CBMALAGA
Insurance Services LLC

1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

Medical Corporation Professional Liability Insurance Application

With your fully completed, signed and dated application, please submit the following information:

1. Current insurance policy declaration page.
2. Written verification of the purchase of a reporting endorsement (tail) from your present carrier if your current coverage is claims-made and you are *not* applying for prior acts coverage.
3. Articles of Incorporation (including amendments).
4. Current business letterhead.
5. Roster of all health care providers, including paramedicals, who practice with this organization. (See section 4.B. for providers considered paramedical.) Any paramedical or physician requesting coverage must submit a healthcare provider application.
6. Loss runs from prior insurance companies or explanation as to why they are not available.

Note: Submission of a completed application confers no obligation upon the Company to bind coverage.

1. Organization Information

Organization Name: _____

Federal Tax ID: _____-_____

Primary Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Preferred Billing Address: _____

Contact Name: _____ Title: _____

Phone: _____ Email: _____

Is this contact the authorized representative for access to policy information? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative. _____

Please list additional practice locations:

Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

A. Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership
☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other _____

B. Has the Organization ever been incorporated under a name other than that listed above? Yes ☐ No ☐
If yes, please list all previous names and the first use date of each:

_____

C. Is or has the Organization ever been incorporated in a state other than that listed above? Yes ☐ No ☐
If yes, please list states and first use date in each:

_____

D. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐
If yes, please list all d/b/a names:

_____

E. List other separate entities for which coverage is requested not listed above:

2. Coverage Requested

A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR

B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
Excess Coverage Limits (where available): _____

C. Deductible amount (where available): $_____
☐ Indemnity Only ☐ Indemnity & Expense ☐ None

D. Is the organization requesting Prior Acts Coverage? Yes ☐ No ☐
Requested Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

3. Professional Liability Insurance and Claims History

A. Current Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Previous Insurance Information (please indicate if none):

i. Name of Insurer: _____

ii. Policy Limits: _____ Shared ☐ Separate ☐

iii. Dates Covered, From: _____ To: _____

iv. Policy Type: ☐ Claims-Made ☐ Occurrence

v. If Claims-Made, Retro Date: _____ / _____ / _____
MONTH DAY YEAR

vi. Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

C. Have any claims or suits ever been filed against your organization as a result of professional services? Yes ☐ No ☐

D. Are you aware of any conduct, circumstances, occurrences, or incidents likely to give rise to a claim? Yes ☐ No ☐

E. If you are answered "yes" to question 3.C. or D., have the claims, conduct, circumstances, occurrences, or incidents been reported to a previous insurer? (Please complete the Supplementary Claims information form at the end of the application.) Yes ☐ No ☐

F. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? *(This question is not applicable in Missouri.)* Yes ☐ No ☐
If yes, please describe in the space provided at the end of the application.

4. Practice Information

A. List all physicians who will be *insured elsewhere* and provide proof of coverage. Please provide explanation in the space provided at the end of the application.

Name	Specialty	Current Insurer

B. List all paramedicals who will be *insured elsewhere* and provide proof of coverage.

Name	Specialty	Current Insurer

*Paramedicals include a person practicing as a psychologist, nurse midwife, nurse anesthetist, nurse practitioner, physician assistant, surgical assistant, perfusionist, optometrist, cytotechnologist, emergency medical technician, anesthesiologist assistant, or any person licensed, certified or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician.

C. Do physicians/individuals not affiliated with your organization use your facilities and/or equipment? Yes ☐ No ☐

D. Is the organization or any member physician whole or part owner in any medical professional joint venture outside of this practice? Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

E. Is this organization considered a medical spa? Yes ☐ No ☐

GENERAL FRAUD WARNING – 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.

Applicant's Signature: _____ Title: _____

Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

For Agent's Use Only (if applicable)

Agent's Name	CB Malaga Insurance Services LLC - www.cbmalagains.com Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Please attach additional sheets as necessary.