Admiral INSURANCE GROUP
a Berkley Company

MEDICAL DIRECTOR'S PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE COVERAGE)

Physician's Personal Information

1. Full Name of Applicant:

2. Mailing Address:

3. Medical License # and State of Issuance:

4. Date of Birth: 5. Place of Birth:

6. Medical School & Year of Graduation:

7. Medical Specialty: Sub-Specialty:

8. Are you American Board Certified? Yes No
If Yes, in what specialty? Year Certified:

*PLEASE ATTACH A COPY OF YOUR RESUME OR C.V.

ENTITY INFORMATION-*provide the following information for every entity for which you provide medical director services and are seeking coverage for those medical director services – Note, entities are not covered by the policy for which you are applying.*

9. Name & Location of Facility Where Medical Director Services are Performed:

10. Your relationship to this entity:
owner/partner contractor employee
other. Provide Details:

11. When was this facility established?

12. Type of Facility-describe in detail medical services provided:

13. Does this entity have any beds for overnight occupancy? Yes No
If Yes, how many beds is this facility licensed for?

14. What is the total number of outpatient visits and/or tests per year at this facility?

15. Is surgery performed at this facility? Yes No
If Yes, how many surgeries per year?
*PLEASE ATTACH A LIST OF THE SURGERIES PERFORMED AT THIS FACILITY.

16. Are obstetrics practiced at this facility? Yes No
If Yes, how many deliveries per year?

17. What is the estimated revenue of the facility for the next 12 months?

18. Is this facility currently covered by a Medical Malpractice policy? Yes No
If Yes, who is the medical malpractice insurance carrier?
*PLEASE ATTACH A COPY OF THE MEDICAL MALPRACTICE DECLARATIONS PAGE.

19. State the approximate division of patients at this facility:

%	Alcoholics/Drug Addicts	%	Counseling/Family Planning
%	Dental/Orthodontic	%	General Public
%	Hemodialysis	%	Holistic Medicine/Acupuncture
%	Mentally Retarded	%	Obstetrical
%	Pediatric	%	Psychiatric
%	Research or Experimental	%	Senile or Aged
%	Surgical	%	Other:

20. List the number and type of employees at this facility:

NUMBER	Type of Profession	NUMBER	Type of Profession
	Inhalation Therapists		Nurse Practitioner
	Laboratory Technicians		Nurses Registered
	Nurse Anesthetists		Opticians
	Nurses, Licensed Practical		Optometrists
	Perfusionists		Pharmacists
	Social Workers		Physicians-minor surgery
	Physicians- no surgery		Speech Therapists

Other:

21. List the number and type of independent contractors who provide professional services at this facility:

22. Are all physicians, whether employed or contracted, required to carry medical malpractice insurance? Yes No If Yes, at what limits of liability?

23. Is this facility currently insured under a Commercial General Liability Policy?
Yes No If Yes, what is the name of the CGL carrier?

Medical Director Services Information-NOTE: Policy excludes medical malpractice

24. How many hours per week are dedicated to medical director services only?

25. Do you also provide medical services at this facility? Yes No
If Yes, how many hours per week are dedicated to medical services only?
If Yes, please describe, in detail, the medical services you provide:

26. How long have you worked as medical director at this facility?

27. Please describe your duties as medical director:

Prior Insurance and Claim Information

28. Do you currently carry Professional Liability Insurance for your medical director services?
Yes No If Yes, please complete the following:

Company	Policy Term	Limits of Liability	Retro Date	Premium

29. Has any claim ever been made against you solely as respects your duties as a medical director? Yes No If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs.

30. Are you aware of any circumstances, solely as respects your duties as a medical director, which may result in a claim against you? Yes No If Yes, please provide details:

31. Do you currently carry Medical Malpractice Insurance for your medical services?
Yes No If Yes, please complete the following:

Company	Policy Term	Limits of Liability	Retro Date	Premium

*PLEASE ATTACH A COPY OF YOUR MEDICAL MALPRACTICE DECLARATIONS PAGE

32. Has any claim ever been made against you for Medical Malpractice? Yes No
If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs.

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell, nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Date

Signature of Applicant

Please attach copies of the following documents:
- A minimum of five years of currently valued company loss runs
- CV or resume
- Proof of medical malpractice coverage for applicant
- Proof of medical malpractice coverage for the medical facility
- A copy of the contract between applicant and medical facility

SUPPLEMENTAL CLAIM INFORMATION FORM

(COMPLETE ONE FORM FOR EACH CLAIM)

Type of Claim (check one): ☐ Medical Director Claim ☐ Medical Malpractice Claim

1. Name of applicant/named insured:
2. Name of other parties or defendants named in suit:
3. Data of alleged error or occurrence, or contact date:
4. Data claim was made:
5. Name of claimant:
6. Name of Insurance Company handling your claim:
7. Present status of claim or final disposition:

   Select One: ☐ CLOSED ☐ OPEN
8. Defense costs paid to date inclusive of any deductible:
9. If closed, total loss paid, inclusive of any deductible:
10. If claim is open or pending, what are the insurers reserves?
    Defense: Loss:
11. Description of case and events including allegations and assessment of liability:
12. Claimants last settlement demand:

Date Signature