ADMIRAL INSURANCE COMPANY
6455 East Johns Crossing, Suite 240
Duluth, GA 30097
Phone: 770-476-1561 — Fax: 770-418-9597
Internet: http://www.admiralins.com

MEDICAL DIRECTOR'S PROFESSIONAL LIABILITY APPLICATION (CLAIMS-MADE FORM))

Physician's Personal Information

1. Full Name of Applicant: _____

2. Mailing Address: _____

_____

3. Location Address: _____

_____

4. Medical License # and State of Issuance: _____

5. Date of Birth: _____ 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 FACILILTY.**

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 the 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	_____%	Physicians-minor surgery
_____%	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	_____	Nurse 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 directors 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 ATTACHA 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 and this application will be made a part of this policy.

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 currently valued 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/insured: _____

2. Name of other parties or defendants named in suit: _____

_____

3. Data of alleged error or occurrence, or contact date: _____

4. Date claim was made: _____

5. Name of Claimant: _____

6. Name of Insurance Company handling your claim: _____

7. Present status of claim or final disposition: _____

_____

Circle 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 insurer's loss reserves?
Defense: _____ Loss: _____

11. Description of cause and events including allegations and assessment of liability: _____

_____

_____

_____

12. Claimants last settlement demand: _____

_____ _____

Date Signature