5005 Maryland Way, Suite 300
Brentwood, Tennessee 37027
P: 800.342.2239 F: 615.370.1343

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Name _____

Office Address _____

_____

_____

Mailing Address (if different from above) _____

_____

Applicable Med. License No. _____

NPI No. _____

Office Phone No. _____

Cell Phone No. _____

Email Address _____

Website Address _____

Specialty Board Certification No. (if applicable) _____

Type of Practice (Check as many as apply)

- ☐ Solo, not incorporated
- ☐ Solo — my corporation's name is _____
  - ☐ My solely-owned entity conducts business at more than one practice location
- ☐ Member of a group practice called _____
- ☐ Full-time faculty member of _____
- ☐ Resident/fellow member of _____
- ☐ Practice under contract with _____
- ☐ Employed by _____
- ☐ I employ the following physician(s) _____
- ☐ Temporarily substituting for (physician's name) _____

States in which you are licensed to practice and percentage of your practice in each state _____

_____

Date you began practice at your present professional location _____

Previous locations of practice, including dates (please attach CV) _____

_____

Date of Birth _____ Place of Birth _____

Date coverage desired _____

Payment plan desired ☐ Advanced Payment Plan (5% discount) ☐ Semi-annual ☐ Quarterly ☐ 10 Monthly

Limits requested for Professional Liability Insurance ($ each medical incident/$ annual aggregate)

☐ 1 million/3 million	☐ 2 million/4 million	☐ 3 million/5 million
☐ 4 million/6 million	☐ 5 million/7 million	☐ 6 million/8 million
☐ 7 million/9 million	☐ 8 million/10 million	☐ 9 million/11 million
☐ 10 million/12 million	☐ Virginia Only - Applicable Recovery Limit	

Name of most recent insurance carrier _____

Termination date of current or last policy _____ Retroactive date of last policy _____

Applicant's Initials: ☐

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Revised 7. 2025

	Institution and Location	Dates (From/To)
Medical School		
Internship		

Residencies/Fellowships

	Institution and Location	Specialty	Dates (From/To)
1.			
2.			
3.			

If you graduated from a foreign medical school, are you ECFMG certified? ☐ Yes ☐ No

What is your current specialty? _____ Percentage of practice _____

Specialties in which you are Board eligible _____

Specialty Board Certifications which you hold _____

List all hospitals where you have privileges. Indicate whether you wish us to send verification of insurance to each. Please also include any credentialing agencies you wish to for us to send verification of insurance to.

	Send Verification (yes/no)		Send Verification (yes/no)

Additionally, these entities may request your claims history information. Please indicate below if SVMIC is authorized to provide this information to the entities listed above.

Yes _____ No _____

By checking "yes", I authorize SVMIC to provide to the above person or organization information relating to any medical professional liability claims activity against me that has been reported and covered by SVMIC, but specifically limited to: a) Claims that have resulted in paid losses (settlements), and/or b) Lawsuits (open or closed). Additionally, I HEREBY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS, DAMAGES, OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE.

Describe the professional activities for which you are requesting coverage

_____

_____

_____

How many hours per month do such activities involve? _____

Do you or will you render any medical professional services via telecommunications technology (telemedicine or internet medicine) that involves patients who reside in states other than your indicated state of practice? ☐ Yes ☐ No

Do you serve as a Medical Director? ☐ Yes ☐ No

If "yes", please list the name of the facility(ies) _____

_____

Do you have other medical professional liability coverage for this exposure? ☐ Yes ☐ No

With whom? _____

Applicant's Initials: ☐

Please carefully review the following list and check any procedures that apply or will apply to your practice

- ☐ Abortion
- ☐ Acupuncture
- ☐ Amniocentesis
- ☐ Anesthesia
  - ☐ General
  - ☐ Spinal (including caudal)
  - ☐ Regional
  - ☐ Conscious sedation
  - ☐ Local only
- ☐ Angiography
- ☐ Angioplasty (with or without stents)
  - ☐ Coronary
  - ☐ Peripheral
- ☐ Appendectomy
- ☐ Assist in major surgery
  - ☐ On own patients only
  - ☐ On patients of others
- ☐ Bariatric surgery
  - ☐ Only at MBSAQIP accredited center
- ☐ Biopsy — endoscopic
- ☐ Breast biopsy
- ☐ Cardiac catheterization
  - ☐ Diagnostic
  - ☐ Therapeutic
- ☐ Chelation therapy (for other than heavy metal poisioning)
- ☐ Cholangiography
- ☐ Cosmetic surgery
  - ☐ Abdominoplasty
  - ☐ Breast implant
  - ☐ Facial cosmetic surgery
  - ☐ Liposuction
  - ☐ Other cosmetic procedures
    Please list:

    _____

    _____
- ☐ Cosmetic/dermatological procedures
  - ☐ Blepharoplasty
  - ☐ Chemical peel
  - ☐ Chemabrasion
  - ☐ Collagen injection
  - ☐ Dermabrasion
  - ☐ Fat transfer
  - ☐ Hair transplant
  - ☐ Laser skin resurfacing
  - ☐ Lipodissolve/mesotherapy
  - ☐ Microdermabrasion
  - ☐ Silicon injection
  - ☐ Other _____
- ☐ Electroconvulsive/shock therapy
- ☐ Endoscopy
  - ☐ Arthroscopy
  - ☐ Bronchoscopy
  - ☐ Colonoscopy
  - ☐ Colposcopy
  - ☐ Cystoscopy
  - ☐ EGD
  - ☐ ERC
  - ☐ ERCP
  - ☐ Hysteroscopy
  - ☐ Laparoscopy
  - ☐ Sigmoidoscopy
  - ☐ Thoracoscopy
  - ☐ Esophogeal dilation
- ☐ Interventional cardiology
- ☐ Interventional radiology
- ☐ Hemorrhoidectomy
- ☐ Lumbar puncture
- ☐ Myleography
- ☐ Obstetrics
  - ☐ Non-surgical ☐ Surgical
- ☐ Orthopedics — hand surgery only
- ☐ Orthopedics — fracture reduction
  - ☐ Open
  - ☐ Closed
- ☐ Orthopedics — spine surgery
  - ☐ With instrumentation
  - ☐ Without instrumentation
- ☐ Pacemaker insertion
- ☐ Pain management
  - ☐ Medication only
  - ☐ Selective nerve block
  - ☐ Facet joint injection
  - ☐ Rhizotomy
  - ☐ Lumbar epidural
  - ☐ Cervical epidural
  - ☐ Spinal cord stimulator
  - ☐ Trigger point injection
- ☐ Penile implants
- ☐ Percutaneous vertebroplasty
- ☐ Prenatal care past 1st trimester
- ☐ Prolotherapy
- ☐ Pulmonary artery catheterization (Swan-Ganz)
- ☐ Radiation therapy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Tubal ligations
- ☐ Tumor ablation therapy
  List types

  _____
- ☐ Vascular surgery
- ☐ Vein procedures
  - ☐ Endovenous laser ablation
  - ☐ Sclerotherapy
  - ☐ Surface laser for spider veins
- ☐ Vena cava filter placement

1. If **none** of the above procedures apply to your practice, please initial here _____

2. Do you perform procedures that are outside the customary scope of practice within your specialty? ☐ Yes ☐ No

IF "YES", PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER AND INCLUDE DOCUMENTATION OF TRAINING FOR SUCH PROCEDURES.

Applicant's Initials: ☐

ANSWER EACH QUESTION. FOR ALL YES ANSWERS, ATTACH COMPLETE DETAILS ON A SEPARATE SHEET

YES NO

☐☐ 1. Has your LICENSE to practice in any state ever been denied, suspended, revoked, voluntarily surrendered, restricted, or subject to probationary terms?

☐☐ 2. Has your DEA Certificate for prescribing or dispensing narcotics ever been denied, suspended, revoked, voluntarily surrendered, restricted, or subject to probationary terms?

☐☐ 3. Has your MEMBERSHIP in any medical society or professional organization ever been denied, suspended, revoked, or voluntarily surrendered?

☐☐ 4. Have you ever been the subject of any DISCIPLINARY proceedings or reprimand by any medical board, administrative agency, medical society, or licensing board?

☐☐ 5. Has your application for hospital staff PRIVILEGES ever been denied or restricted?

☐☐ 6. Have your hospital PRIVILEGES ever been modified, revoked, non-renewed, subject to probationary or disciplinary action, or voluntarily surrendered while under review?

☐☐ 7. Have PRECEPTOR(S) or assisting physician(s) ever been assigned to any aspect of your practice by a hospital other than during your Residency or Fellowship Program?

☐☐ 8. Have you ever had specialty BOARD CERTIFICATION refused, suspended, or revoked?

☐☐ 9. Have you ever been convicted of, or plead nolo contendere, to a VIOLATION of any law or ordinance other than a traffic offense?

☐☐ 10. Has any hospital, medical society, administrative agency, or professional organization ever requested or required you to be EVALUATED for any medical condition, alcohol and/or drug abuse/dependency, anger or behavior problems, or alleged sexual boundary questions?

☐☐ 11. Have you ever had or do you currently have an ILLNESS OR DISABILITY that impaired, impairs or could impair your ability to practice your medical specialty including, but not limited to, alcoholism, drug addiction, compulsive disorders, tremors, multiple sclerosis, or rheumatoid arthritis?
If "yes", the details required on a separate sheet must include the name and address of your treating physician.

☐☐ 12. Has any CLAIM OR LAWSUIT for any alleged malpractice ever been brought against you?
If "yes", how many? _____ PLEASE ATTACH A COMPLETED CLAIMS ADDENDUM FORM FOR EACH "YES" ANSWER.

☐☐ 13. Has any CLAIM OR LAWSUIT for alleged malpractice ever resulted in a court judgment against you or a settlement by you or by an insurance company, self-insured plan, other form of indemnification, or other form of protection on your behalf?

☐☐ 14. Are you aware of any INQUIRY by an attorney representing any patient (other than worker's compensation or accident claims) about medical care you provided?

☐☐ If "yes", has the inquiry (or inquiries) been reported to and accepted by another medical professional liability insurer?

☐☐ 15. Are you aware of any patient or family member of a patient who has expressed DISSATISFACTION with medical care you provided?

☐☐ If "yes", has the inquiry (or inquiries) been reported to and accepted by another medical professional liability insurer?

☐☐ 16. Has your medical professional liability INSURANCE ever been cancelled, non-renewed, or issued on special terms or has your application for such medical professional liability insurance ever been declined? (Missouri applicants are not required to respond.)

Applicant's Initials: ☐

INDICATE THE NUMBER OF YOUR EXTENDER EMPLOYEES	Number at Primary Location	Number at Remote Location
☐ None		
☐ Anesthesiologists Assistant – Certified		
☐ Clinical Nurse Specialist		
☐ Nurse Anesthetist (CRNA)		
☐ Nurse Midwife (no deliveries)		
☐ Nurse Midwife (with deliveries)		
☐ Nurse Practitioner		
☐ Optometrist		
☐ Perfusionist		
☐ Physician Assistant		
☐ Psychologist		
☐ Radiology Practitioner Assistant		
☐ Registered Radiology Assistant		
☐ Surgical Assistant		

Are you a medical director or do you have a collaborative agreement to any of the above? ☐ Yes ☐ No

PLEASE CHECK ONLY ONE

☐ I am applying for Extender Employee Professional Liability Coverage for my extender employees (provides a single separate limit of coverage for each extender employee and requires additional premium). A separate application will be required for each extender employee.

☐ I am NOT applying for insurance for my extender employees.

I **REPRESENT** that the statements made and the answers provided herein are complete, true, and correct, and are for the purpose of inducing State Volunteer Mutual Insurance Company ("the Company") to issue the policy for which the application is hereby made.

I **UNDERSTAND** that the entire policy shall be void if, whether before or after a loss or claim, I am found to have willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

I **UNDERSTAND** that the medical professional liability insurance for which I am applying covers only those medical incidents which arise from professional services or peer review services rendered on or after the retroactive date, and then only if such medical incidents are first reported to the Company during the policy period. I UNDERSTAND that upon termination of a policy, extended reporting (tail) coverage is available for additional premium, except in the event the policy is canceled for non-payment of the premium.

I **AUTHORIZE** all hospitals, past or present medical associates, licensing boards, past or present professional liability insurers, and all other persons or organizations to release information concerning me and my medical practice history to the Company for the purpose of evaluating my liability risk. I AUTHORIZE the Company to use a copy of this authorization in place of the original. I UNDERSTAND that any such information will be used by the Company solely for underwriting purposes.

REGULATORY NOTICE: I **ACKNOWLEDGE** that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company, and that penalties include imprisonment, fines and denial of insurance coverage.

I further **ACKNOWLEDGE** that execution of this application by me does not bind the Company to issue an insurance policy, but that this application shall be the basis of the contract should a policy be issued.

Applicant's Signature _____ Date _____

NOTE: IF SIGNED ELECTRONICALLY, AUDIT DOCUMENT MUST BE ATTACHED TO APPLICATION.

Print or type name as it appears above _____

Fraud Warnings

Notice to Alabama, Arkansas, Louisiana, and West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Florida and Oklahoma Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in Florida only.

Notice to Kansas Applicants: A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Kentucky and Ohio Applicants: 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.

Notice to Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. All policies are subject to a 45-day underwriting period beginning on the effective date of coverage. In accordance with §12-106 of the Insurance Article, Annotated Code of Maryland, if the Company discovers a material risk factor during the underwriting period, the Company may cancel a policy with 15 days written notice, or recalculate the premium from the effective date of the policy.

Notice to Applicants of all other states: 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 the person to criminal and civil penalties.

Applicant's Initials: ____

Claims Detail Addendum

Applicant's Name (please print) _____

Please supply the following information for each "yes" response to questions #12-15 on the application for Medical Professional Liability Insurance:

Total number of claims, suits, incidents or inquiries: _____

Please print or type answers to each of the following questions in detail. If more than one case exists, please photocopy this sheet for each case. FULL DISCLOSURE OF THE INFORMATION REQUESTED BELOW IS NECESSARY.

Patient/Plaintiff's Name _____ Insurance carrier involved _____

Date of occurrence _____ Date reported _____ Date closed (if applicable) _____

What is the status of the case? (check one)

☐ Pending ☐ Settled Out of Court ☐ Found for Plaintiff

☐ Dropped ☐ Dismissed ☐ Found for Defendant

If damages were paid, either by settlement or court award, what was the amount? _____

Paid on your behalf $ _____ Paid by all parties $ _____

What is/was your status? (check one) ☐ Primary Defendant ☐ Codefendant ☐ Other

In the space below (attach additional page(s) if needed), provide detailed information of the following for each case

A) Provide a brief description of the incident/claim/suit.

B) What were you alleged to have done incorrectly or failed to have done correctly?

C) Provide any other details you feel are pertinent to the case.

D) Identify any other parties who are named in the claim or suit.

Applicant's Signature _____ Date _____

NOTE: IF SIGNED ELECTRONICALLY, AUDIT DOCUMENT MUST BE ATTACHED TO APPLICATION.

Print or type name as it appears above _____

Supplemental Application for Prior Acts Coverage for Medical Professional Liability Coverage

If you are desiring to change your professional liability coverage from another claims-made type carrier to SVMIC, you should either arrange to purchase tail coverage from that carrier or make application to SVMIC for prior acts coverage. Without one or the other of these coverages, medical incidents that occurred prior to the initial effective date of SVMIC's policy (if approved), may not be covered under either policy.

In addition to applying for prior acts coverage with SVMIC, it is important that you maintain your option to purchase tail coverage from your current or previous carrier until you have received an official approval letter or declarations page from SVMIC indicating prior acts coverage has been provided. Please note that most insurance carriers require that you notify them of your desire to purchase tail coverage within a limited period of time — usually 30 days from the termination of your policy. Prior Acts Coverage is not granted automatically and requires separate approval from SVMIC.

Applicant's Name (please print) _____

Option 1. _____ **I am requesting Prior Acts Coverage from SVMIC.**

What is the Prior Acts date requested? _____

This generally should be the date stated as the "Retroactive Date" under your current policy. **Please attach a copy of the policy document showing your current retroactive date and limits of liability.**

During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g. different states, procedures, coverage, etc.) ☐ Yes ☐ No

IF "YES", DESCRIBE SUCH CHANGES, INCLUDING ALL APPLICABLE DATES, ON A SEPARATE SHEET

Option 2. _____ **I am <u>not</u> requesting Prior Acts Coverage from SVMIC.**

By making this selection, it is assumed that you either do not need or desire this coverage, or that you have made arrangements with your current carrier to purchase tail coverage.

This Supplemental Application is being submitted with SVMIC's Application for Medical Professional Liability Insurance ("Application"), and I certify that I have specifically referred to questions #12, #13, #14, #15 on page 5 of such Application and have fully disclosed any requested claims, suits, incidents or inquires and the details thereof.

(In order for this application to be considered, *ONE* of the above Options must be marked indicating your request.)

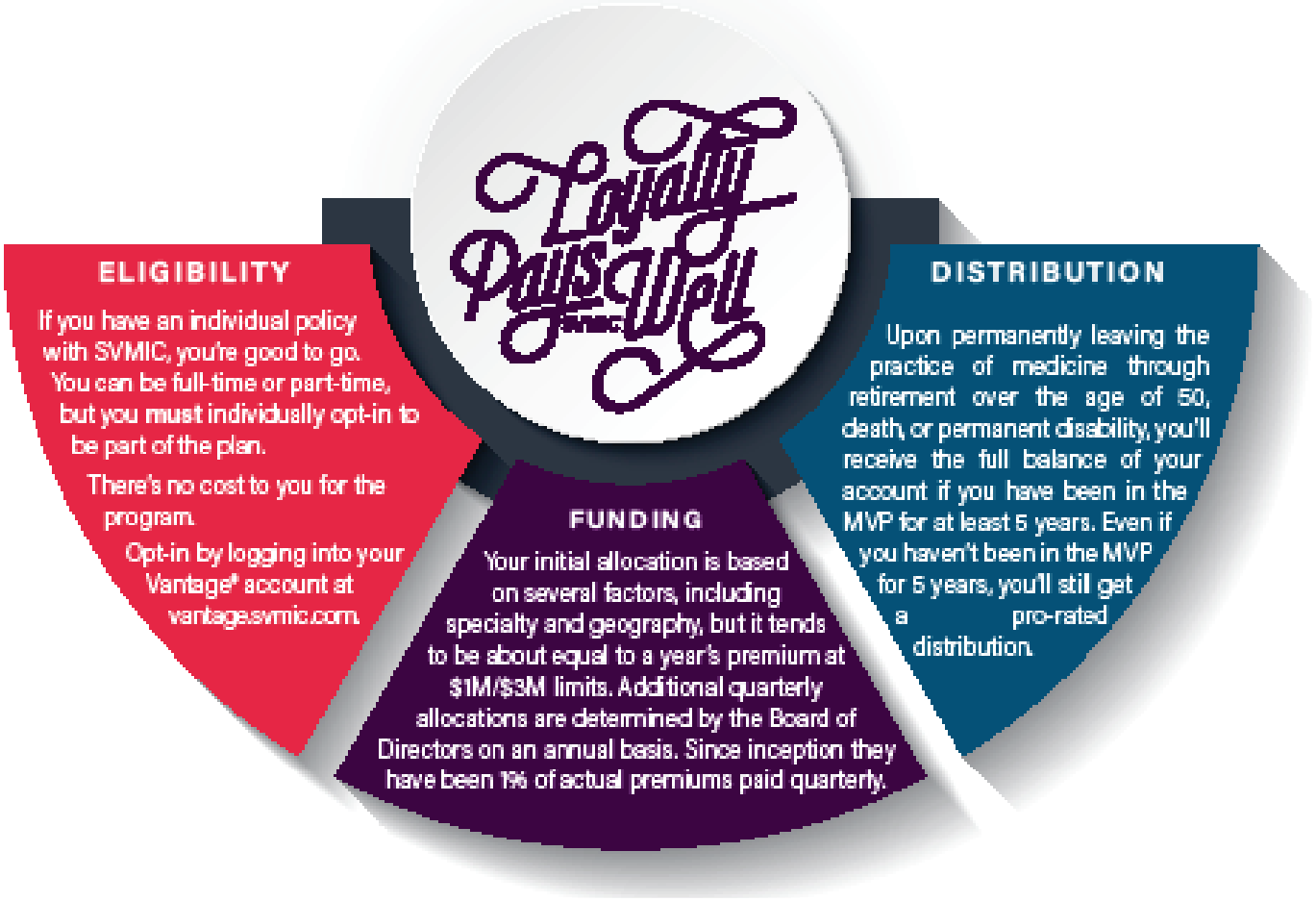
Signature of Applicant _____ Date _____

NOTE: IF SIGNED ELECTRONICALLY, AUDIT DOCUMENT MUST BE ATTACHED TO APPLICATION.

Print or type name as it appears above _____

Loyalty Pays Well.
The Mutual Value Plan®

The MVP is SVMIC's physician loyalty program. We make an initial contribution into an account for each physician policyholder. The account grows over time with quarterly allocations as long as the physician continues to be insured by SVMIC. Upon retirement, disability, or death, the balance is paid in a lump sum to the physician.*



MORE DETAILS ARE AVAILABLE ON THE FOLLOWING PAGE.

* PLEASE REFER TO THE MVP OWNER'S MANUAL, AVAILABLE AT SVMIC.COM, FOR THE FULL TERMS AND CONDITIONS OF THE MUTUAL VALUE PLAN.

Loyalty Pays Well.
The Mutual Value Plan®

WHAT IS THE MVP?

The Mutual Value Plan® (MVP) is a financial reward program for loyal SVMIC policyholders. SVMIC created the program to allow the company to set aside funds over time for its insured physicians; these funds will be disbursed to doctors upon a qualifying event such as retirement, disability, or death.

WHAT IS THE PURPOSE OF THE MVP?

SVMIC created the MVP to recognize and reward the loyalty and commitment of our physician policyholders. As a physician-owned mutual, our interests are completely aligned, and the MVP is one more way to allow us all to share in the long-term success of the company.

WHO IS ELIGIBLE TO PARTICIPATE IN THE MVP?

All individually-insured SVMIC physicians with an active professional liability policy are eligible to participate in the MVP. Policyholders may be full-time or part-time and must individually opt-in to the plan. Please be sure to read the rules and the FAQs to understand the details of eligibility.

HOW IS THE ACCOUNT FUNDED INITIALLY?

SVMIC makes an initial allocation into the policyholder's account that is roughly equal to one year's premium at $1 Million/$3 Million limits for their geography and medical specialty. Initial allocations will be posted to the MVP account on the last day of the calendar quarter of enrollment (enrollment requires opt-in). MVP balances and account information is always available via the Vantage® portal.

HOW ARE FUTURE ALLOCATIONS MADE?

Future MVP allocations are posted on the last day of each calendar quarter providing the policyholder continues to meet the eligibility requirements for the MVP. SVMIC's Board of Directors will determine the amount of future allocations. Since inception, they have been 1% of actual premiums paid per quarter. In 2026, SVMIC increased that percentage to 2%, doubling the value returned to policyholders. Policyholders receive a quarterly email statement and can view their MVP balance at any time in their Vantage® portal.

WHAT ARE THE DISTRIBUTION REQUIREMENTS?

In order to receive a distribution, the policyholder must have a current account balance, have been in the MVP for at least 5 continuous years, and have permanently ceased the practice of medicine as a result of retirement, permanent disability, or death. In the case of retirement, the policyholder must be past the age of 50. Policyholders with fewer than 5 years of MVP membership will have their distributions pro-rated. Distributions can be requested via Vantage® or by calling SVMIC.

* PLEASE REFER TO THE MVP OWNER'S MANUAL, AVAILABLE AT SVMIC.COM, FOR THE FULL TERMS AND CONDITIONS OF THE MUTUAL VALUE PLAN.

Mutual Value Plan®

Mutual Value Plan® Request to Participate

On the date indicated below, I, the undersigned Insured Policyholder of State Volunteer Mutual Insurance Company (SVMIC):

☐ **Request to participate in the Mutual Value Plan (MVP).**

☐ **<u>Decline</u> to participate in the Mutual Value Plan (MVP).**

If I have requested to participate in the State Volunteer Mutual Insurance Company Mutual Value Plan (MVP), I acknowledge and agree that my request may be accepted or rejected by State Volunteer Mutual Insurance Company in its sole discretion in accordance with the eligibility requirements for participation in the MVP now or hereafter in effect. I also acknowledge and agree that my participation in the MVP will be governed by the Mutual Value Plan Document (MVP Plan Document) and certain policies, procedures, and requirements adopted by State Volunteer Mutual Insurance Company's Board of Directors from time to time.

I acknowledge that I have received, read, and understand the MVP Plan Document and accept and agree to abide by and honor the details, terms and conditions of the MVP as described in the MVP Plan Document. I understand that State Volunteer Mutual Insurance Company's Board of Directors, in its sole discretion and without prior notice, may withdraw, cancel, or modify the MVP.

PRINT Insured Name: _____

SVMIC Account Number, Medical License Number, or NPI Number: _____

Email Address: _____

Phone Number: _____

Insured Signature: _____

Date: _____

NOTE: IF SIGNED ELECTRONICALLY, AUDIT DOCUMENT MUST BE ATTACHED TO APPLICATION.

Please create a Vantage® account at your earliest convenience so that you can manage your policy, pay your premium, see your MVP balance, take free risk education courses, and access our secured resources. <u>vantage.svmic.com</u>