provide any peer review services for any third parties? ☐ Yes ☐ No

   If yes, please explain _____

7. Does Applicant serve in any public health capacity? ☐ Yes ☐ No

PART III – EXPOSURES B & C (Medical Director Administrative Duties & Resident Care Services)

1. Does Applicant treat residents where Medical Director Duties are performed? ☐ Yes ☐ No

2. Describe any circumstances wherein the Applicant in his/her capacity as a Medical Director may also be called upon to act within his/her capacity as a "physician" to treat, intervene in the treatment, direct the treatment, or consult in the treatment of any person:
____
____

3. Does Applicant have hospital admitting privileges? ☐ Yes ☐ No

   If yes, Coverage A may be needed. Please provide a list of all hospitals where admitting privileges exist.

4. Using the table below, provide details where the Applicant works as a medical director and/or provides direct patient care to the residents at Long Term Care Facilities. **DO NOT INCLUDE THE PATIENT ENCOUNTERS LISTED IN PART II OF THIS APPLICATION; ENTER ESTIMATED PATIENT ENCOUNTERS SPECIFIC TO EACH LOCATION.** Please be sure to include the full name and address of each facility. In the last column, be sure to indicate what Professional Liability limits the facility has for its own liability, not your liability. If you are at more than 5 Long Term Care Facilities, print this page more than once to complete additional tables.

Long-Term Care Facilities			
Facility Name & Address	**Facility Type**	**Facility's# of Licensed Beds**	**Applicant's Annual # of Patient Encounters**
____________ ____________ ____________	☐ Skilled Nursing Facility ☐ Intermediate Care Facility ☐ Assisted Living ☐ Independent Living Facility ☐ Sub-Acute Care Facility		
____________ ____________ ____________	☐ Skilled Nursing Facility ☐ Intermediate Care Facility ☐ Assisted Living ☐ Independent Living Facility ☐ Sub-Acute Care Facility		
____________ ____________ ____________	☐ Skilled Nursing Facility ☐ Intermediate Care Facility ☐ Assisted Living ☐ Independent Living Facility ☐ Sub-Acute Care Facility		
____________ ____________ ____________	☐ Skilled Nursing Facility ☐ Intermediate Care Facility ☐ Assisted Living ☐ Independent Living Facility ☐ Sub-Acute Care Facility		
____________ ____________ ____________	☐ Skilled Nursing Facility ☐ Intermediate Care Facility ☐ Assisted Living ☐ Independent Living Facility ☐ Sub-Acute Care Facility		

5. Using the table below, provide details where the Applicant works as a medical director and/or provides direct patient care to the residents at "Other Facility Types". **DO NOT INCLUDE THE PATIENT ENCOUTERS LISTED IN PART II OF THIS APPLICATION; ENTER ESTIMATED PATIENT ENCOUNTERS SPECIFIC TO EACH LOCATION.** Please be sure to include the full name and address of each facility. In the last column, be sure to indicate what Professional Liability limits the facility has for its own liability, not your liability. If you are at more than 5 "Other Facility Types", print this page more than once to complete additional tables.

Other Facility Types			
Facility Name & Address	**Facility Type**	**Facility's # of Annual Clients**	**Applicant's Annual # of Patient Encounters**
_____ _____ _____	☐ Home Health Care Agency ☐ Hospice Care Facility ☐ Other: _____		
_____ _____ _____	☐ Home Health Care Agency ☐ Hospice Care Facility ☐ Other: _____		
_____ _____ _____	☐ Home Health Care Agency ☐ Hospice Care Facility ☐ Other: _____		
_____ _____ _____	☐ Home Health Care Agency ☐ Hospice Care Facility ☐ Other: _____		
_____ _____ _____	☐ Home Health Care Agency ☐ Hospice Care Facility ☐ Other: _____		

PART IV – CURRENT INSURANCE

1. Does Applicant currently have Professional Liability insurance for his/her Private Practice, including Resident Care at facilities where Applicant works as a Medical Director? ☐ Yes ☐ No
2. Does Applicant currently have Professional Liability insurance for Medical Directorships? ☐ Yes ☐ No
3. Has the Applicant's insurance ever been cancelled or non-renewed? ☐ Yes ☐ No

   If yes, please explain _____

4. Please complete the table below regarding your current insurance coverage.

	Private Practice Policy	Medical Director Policy
Carrier Name		
Premium		
Expiration Date		
Retroactive Date		
Professional Liability Limits		
Deductible Amount		
Optional Coverage	Includes Medical Director Coverage? ☐ Yes ☐ No	Includes Physician Coverage? ☐ Yes ☐ No

PART V – LOSS HISTORY

1. In the past 5 years, has the Applicant ever been named as a defendant/co-defendant as respects to any claim or suit arising out of his/her performance of duties as a *Medical Director*? ☐ Yes ☐ No

   If yes, was there more than a single claim or suit? ☐ Yes ☐ No
   If yes, was any loss greater than or equal to $250,000? ☐ Yes ☐ No

2. In the past 5 years, has the Applicant ever been named as a defendant/co-defendant as respects to any claim or suit arising out of his/her *Private Practice*? ☐ Yes ☐ No

   If yes, was there more than a single claim or suit? ☐ Yes ☐ No
   If yes, was any loss greater than or equal to $250,000? ☐ Yes ☐ No

3. In the past 5 years, has the Applicant ever been named as a defendant/co-defendant as respects to any claim or suit arising from *Resident Care Services* provided to residents at long term care facilities? ☐ Yes ☐ No

   If yes, was there more than a single claim or suit? ☐ Yes ☐ No
   If yes, was any loss greater than or equal to $250,000? ☐ Yes ☐ No

4. Is the Applicant aware of any incidents that may give rise to a claim in the future? ☐ Yes ☐ No

   If yes, please attach a detailed explanation of the incident(s).

Additional Loss Information Requirement:

If answered "Yes" to any of the above questions, please provide currently valued carrier loss runs (preferred) or other legitimate loss documentation for the past 5 years. The details must include:

a. Current status of the claim (open/closed)
b. Nature of the allegation(s)
c. Total defense costs paid
d. Total indemnity (i.e. damages) paid
e. Any reserves for both defense and indemnity
f. In the case of a paid claim or settlement, the applicant must provide a narrative on what corrective measures he/she has implemented to avoid the same type of claim from occurring in the future.

PART VI – REPRESENTATIONS & WARRANTIES

The undersigned authorized officer of the applicant declares that the statements set forth herein are true to the best of my knowledge and that no material fact has been omitted or misstated. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such change, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant to purchase or the insurer to provide the insurance. Acceptance of the applicant by the company is required prior to quotation or binding of coverage or the issuance of a policy. It is agreed that this application and the reliance upon its contents shall be the basis of the issuance of a policy and shall be attached and made part of said policy.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY SUBMITS AN APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

I HAVE READ AND FULLY UNERSTAND THE QUESTIONS AND MY ANSWERS ON THIS APPLICATION. UNDERSTAND THAT ANY OMISSION OR MISSTATEMENT OF ANY OF THE RESPONSES THAT ARE MATERIAL TO THE RISK ASSUMED (AS WELL AS ATTACHED TO THIS APPLICATION), MAY CAUSE THIS POLICY TO BECOME NULL AND VOID AND/OR MAY GIVE RISE TO RESCISSION OF THE POLICY.

The Signatory hereby acknowledges that he/she is aware that the Aggregate Limit in the CPL policy shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Company shall not be liable for the costs of legal defense or for the amount of any judgment or settlement or cleanup costs to the extent that such exceeds the limit of liability of this policy.

The Signatory hereby further acknowledges that legal defense costs that are incurred shall be applied against the deductible amount.

Should the signatory become aware of any change or omission relative to the information provided herein subsequent to the completion of this application and precedent to the effecting of insurance, the undersigned promissorily warrants that he will submit to American Safety Insurance Services, Inc. supplementary advice specifying such change or omission. Notwithstanding the immediate foregoing, however, the signatory further promissorily warrants that he will inform American Safety Insurance Services, Inc. of any change or omission with respect to any answers given in this application at any time subsequent to the completion thereof, provided insurance has been effected. It is agreed that the duty imposed upon the signatory by virtue of the foregoing promissory warranties, shall be non-delegable. It is further agreed that this application shall be the basis of any insurance as may be subsequently affected by American Safety Insurance Services, Inc. and that American Safety Insurance Services, Inc. will rely upon the veracity of all responses thereto in causing such insurance to be effected. It is further understood and agreed that all representations and warranties made to American Safety Insurance Services, Inc. also are made to the issuing carrier.

It is finally agreed that the completion of this application neither obligates the Applicant to purchase insurance nor binds American Safety Insurance Services, Inc. or the issuing carrier to affect insurance.

I have read the Required Fraud Warnings and further agree to the signatory statement.

To submit your application: fax to (913) 652-7599

If you have questions, please call (888) 544-2183

APPLICANT:	_____	_____	_____
	Signature	Print Name	Date
PRODUCER:	_____	_____	_____
	Signature	Print Name	Date