The Hanover Insurance Group

Application for Physicians – Clinical Trials Only Practice
Professional Liability Insurance
(Claims Made Basis)

This application is designed for physicians performing clinical trials only, or for physicians desiring coverage only for their clinical trials practice. If you would like coverage for both your clinical trials and your conventional practice, please complete our Physicians and Surgeons Application.

Applicant's Instructions:

1. Answer all questions. If the answer requires detail, please attach a separate sheet. If a question is not applicable, state NOT APPLICABLE.
2. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. GENERAL INFORMATION

a. Full Name of Applicant (Include professional degree) _____

b. Principal business address: _____

City: _____ County: _____ State: _____ Zip: _____

c. Additional business address(s): _____

City: _____ County: _____ State: _____ Zip: _____

d. Please attach list of any additional locations.

e. Home address: _____

City: _____ County: _____ State: _____ Zip: _____

f. Phone: Business: _____ Fax _____ Home: _____

g. Email: _____ Web address: _____

h. Date of Birth: _____ Social Security #: _____

i. Medical License # _____ Exp: _____ DEA License # _____ Exp: _____

j. Are you a US Citizen? O Yes O No
If no, please indicate your status and the date of entry into the US.

2. APPLICANT PRACTICE INFORMATION

a. Practice is:

O Solo Practitioner O Professional Corporation
O Employee O Professional Association
O Partnership O Other: _____

b. If you are employed by an entity outside your primary practice, give name and address of employer, and provide copy of employment contract: _____

_____

c. If you are a member of a professional entity, give the formal corporation, association, partnership or business name:

_____

d. Are all members of the professional entity covered by professional liability insurance? O Yes O No
If yes, by what company? _____

e. Do you wish to have coverage for the professional entity? O Yes O No
If yes, please complete the attached Professional Entity Application Addendum.

f. Please list the number and type of Allied Healthcare Workers in your practice. If NONE, state none.

_____ Nurse Practitioners* _____ Physician's Assistants*

_____ Nurse Anesthetics _____ Other _____

*Describe duties in detail, including extent supervised, on separate sheet.

g. Do you wish to have coverage for your Allied Healthcare Workers? O Yes O No
If yes, please complete the attached Allied Healthcare Worker Addendum.

h. Is your office compliant with the HIPAA rules? O Yes O No

i. Is any portion of your practice outside your primary practice state? O Yes O No

State	License #	License Exp. Date	Avg Hours / Week

j. What is your medical or surgical specialty? _____

_____

k. Do you limit your practice to the above specialty? O Yes O No

l. Do you have a sub-specialty? O Yes O No
If yes, please attach a detailed explanation.

m. Do you perform surgery in your office? O Yes O No
If yes, please complete the Physicians and Surgeons Application.

n. What is the approximate gross annual income from your practice? (check one)

O less than $50,000 O$150,000 to $199,999

O$50,000 to $99,999 O$200,000 or more (Please estimate) $ _____

O$100,000 to $149,999 OOther: _____

o. Do you anticipate any changes in your practice within the next year? O Yes O No
If yes, please explain on a separate sheet.

p. Has your practice (specialty, procedure) changed in the last five years? O Yes O No
If yes, please explain on a separate sheet.

q. Do you anticipate your practice (specialty, procedure) changing within the next year? O Yes O No
If yes, please explain on a separate sheet.

r. Hospitals / Outpatient Centers where you have privileges:

Hospital /Surgical Center Name & City/State	Type & Extent of Privileges / Procedures Performed	Avg Hrs/Week

s. Please list prior professional liability insurance for the past 3 years. If None, state none.

Carrier	Policy #	Liability Levels	Premium	Coverage Dates	Claims Made Form?		Retro Date
					O Y	O N	
					O Y	O N	
					O Y	O N	

3. CLINICAL TRIALS PRACTICE INFORMATION

Do you perform clinical trials in your practice? O Yes O No
If yes, please answer a – d below.
If no, proceed to section 4.

a. Do you ever act as a Principal Investigator? O Yes O No

b. How many trials have you done in the last five years? _____

c. Do you test medical devices? O Yes O No

d. Please list all current clinical trials below. Continue list on separate page if necessary.

Indication, e.g., Diabetes, Depression, etc.	Duration	# of Patients	Phase I, II, III or IV	Comp. Sponsored or Invest. Initiated?

4. POLICY FORM INFORMATION

a. Proposed Effective Date: _____ Retroactive Date Requested: _____

b. Coverage limits requested:

O $100K / $300K O $250K / $750K O $500K / $1.5M

O $1M / $3M O $1.3M / $3.9M O $2M / $6M

c. Do you practice part-time? O Yes O No
If yes, list average hours worked per week: _____

d. Do you intend to purchase a reporting endorsement (aka tail coverage) from your current insurer (if currently Claims Made Form)? O Yes O No
If No, do you wish to obtain Prior Acts Coverage from us? O Yes O No
If Yes, please complete the following:

Applicant O **is** / O **is not** as of this date aware of any claims against him/her that have not been reported to his/her present or prior insurer(s).
Applicant O **is** / O **is not** as of this date aware of any conduct, circumstances or incidents which occurred during the periods of coverage listed above which could reasonable be expected to result in a claim, and has not been reporting to his/her present or prior insurer(s).

NOTE: IF YOU DO NOT OBTAIN PRIOR ACTS COVERAGE, YOU WILL HAVE NO COVERAGE THROUGH US FOR ANY CLAIM OR SUIT BASED UPON THE RENDERING OF OR FAILURE TO RENDER PROFESSIONAL SERVICES PRIOR TO THE EFFECTIVE DATE OF THIS POLICY.

5. APPLICANT EDUCATION

Undergraduate Degree:

Degree Obtained:	Institution:
Dates Attended:	Location (City/State):

Medical Degree:

Degree Obtained:	Institution:
Dates Attended:	Location (City/State):

If foreign medical school, are you certified by the Educational Council for Medical School Graduates? O Yes O No

If yes, state year of certification _____

Residency Training:

Type:	Institution:
Inclusive Dates:	Location (City/State):

Type:	Institution:
Inclusive Dates:	Location (City/State):

a. Have you received any additional medical training? O Yes O No
If yes, please provide an explanation on a separate sheet specifically detailing the type of training, where received, and the time period in which it was obtained.

6. APPLICANT CERTIFICATIONS AND AFFILIATIONS

a. Are you American Board Certified? O Yes O No

If yes, Medical Specialty: _____

Original Certification Date: _____ Recertification Date: _____

b. Are you American Board Qualified? O Yes O No

If yes, Medical Specialty: _____

c. Have you obtained any professional certifications or designations? O Yes O No

Certification: _____

Original Certification Date: _____ Recertification Date: _____

d. Are you a member of any professional societies? O Yes O No

If yes, please provide information regarding your membership(s):

_____

_____

e. List or attach any Risk Management related Continuing Education Programs and credit hours received within the last 12 months. **Course description and proof of participation required in order to receive credit.**

_____

_____

f. Have you met your state's Continuing Medical Education requirements to maintain your medical license? O Yes O No O N/A

If yes, please attach copy of certificates.

7. CLAIMS

(Attach a detailed explanation for any "yes" answers.)

a. Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? O Yes O No

Attach a copy of the Complaint and Consent Order, if applicable.

b. Have you ever been convicted for an act committed in violation of any law or ordinance? O Yes O No

c. Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required that you be evaluated for any alleged mental condition and/or alcohol or drug addiction? O Yes O No

d. Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? O Yes O No

e. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? O Yes O No

f. Have you ever failed any medical licensing or specialty organization examination? O Yes O No

g. Do you have any chronic physical illness or defect? O Yes O No

h. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? O Yes O No

i. Has any claim or suit for alleged malpractice been brought against you? O Yes O No
If yes, provide a loss run from each carrier for the past five (5) years.

j. Are you aware of any medical incidents, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? O Yes O No
If yes, have they been reported to your prior insurance carrier?

8. MANDATORY ATTACHMENTS

a. Curriculum Vitae (C.V)
b. Copy of Current License
c. Copy of Board Certification Certificates
d. Proof of Risk Management Credits
e. Declarations Page from Current Professional Liability Policy
f. 5 Years of Loss Runs from Prior Carriers
g. Copies of all contracts with Clinical Trials Sponsors
h. Copies of all informed consent forms used with study participants
i. Research protocols

By my signature below:

1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.

2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.

3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify Campmed in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.

4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and Campmed Casualty & Indemnity Company, Inc. of Maryland and my broker, agent or peer review.

CAMPMED FRAUD STATEMENT

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 and denial of insurance benefits.
Please see the attached specific Fraud Warnings required by some states.

APPLICANT SIGNATURE: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

FRAUD WARNINGS

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or any application containing any false, incomplete 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 materially false information or conceals, for the purpose of misleading, information or concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana And West Virginia Applicants: Any person who knowing 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 fines and confinement in prison.

Notice to Maryland Applicants: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information or 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 each such violation.

Notice to North Carolina Applicants: Any person who knowingly presents false information in an application for insurance is guilty of a felony and may be subject to fines and imprisonment.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he 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.

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.

Notice to 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 include imprisonment, fines and denial of insurance benefits.

Allied Healthcare Worker Application Addendum

(PLEASE TYPE OR PRINT IN INK)

Primary Applicant Name: _____

The following is a list of some "allied health care professionals":
CRNA, Cytotechnologist, EMT, Nurse (including RN, LPN, Nurse Practitioners, etc.), Optometrist, Perfusionist, Physician's Assistant, Psychologist, Surgeon's Assistant, Coordinators, Phlebotomists

Name of entity or corporation which employs allied healthcare professionals and office staff: _____

_____

Please list all such allied healthcare professionals who provide services in your office as employees:

Name	Professional Designation	Job Title	Retro Date or Start Date with Practice

Please complete a separate application form for any Nurse Practitioners or Physician's Assistants.

Do you, or any member of your group, currently supervise an "allied healthcare professional" (as defined above who is not in your employment? O Yes O No

Do you plan to do so in the future? O Yes O No

Subject to same warranties and statements as primary application.

_____ _____

Printed Name Title (Officer, partner, etc.)

_____ _____

Signature Date

Professional Entity Application Addendum

(One form for each entity)

(PLEASE TYPE OR PRINT IN INK)

Primary Applicant Name: _____

Entity Name: _____

Principal business address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Additional business address(s): _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Additional business address(s): _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please complete for all members of the professional entity. Attach a separate page if necessary.

Name	Professional Designation	Prof Liab Carrier	Policy #	Policy Dates	Policy Limits

Do independent contractors work for the professional entity? O Yes O No

If yes, please list and describe type and work performed.

Name	Professional Designation	Work Performed	Covered by own Prof. Liability?
			O Yes O No
			O Yes O No
			O Yes O No
			O Yes O No

Subject to same warranties and statements as primary application.

_____ _____

Printed Name Title (Officer, partner, etc.)

_____ _____

Signature Date

Supplemental Claim Information

(One form for each claim)

(PLEASE TYPE OR PRINT IN INK)

Proposed Insured: _____

Claimant: _____

Date of Occurrence: _____ Date Reported to Insurance Co.: _____

Where was claim filed? _____

Status *(choose one)*: ○ POTENTIAL ○ OPEN ○ CLOSED

If closed, disposition:

a. Trial verdict for ○ INSURED ○ CLAIMANT *(choose one)*
   Verdict amount, if any $ _____

b. Settled for $ _____

c. Other: _____

Defense Attorney, if any: _____

Brief description of the claim: _____