Applicant's Name:

Name of Corporation, Partnership or Association

Coverage Requested:	☐ **Occurrence** ☐ **Claims-Made**	**Requested Effective Date:**	
Coverage period *if less than 1 year*:		**From:**	**To:**
		Requested retroactive date:	
(Coverage cannot begin prior to application and premium receipt by the JUA)			

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION
Hickory Pointe, Suite 125, 2250 Hickory Road, Plymouth Meeting, PA 19462
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

Application For CORPORATION, PARTNERSHIP OR ASSOCIATION PROFESSIONAL LIABILITY INSURANCE
Limits of Liability: $500,000 Per Occurrence / $1,500,000 Per Annual Aggregate

Part I - General Information

Principal Office Address: _____

Number and Street City State Zip

Business Phone: (___) _____ **Home Phone:** (___) _____

Business Fax: (___) _____ **E-mail Address:** _____

EIN: _____ **PA Medical License No.:** _____

IS ABOVE ADDRESS ONLY LOCATION? ☐ **YES** ☐ **NO** **IF NO, ATTACH AN ADDRESS LIST OF OTHER LOCATIONS.**

Part II – Broker Information: (If this is being submitted by an insurance broker):

Broker: _____ **Contact Person:** _____

Phone: (___) _____ **Fax No.** (___) _____ **E-Mail Address:** _____

Address: _____

Number and Street City State Zip

If "new" to JUA:

EIN or SS No:

Part III – Coverage Information:

List all Prior Insurers for the last 10 years – include all places of employment: (attach separate list if necessary)

Carrier or Self-Insurer	Policy Number	Coverage Dates Eff. Exp.	Coverage (Occurrence or Claims-Made)	Retroactive Date/ Comments
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	

Have any claims been made or suits brought against the entity during the past 10 years as a result of professional services rendered? ☐ Yes ☐ No If yes, attach a description of all claims made or suits brought.

Attach a copy of the current Declarations and Policy History / Claim History Reports or Loss Runs from each of the above carriers or self-insurers plus Mcare.

Each of the current or prior carriers should be contacted with a request they send these reports. They are required to provide these reports if requested. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if there have been no claims.

Medical Incidents (Applicable if a claims-made retroactive date is being requested before the effective date):

Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? ☐ Yes ☐ No If yes, attach a complete description of the incidents including the date and status of the incident.

PLEASE ATTACH COPIES OF THE ARTICLES OF INCORPORATION AND ANY ARTICLES OF AMENDMENT – These are required in order to determine eligibility for coverage by the JUA.

Authorized Signature (all pages must be signed): _____ _____ _____

(Name) (Position) (Date)

Part IV* - LIST NAMES OF ALL OFFICERS, PARTNERS OR MEMBERS

Name	Specialty	PA J.U.A. Policy Number	Name of Company if **NOT** Insured by J.U.A.

LIST ANY NON-MEDICAL PROFESSIONALS WHO ARE PRINCIPALS OF THE CORPORATION, PARTNERSHIP OR ASSOC.

PART V

1. Does any principal of the Corporation, Partnership or Association practice in any state other than PA? ☐ Yes ☐ No
2. If "Yes", indicate:
   a. Name of Principal _____
   b. Name of Other State _____
   c. Percent of Patient Care in Pennsylvania _____%

PART VI – PLEASE ANSWER. (IF NONE – INDICATE WITH A ZERO)

COMPLETE BELOW IF ANY OF THE FOLLOWING ARE EMPLOYED

☐ Physician Assistants Number Employed _____

☐ Employed Physicians or Certified Nurse Midwife Number Employed _____

PLEASE ATTACH A LIST OF LIST EMPLOYED PHYSICIANS (List Name, Specialty & License #)

☐ Contracted Physicians or Certified Nurse Midwife Number Contracted _____

PLEASE ATTACH A LIST OF LIST CONTRACTED PHYSICIANS (List Name, Specialty & License #)

☐ Laboratory Technicians Number Employed _____

☐ X-Ray Technicians Number Employed _____

INCLUDE ALL FOR EACH CATEGORY ABOVE EVEN IF CORPORATE COVERAGE IS PROVIDED ELSEWHERE.

*** Part VI - A SUPPLEMENTAL APPLICATION FOR CORPORATION, PARTNERSHIP OR ASSOCIATION must be completed for any physician or Certified Nurse Midwife not insured by the JUA.**

I certify that I am authorized to act on behalf of the Insured.

I certify that I will not accept insurance from the JUA if I am able to obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information with is calculated to influence the judgment of the JUA in considering this application.

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.

Print or type name and title: _____
(Name) (Position)

Applicant's Signature (all pages must be signed): _____ _____
(Name) (Position) (Date)

Supplement for:

Name of Corporation, Partnership or Association

Physician's Name ☐ **M.D.** ☐ **D.O**
(Not to be insured by the JUA)

First Name Middle Name Last Name

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION
Hickory Pointe, Suite 125, 2250 Hickory Road, Plymouth Meeting, PA 19462
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

SUPPLEMENTAL APPLICATION FOR CORPORATION, PARTNERSHIP OR ASSOCIATION

(Use this application to supply information regarding a physician NOT to be insured by the JUA)

Part I - General Information

Principal Business Address:

_____

Number and Street ***City*** ***State*** ***County*** ***Zip***

Part II – License Information

PA Medical License No.: _____ Federal DEA No.: _____

Part III – Coverage Information:

List all Insurers for the last 10 years – include all places of employment: (attach separate list if necessary)

Carrier or Self-Insurer	Policy Number	Coverage Dates Eff. Exp.	Coverage (Occurrence or Claims-Made)	Retroactive Date/ Comments
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	
			☐ Occ ☐ CM	

Have any claims been made or suits brought against you during the past 10 years as a result of professional services rendered? ☐ Yes ☐ No If yes, attach a description of all claims made or suits brought.

Attach Policy History Reports, Claim History Reports or Loss Runs From Each of the Above Carriers or Self-Insurers plus Mcare.

You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if you have had no claims.

Medical Incidents (Applicable if a claims-made retroactive date is being requested before the effective date):
Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? ☐ Yes ☐ No If yes, attach a complete description of the incidents including the date and status of the incident.

Part IV – Locations (AT LEAST ONE LOCATION MUST BE LISTED – all locations must total 100%):
List locations and Hospitals at which you will practice during the policy period (even if outside Pennsylvania). Base percentage of practice on the number of patients. (use additional pages if needed)

Practice Locations:

1._____ _____ _____
Suite Number & Street City State Zip County % of Practice

2._____ _____ _____
Suite Number & Street City State Zip County % of Practice

3. _____ _____ _____
Suite Number & Street City State Zip County % of Practice

Signature (all pages must be signed): _____
Name Date

Hospital Locations:

	Name of Hospital	City	State	Type of Privileges	County	% of Practice
1.						
2.						

If any of the above are not work for the covered entity, please indicate:

History:

List other locations and hospitals at which you have practiced in the past 10 years:

	Address or Name of Hospital	City	State	County	Dates of practice
1.					
2.					
3.					

Part V – Educational Background (attach separate sheet if needed to fully describe)

Medical School: _____ **Year Graduated:** _____

Location of School: _____ **Degree:** _____

City State Country

If this is a foreign medical school, are you certified by the Educational Council for Medical School Graduates? ☐ Yes ☐ No

Internship: _____

Name of Hospital City State

From _____ to _____ Type of Internship _____

Month/Year Month/Year

Residency: _____

Name of Hospital City State

From _____ to _____ Type of Residency Completed: _____

Month/Year Month/Year

Residency: _____

Name of Hospital City State

From _____ to _____ Type of Residency Completed: _____

Month/Year Month/Year

Additional Training/Fellowship: _____

Name of Hospital City State

From _____ to _____ Type of Training Completed: _____

Month/Year Month/Year

Board Certification: **Are You Board Certified?** ☐ **Yes** ☐ **No**

If Yes, list Board Certificates and date certified:

Part VI – Licenses

Have you ever been licensed in a state other than Pennsylvania? Yes No If Yes:

State	License Number	Date Received	Currently Active?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Signature (all pages must be signed): _____

Name Date

Part VII – Rating Information

1. What is your current Medical Specialty? _____

Other Specialty? _____ Sub-Specialty? _____

General Description of practice: _____

2. Procedures and Practices

In **Column A** check the box for all of those items applicable to your practice **Now** and **During the Coverage Period**.
In **Column B** check the box for all of those items that were applicable to your practice at any time **During the Last 10 Years**.
If neither Column A or B apply, check the box in the column labeled **No** (at least one column must be checked for each)

No	Col. A	Col. B		No	Col. A	Col. B	
☐	☐	☐	Minor Surgery (see last page for definitions)	☐	☐	☐	Employ/Supervise Nurse Midwives # _____
☐	☐	☐	Major Surgery (see last page for definitions)	☐	☐	☐	Employ/Supervise CRNA's # _____
☐	☐	☐	Assistance in Major Surgery on own patients only	☐	☐	☐	Employ/Supervise Physician Assistant # _____
☐	☐	☐	Assistance in Major Surgery on other than own patients	☐	☐	☐	Employ/Supervise Nurse Practitioner # _____
☐	☐	☐	Colon-Rectal Surgery: ____ % of surgical practice	☐	☐	☐	Employ/Supervise Other than above # _____
☐	☐	☐	Bariatric / Intestinal Surgery for Obesity	☐	☐	☐	BoTox Injections
☐	☐	☐	Laser Surgery	☐	☐	☐	Dermal Fillers (List)
☐	☐	☐	Plastic Surgery	☐	☐	☐	Light Chemical Peels (List)
☐	☐	☐	Administration of general, spinal or caudal anesthesia	☐	☐	☐	Medium Chemical Peels (List)
☐	☐	☐	Caesarian Sections	☐	☐	☐	Deep Chemical Peels (List)
☐	☐	☐	Normal Obstetrical Deliveries	☐	☐	☐	Dermabrasion
☐	☐	☐	Abortions	☐	☐	☐	Sclerotherapy
☐	☐	☐	Interventional Radiology	☐	☐	☐	Mesotherapy
☐	☐	☐	Deep Radiation / X-ray Therapy – (Over 120 K.V.)	☐	☐	☐	Laser Therapy (type)
☐	☐	☐	Contrast Material: Injection, supervision of others who inject, reading images	☐	☐	☐	Hair Transplant (Describe)
☐	☐	☐	Endoscopic Procedures (describe)	☐	☐	☐	Hair removal
☐	☐	☐	Sigmoidoscopy greater than 60cm	☐	☐	☐	Epidurals
☐	☐	☐	Polypectomy	☐	☐	☐	Facet Injections
☐	☐	☐	Lithotripsy	☐	☐	☐	Trigger Point Injections
☐	☐	☐	Left or Right Heart Catheterization	☐	☐	☐	Other Nerve Blocks (List)
☐	☐	☐	Swan Ganz Catheterization	☐	☐	☐	Spinal Cord Stimulation
☐	☐	☐	Biopsy (type)	☐	☐	☐	Fracture Reduction - Open
☐	☐	☐	Remote Services Provided (give details)	☐	☐	☐	Fracture Reduction - Closed

Signature (all pages must be signed): _____

Name Date

3. How many hours per week are generally spent in the practice of your medical profession? _____
If only a portion of your practice is associated with the entity applying for coverage, how many hours per week are generally spent in the portion of your practice associated with this entity? _____

4. Do you serve in a hospital emergency room? [ ] Yes [ ] No If yes, how many hours per week? _____

5. Do you serve in a prison environment? [ ] Yes [ ] No If yes, how many hours per week? _____

6. Will you be performing professional activities that will be covered by another professional liability policy?
[ ] Yes [ ] No If yes: Practice description and location: _____
Are you [ ] an employee [ ] independent contractor
Name of insurance company and policy number: _____

7. Do you participate as a member of any medical peer review or accreditation board or group? [ ] Yes [ ] No
If yes, give details: _____
_____

8. Do you provide any remote services (e.g. on the internet, telemedicine)? [ ] Yes [ ] No
If yes, give details: _____
_____

9. With respect to the *above questions* have any aspects of your practice changed in the past **2 years**? [ ] Yes [ ] No
If yes, give details: _____
_____

Part VIII – Practice Organization

Please check the box that describes your practice:

Sole Corporation
Partner or partnership
Independent contractor
Employee of individual/Group (not a shareholder)
Corporate shareholder

Part IX – Additional Professional Information

1. Have your staff privileges, license to practice, participation in any Medicaid or Medicare program, or ability to prescribe drugs ever been revoked, suspended, placed on probation, voluntarily surrendered or subject to reprimand or fine? Yes No
If yes, give details: _____
_____

2. Have you ever been charged or convicted of any crime, or are you currently under investigation for a criminal act, other than minor traffic violations? Yes No
If yes, give details: _____
_____

3. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by any regulatory agency? Yes No
If yes, give details: _____
_____

Signature (all pages must be signed): _____
Name Date

DEFINITIONS

* Major Surgery:
  Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis: any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.

* Minor Surgery:
  Any operation not defined as Major surgery.

* No Surgery
  The term "no surgery" applies to general practitioners and specialist who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information with is calculated to influence the judgment of the JUA in considering this application.

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.

Applicant's Signature (all pages must be signed): _____
Name Date

Signature (all pages must be signed): _____
Name Date