



FAIRWAY PHYSICIANS INSURANCE COMPANY

A RISK RETENTION GROUP

APPLICATION INSTRUCTIONS

HEALTHCARE FACILITIES APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

In order to hasten your request for coverage and avoid any unnecessary delay, please complete all questions. If a question does not apply to your specialty, mark "None" or "N/A" (Not Applicable). Do not leave any question unanswered! Please use separate paper for any additional comments, explanation or clarification if necessary.

Before submitting your application, please review this checklist to ensure the information below has been included. Missing information could delay the approval of your application.

- ☐ Sign, initial and date the application where indicated. The company will not issue quotes for unsigned applications.**
- ☐ Include a copy of your most recent professional liability declaration page and claims history with retroactive date.**
- ☐ Complete the "Remarks" section for any questions requiring additional details.**

If you need assistance with the application, please call (818) 889-7399 and ask to speak with a medical liability specialist.

This application is issued by a risk retention group. The risk retention group may not be subject to all the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for the risk retention group.



HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

APPLICATION FOR HEALTHCARE FACILITIES FOR PROFESSIONAL LIABILITY INSURANCE (CLAIMS MADE BASIS)

APPLICANT INSTRUCTIONS:

- 1. Please type or print.
2. Answer all questions. If the answer requires detail, please attach a separate sheet.
3. Application must be signed and dated by owner, partner or officer.
4. Please complete application at least 45 days before the proposed effective date.
5. Please carefully read the statements at the end of this application.

I. PROFESSIONAL INFORMATION

1. Name of Applicant

2. Primary Facility Address

Do you lease, rent or own this location? q LEASE q RENT q OWN Sq. Ft.

3. Business Phone () Business Fax ()

4. Website Address Email Address

5. Billing Address

6. Contact Person

Phone Number () Fax Number ()

7. Federal Tax I.D. # Social Security #

8. Additional Office Locations (Please list any secondary offices below)

a. STREET ADDRESS CITY STATE ZIP

Do you lease, rent or own this location? q LEASE q RENT q OWN Sq. Ft.

b. STREET ADDRESS CITY STATE ZIP

Do you lease, rent or own this location? q LEASE q RENT q OWN Sq. Ft.

Please list additional names and/or locations in the Remarks Section or on a separate page. Also attach a copy of any fictitious name permits or licenses if applicable.

NOTE: A LOCATION MAY BECOME AN "INSURED PREMISES" UNDER THE POLICY ONLY IF IT IS LISTED.

9. Name of Director LAST FIRST MIDDLE q M.D. q D.O.

10. Name of Assistant Director LAST FIRST MIDDLE q M.D. q D.O.

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION**III. ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS (CONTINUED)**

2. Is your organization a member of The National Association for Home Care (NAHC)? YES NO

3. Is your organization a member of The Health Industry Distributors Assoc (HIDA)? YES NO

If YES, your HIDA Membership Number: _____

4. Are you a member of any state association(s)? YES NO

If YES, Name of the State Association(s): _____

5. Are you a member of any other industry association(s)? YES NO

If YES, please specify: _____

IV. HIRING/SCREENING AND EMPLOYMENT PROCEDURES

1. Are employees' references contacted before hiring? YES NO

2. How are references checked? WRITTEN VERBAL BOTH

If VERBAL ONLY, please explain: _____

3. Do you screen prospective employees for criminal records? YES NO

If NO, please explain: _____

4. Do you verify certification and/or professional licensure status of employees? YES NO

5. Do you screen employees to rule out drug, alcohol and sexual abuse? YES NO

6. Do you verify the following when hiring professionals and clinical support staff to provide patient care services at your facility:

- Check of educational background, or residency program, when applicable. YES NO
- Confirm hospital privileges for physicians, oral surgeons and dentists.
How often do you update your list of specific privileges? _____ YES NO
- Confirm that they have no pending license suspensions or revocations, or any pending disciplinary actions by other facilities. YES NO
- Require information on any claim previously made against any individual resulting from the performance of or failure to perform professional services while working within the scope of his or her duties. YES NO

7. Are written job descriptions provided for all professional and nonprofessional employees? YES NO

V. RISK MANAGEMENT/QUALITY ASSURANCE

1. Does the applicant have a formal written Quality Assurance Program in place? YES NO

If NO, please explain: _____

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

V. RISK MANAGEMENT/QUALITY ASSURANCE (CONTINUED)

2. Does the applicant have a formal written Risk Management Program in place? YES NO
 If NO, please explain: _____
3. Is the overall responsibility for Risk Management activities assigned to one individual in your organization? YES NO
 If YES, please list Name and Title: _____
 If NO, please describe how these functions are monitored: _____
4. Does the applicant conduct patient/client surveys? YES NO
 If YES, please attach a sample.
5. Are the results of patient/client surveys used to improve day-to-day operations? YES NO

VI. DESCRIPTION OF SERVICES

1. Services Provided

Check each box that applies. Please provide requested information for each classification. (Provide projected information for the next 12 months.)

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HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

VI. DESCRIPTION OF SERVICES (CONTINUED)

Treatment	Visits	Ambulance Companies	# of Staff
<input type="checkbox"/> College or University Health Center	_____	<input type="checkbox"/> Air Ambulance	_____
<input type="checkbox"/> Dialysis	_____	<input type="checkbox"/> Ambulance Service Company	_____
<input type="checkbox"/> Health Department	_____	<input type="checkbox"/> Medical Registry Services/ Medical Personnel Pools	_____
Examinations		Community Health Center (Non-Profit)	
<input type="checkbox"/> Health Examinations Annual Exams (Diagnosis and Inoculations/No Follow-up)	_____	<input type="checkbox"/> Visits	_____
<input type="checkbox"/> Insurance Physicals Annual Physicals	_____	<input type="checkbox"/> Physician Hours	_____
<input type="checkbox"/> Pharmacy Annual Receipts	_____	<input type="checkbox"/> Surgical Procedures	_____
<input type="checkbox"/> Blood/Plasma Bank Annual Donations	_____	<input type="checkbox"/> Deliveries	_____
		<input type="checkbox"/> Abortions	_____
Board & Care Facilities			
	Beds		
<input type="checkbox"/> Detoxification Facility	_____		
<input type="checkbox"/> Group Home	_____		
<input type="checkbox"/> Halfway House	_____		

VII. SERVICES

Locations Where Services Are Provided – In Percentages (%) (Total must equal 100%)			
<input type="checkbox"/> Private Homes	%	<input type="checkbox"/> Clinics	%
<input type="checkbox"/> Nursing Homes	%	<input type="checkbox"/> Doctor's Office	%
<input type="checkbox"/> Hospitals	%	<input type="checkbox"/> Other Locations	%
		Please Specify: _____	
Types Of Services Provided – In Percentages (%) (Total must equal 100%)			
<input type="checkbox"/> Personal Care Chore or Companion	%	<input type="checkbox"/> Respiratory Therapy	%
<input type="checkbox"/> Rehabilitation	%	Circle One: Trachea Care / Ventilator Care	
<input type="checkbox"/> Infusion Therapy	%	<input type="checkbox"/> Radiation	%
<input type="checkbox"/> Hospice	%	<input type="checkbox"/> Radiation Therapy	%
<input type="checkbox"/> Supplemental Staffing	%	<input type="checkbox"/> Skilled Nursing Care	%
<i>Please Complete Section VIII – Supplemental Staffing</i>			
<input type="checkbox"/> Obstetrical Services	%	<input type="checkbox"/> Training Consultants	%
<input type="checkbox"/> Adult Daycare	%	<input type="checkbox"/> Infant Care	%
<input type="checkbox"/> Child Daycare	%	<input type="checkbox"/> Pediatric Care	%
<input type="checkbox"/> Medical Equipment Supplier	%	<input type="checkbox"/> Retail Pharmacy	%
<input type="checkbox"/> Meals On Wheels	%	<input type="checkbox"/> Closed Pharmacy	%
<input type="checkbox"/> Other Services	%	<input type="checkbox"/> Clinics Owned/Operated	%
		Please Specify: _____	

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

VII. SERVICES (CONTINUED)

Services Of Healthcare Professionals – Indicate Number In Each Category

HEALTHCARE PROFESSIONALS	EMPLOYEES		CONTRACTORS		VOLUNTEERS	
	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
Acupuncturists						
Chiropractors						
Dentists						
Dietitians						
Emergency Medical Technicians						
Hearing Aid Dispensers						
Home Health Aides						
L.P.N.s / L.V.N.s						
Marriage and Family Therapists						
Mental Health Counselors						
Nurses (R.N.s)						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Clinicians						
Nutritionists						
Occupational Therapists						
Opticians						
Orthopedic Technicians						
Oral and Maxillofacial Surgeons						
Perfusionists						
Pharmacists						
Physical Therapists						
Physicians						
Physician Assistants						
Podiatrists						
Psychologists						
Respiratory Therapists						
Social Workers						
Speech Therapists						
Technicians						
Other (Describe in Remarks Section)						

VIII. SALARIED EMPLOYEES / INDEPENDENT CONTRACTORS

Physicians Who Are Salaried Employees Of Or Independent Contractors For The Facility.

EACH PHYSICIAN MUST COMPLETE A SEPARATE PHYSICIAN APPLICATION.

Note: If Applicant is a Surgicenter, Physician Applications should not be completed.

PHYSICIAN'S NAME	NUMBER OF HOURS WORKED PER MONTH

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION**IX. SUPPLEMENTAL STAFFING****Supplying Healthcare Providers To Other Facilities For A Fee**

<input type="checkbox"/> Clinics	_____ %	<input type="checkbox"/> Nursing Homes	_____ %
<input type="checkbox"/> Hospitals	_____ %	<input type="checkbox"/> Physicians' Offices	_____ %
<input type="checkbox"/> Other Facilities	_____ %	<input type="checkbox"/> Other Facilities	_____ %
Please Specify: _____		Please Specify: _____	

If there is NO Supplemental Staffing, please check here: **X. GENERAL LIABILITY COVERAGE****OWNED OR LEASED PREMISES**1. Are any bed or board or overnight services provided? YES NO

If YES, please explain: _____

2. Do you provide any "high tech" services (i.e. trachea care, ventilator care, chemotherapy, etc.)? YES NO

If YES, please explain: _____

3. Does the applicant enter into any contractual agreements (i.e. with hospitals, nursing homes or other healthcare facilities)? YES NO

If YES, list and attach copies of all agreements. _____

a. Do these agreements contain hold harmless or indemnification clauses favorable to the applicant? YES NO4. Are certificates of insurance obtained from all subcontractors? YES NO

5. List all entities to be named as additional insureds, including names and insurable interest.

PLEASE ATTACH A COPY OF EACH CONTRACTUAL AGREEMENT - EXCLUDING LANDLORDS.

1	NAME	_____
	ADDRESS	_____
	INSURABLE INTEREST	_____
2	NAME	_____
	ADDRESS	_____
	INSURABLE INTEREST	_____

6. Has the applicant sold, acquired or discontinued any operations in the past five years? YES NO

If YES, please explain: _____

7. Is the applicant considering any changes in operations or products handles in the next twelve months? YES NO

If YES, please explain: _____

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION**XI. PRODUCTS LIABILITY/MEDICAL EQUIPMENT/SUPPLIES**

PLEASE ATTACH PRODUCT LISTING OF ALL PRODUCTS SOLD, LEASED OR RENTED.

1. Does the applicant SELL any medical supplies and/or equipment? YES NO
- a. Total Annual Sales \$ _____
- b. Of the amount indicated as "Total Annual Sales," what portion, if any, applies to pharmaceutical products? \$ _____
2. Does the applicant rent or lease any medical supplies and/or equipment? YES NO
- a. Total Annual Lease or Rental Receipts \$ _____
3. Does the applicant repair or do maintenance on any medical supplies or equipment? YES NO
- a. Total Annual Repair or Maintenance Receipts \$ _____

If you answered "NO" to both 1. and 2., please skip the following "Category" Section.

If you answered "YES" to either 1. or 2., please COMPLETE the remainder of this "Category" Section.

CATEGORY I Expendable Items – Intended for one time usage and then disposed (i.e. adhesive tape, bandages, hypodermic needles, etc.)

Annual Sales \$ _____

CATEGORY II Non-Expendable Items – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc., and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales \$ _____ Annual Lease/Rental Receipts \$ _____

CATEGORY III Diagnostic Or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators) treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

Annual Sales \$ _____ Annual Lease/Rental Receipts \$ _____

CATEGORY IV Life Sustaining Or Critical Life Monitoring Equipment Or Devices – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition. (Please attach a list of Category IV equipment or devices.)

Annual Sales \$ _____ Annual Lease/Rental Receipts \$ _____

NOTE: Total Amount of Annual Sales in Categories I-IV must equal amount in 1.; Total Amount of Annual Lease Rental Receipts must equal 2.

4. Does the applicant manufacture any products? YES NO

5. Is the applicant named as an additional insured/vendor on the manufacturer's policy for any/all products? (Required for any Category IV products.) YES NO

If YES, please explain: _____

6. Does the applicant obtain certificates of insurance from its products suppliers? YES NO

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION**XI. PRODUCTS LIABILITY/MEDICAL EQUIPMENT/SUPPLIES (CONTINUED)**

7. Does/has the applicant ever distributed or directly imported products from a foreign manufacturer? YES NO
a. If YES, please describe: _____
b. If YES, does the foreign manufacturer have a U.S. location? YES NO
c. If YES, where? _____
8. Are written instructions for the use of the products provided to the user? YES NO
9. Are these instructions reviewed and required to be signed off by users? YES NO
10. Does the applicant modify any product in any way from its intended use? YES NO
If YES, please explain: _____
11. Does the applicant repackage or relabel any of the items obtained from suppliers? YES NO
If YES, please explain: _____
12. Is any of the equipment sold with the applicant's label? YES NO
13. Does the manufacturer's label remain on the equipment? YES NO
14. Does the applicant maintain a written quality control program? YES NO
15. Is all equipment checked and their condition documented prior to their release? YES NO
16. Are serial numbers of the finished product shown on shipment invoices? YES NO
17. Are complete records kept of inventory shipments? YES NO
18. Does the applicant use the services of an EPA approved contractor for disposal of hazardous waste materials? YES NO
If YES, what are these products? _____
19. Are any products flammable or explosive? YES NO
If YES, please explain: _____
20. Does the applicant have any exposure to nuclear or radioactive materials? YES NO
If YES, please explain: _____
21. On oxygen, oxygen-related equipment, life sustaining or critical life monitoring equipment or devices, describe the twenty-four (24) hour services, three hundred sixty-five (365) day/year program that exists. If extra space is needed, please use the Remarks Section.

22. Does the applicant distribute oxygen cylinders? YES NO
If YES, are they pre-filled? YES NO OR Are they filled at the applicant's facility? YES NO
23. Does the applicant follow FDA and DOT regulations for the sterilization and transportation of oxygen? YES NO

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION
XII. PRODUCTS LIABILITY/MAINTENANCE AND/OR REPAIR OF EQUIPMENT

1. Does the applicant perform maintenance on all equipment according to a written schedule? q YES q NO

2. Does the applicant repair or sell other suppliers' used equipment? q YES q NO
 If YES, please explain: _____
 If YES, give percentage of total sales/receipts: Repair _____ % Sales _____ %

3. If repairs are made, are separate records kept? q YES q NO
 If YES, please provide Repair Payroll: \$ _____

4. Does the applicant subcontract labor for installation, service or repair of any products? q YES q NO
 If YES, please indicate which category of equipment this applies to: _____

5. The applicant performs maintenance and/or repairs on the following types of equipment:

6. Are manufacturers' recommendations followed for all maintenance and repair of equipment? q YES q NO

7. Are certificates of insurance obtained from those entities that provide the maintenance and repair of equipment? q YES q NO

XIII. APPLICANT CLAIMS/LOSS HISTORY

1. List all previous PROFESSIONAL LIABILITY carriers for the last 5 years. If none, state 'None.'

INSURANCE CARRIER	LIMITS OF LIABILITY (i.e. \$1M/\$3M)	PREMIUM	POLICY PERIOD		CLAIMS MADE FORM OR OCCURRENCE	RETRO DATE (CLAIMS MADE ONLY)
			FROM	TO		
	/	\$	/ /	/ /		
	/	\$	/ /	/ /		
	/	\$	/ /	/ /		

2. List all previous GENERAL LIABILITY carriers for the last 5 years. If none, state 'None.'

INSURANCE CARRIER	LIMITS OF LIABILITY (i.e. \$1M/\$3M)	PREMIUM	POLICY PERIOD		CLAIMS MADE FORM OR OCCURRENCE	RETRO DATE (CLAIMS MADE ONLY)
			FROM	TO		
	/	\$	/ /	/ /		
	/	\$	/ /	/ /		
	/	\$	/ /	/ /		

HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION**XIII. APPLICANT CLAIMS/LOSS HISTORY (CONTINUED)**

If a current loss summary is available from present or previous carriers, please attach a copy.

DEFINITION: A claim is a demand for money from a patient or on a patient's behalf, a 90-day notice of intention to sue, a lawsuit, a counterclaim or a demand for arbitration.

Please be advised that you will have no coverage from Fairway Physicians Insurance Company for any known claims or incidents that may lead to a claim or lawsuit. All claims or incidents that may lead to a claim or lawsuit should be reported to your current malpractice insurer before terminating your existing policy (coverage for any such lawsuits, claims or incidents is subject to the terms of your current carrier's policy).

1. Have you ever been or are you now involved in any professional liability (malpractice) claims or lawsuits? YES NO

If Yes, Number of Claims: _____ The Claims Information *MUST* be completed for each claim. See Section XVI.

2. Have all claims been reported to your current or previous professional medical liability insurance carrier(s)? YES NO

3. Have you ever attempted or settled a claim on your own behalf that you did not report to a previous medical liability carrier? YES NO

4. Has any insurance company canceled, declined coverage, modified (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any professional liability insurance? YES NO

If Yes, please describe in the Remarks Section and include the Company Name / Policy Number.

5. Has any claim or suit been brought against you and/or any of your employees? YES NO

If Yes, the Claims Information *MUST* be completed for each claim or suit. Refer to Section XVI.

If Yes, has this information been reported to your current or prior insurance carrier? YES NO

6. Have you ever practiced without professional liability insurance? YES NO

If Yes, please explain and specify dates: _____

7. Has a claim, incident or suit for alleged malpractice been brought against the applicant within the last ten (10) years? YES NO

If YES, complete a Claims Information Sheet for each claim.

8. Is there knowledge of any incident(s) that might provide a basis for any claim or suit to be brought against the applicant? (Include any non-billing or non-record transfer related requires for medical records.) YES NO

If YES, describe in Remarks Section.

9. For renewal business, has the applicant reported any losses to its prior carrier during the last year? YES NO

If YES, describe in Remarks Section.

XIV. SURVEY DATA

1. Please name the individual whom our Risk Management representative may contact for an on-site review of the applicant's facility:

Name and Title

Telephone Number



HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

XV. OFFICE SURGERY

1. Do you have a full ACLS Resuscitation (crash) cart in your office? [] YES [] NO

2. Are you ACLS Certified? [] YES [] NO

If Yes, Expiration Date: ___ / ___ / ___

XVI. CLAIMS INFORMATION

PLEASE COPY THESE PAGES FOR ALL ADDITIONAL CLAIMS YOU ARE REPORTING TO FPIC.

NOTE: This Claims Information Form pertains to lawsuits, claims or demands for arbitration or incidents which could lead to claims. A claims form must be completed for each lawsuit, claim, demand for arbitration or incident. Sufficient information must be provided to evaluate the medical aspects of the case specifically relating to the physician's involvement.

1. Patient's Name: _____ 2. Age: _____ 3. Sex (M/F): _____

4. Your relationship to patient (i.e. Attending Physician, Primary Surgeon, Assistant Surgeon, etc): _____

5. Date of Incident: ___ / ___ / ___ 6. Location: _____

7. Insurance Carrier: _____ 8. Other Defendants: _____

9. Present Status: [] OPEN [] CLOSED _____ / _____ / _____ DATE

[] INCIDENT ONLY [] 90-DAY NOTICE [] SUIT FILED [] SUIT SERVED [] ARBITRATION

Method of Closing: [] DISMISSED [] DEFENSE VERDICT

[] SETTLED AMOUNT PAID ON YOUR BEHALF: \$ _____ TOTAL SETTLEMENT: \$ _____

[] JUDGMENT AMOUNT PAID ON YOUR BEHALF: \$ _____ TOTAL SETTLEMENT: \$ _____

The following questions should be answered in explicit clinical detail to allow proper evaluation by the FPIC Underwriting Department. Attach additional sheets as required.

10. Patient's allegations or circumstances brought to your attention: _____

11. Condition and diagnosis at time of incident: _____

12. Dates and description of treatment rendered: _____

13. Condition of patient subsequent to treatment (and dates of follow-up treatment): _____

I understand information submitted herein becomes part of the FPIC's Named Insured's records.

_____/_____/_____
DATE

APPLICANT'S NAME (PLEASE PRINT)

APPLICANT'S SIGNATURE



HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

XVII. APPLICANT RETROACTIVE COVERAGE

The following questions refer to your application for retroactive coverage (i.e. "Prior Acts" or "Nose Coverage") with Fairway Physicians Insurance Company ("FPIC").
If you are approved for retroactive coverage, you will receive a certificate of coverage with a specified retroactive coverage date.
Retroactive coverage is only available from FPIC to those applicants who have maintained continuous and uninterrupted "Claims-Made" medical professional liability coverage up to the commencement date of their coverage with FPIC.

Whether or not you believe you were at fault:

1. Are you aware of any incidents resulting in injury or death to a patient where your professional services were utilized? [] YES [] NO

2. Are you, your employees or associates aware of any threats or complaints that could lead to legal action against you or your medical practice? [] YES [] NO

If Yes, please indicate the number of threats or complaints and describe below (use separate paper if necessary):

3. Have you ever been the subject of a deposition or subpoena as a result of medical services provided by you on behalf of a patient (other than as an expert witness, but including consultative services)? [] YES [] NO

OBLIGATION OF DISCLOSURE

California law requires you to disclose to Fairway Physicians Insurance Company ("FPIC") any information known to you that would influence FPIC's decision to approve your application for coverage, including the information you provided in this claims section. You also have an obligation to inform FPIC of any information that becomes known to you between the date of your signature below and the effective date of coverage with FPIC that could alter your previous response to the claims information requested herein.

[] YES, I request retroactive coverage from FPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences in California and subsequent to my retroactive coverage date with FPIC.

I represent and warrant that I will maintain my current professional liability coverage up to the commencement date of my membership with Fairway Physicians Insurance Company. I make this representation with the understanding that should any future investigation reveal that I did not maintain continuous claims-made professional liability coverage, FPIC may deny all claims defense and claims payment services for any claim arising out of professional services that I rendered to patients during the retroactive coverage period.

I also make this representation with the understanding that my failure to meet my obligation of disclosure may result in the termination of my policy with FPIC and the loss of all claims defense and claims payment services.

Requested Retroactive Date: ____ / ____ / ____
MM DD YYYY

[] NO, I decline retroactive coverage from FPIC.

This application for Retroactive Coverage is deemed part of your Application for Membership in FPIC and is incorporated by this reference into the FPIC policy.

I declare under penalty of perjury that the foregoing is true and correct. Executed this ____ of ____ DAY, 200__ in ____, ____, by ____ SIGNATURE.
MONTH YR CITY STATE



HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE APPLICATION

XIX. COVERAGE INFORMATION

1. Requested Effective Date: ____ / ____ / ____ Requested Retroactive Date: ____ / ____ / ____

IMPORTANT: Please attach a copy of your most recent Declarations Page of your present Carrier indicating the original effective date of coverage, retroactive date (if requested) and a current paid-through date. The company may not provide requested dates.

2. Desired Policy Limits (NOTE: Professional and General Liability Limits should be the same.)

Health Care Facility Professional Liability – Claims Made Coverage

- \$ 1,000,000 EACH CLAIM / \$ 3,000,000 POLICY AGGREGATE
- \$ _____ EACH CLAIM / \$ _____ POLICY AGGREGATE

Commercial General Liability (Optional) – Claims Made Coverage

- \$ 1,000,000 EACH CLAIM / \$ 3,000,000 POLICY AGGREGATE
- \$ _____ EACH CLAIM / \$ _____ POLICY AGGREGATE

3. Desired Deductible (NOTE: Applicable to both Professional and General Liability Limits.)

- None
- \$5,000
- \$10,000
- \$25,000

Coverage is solely as stated in your FPIC policy, and provided on a "Claims-Made" basis for those claims first reported (i.e. "Tail Coverage") against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I warrant to FPIC my understanding and acceptance of the notice stated above and that the information contained herein is true and shall be inclusive of the basis of the policy of insurance and deemed incorporated therein, should the insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of all claims information from any prior insurer to Fairway Physicians Insurance Company.

NAME OF APPLICANT (PLEASE PRINT)

SIGNATURE OF APPLICANT

____ / ____ / ____
DATE

Signing this application does not bind the applicant or the insurer or the underwriting manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.