TMLT
Texas Medical Liability Trust

P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmlt.org

ENCLOSED ARE THE FORMS NECESSARY FOR ENTITY APPLICATION

Thank you for choosing to apply with TMLT. We know that you have choices when purchasing liability insurance to protect your reputation and your medical practice. We appreciate the opportunity to earn your business.

A few items that are especially helpful to know at the start of the application process:

Completing and submitting your application:

- If you are submitting individual application for your physician members, they must be a member of the Texas Medical Association or have a membership application pending to obtain coverage through TMLT. To start this process, please visit the TMA web site **www.texmed.org** or call 1-800-880-1300.
- Remember to sign and date your application once it is complete.
- Please review the *Business Associate Agreement.*
- Please enclose any documentation requested in the application such as your Office Letterhead, Secretary of State filing, advertising samples or current declarations page.

Our website has a wealth of information on products and services we offer, including Coverage types, Risk Management, Claims, and information about TMLT. Be sure and check out our FAQs**.**

We want to make your application experience as simple as possible. If you have any questions during the process, we will be happy to assist you. Call 1-800-580-8658 and ask for Sales and Business Development.

Payment Options

Consider which billing and payment options are right for you. Billing can be invoiced monthly or quarterly as a recurring automatic draft using your Visa, MasterCard, American Express credit cards or by bank draft. If no billing option is chosen, you will be invoiced quarterly. Please visit www.tmlt.org to select and set up your payment option or call Customer Service at 1-800-580-8658 ext. 5050 for assistance.

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TEXAS MEDICAL LIABILITY TRUST

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APPLICATION FOR ENTITY COVERAGE

PLEASE TYPE OR PRINT IN BLACK INK.
ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER_____
(For Trust Use Only)

I. GENERAL INFORMATION

A. _____
Name of Entity (Professional Association/Partnership, etc.)

_____
Other Name(s) Under Which the Group Practices (i.e. DBA)

_____
Office Street Address

_____
City | County | State | Zip Code

_____
Office Phone: Area Code Number | Fax: Area Code Number | Email

_____
P.O. or other Address

_____
City | County | State | Zip Code

B. Preferred Mailing Address:
Office ☐ P.O. Box ☐ Other ☐

C. President/Partner _____

Business Manager/Administrator _____

D. The Entity above is a:
Professional Association ☐ Limited Liability Partnership (LLP) ☐ Partnership ☐ Other ☐ (Describe)
_____

E. Date Entity was formed: _____ _____ _____
Month Day Year

II. PROFESSIONAL LIABILITY COVERAGE

Entity coverage is available only if all shareholders/partners are covered by TMLT.

A. Requested coverage effective date 12:01 a.m. _____ _____ _____
Month Day Year

In no event shall the effective date of the policy, if issued, be earlier than the date TMLT receives this application.

B. Professional Liability Coverage Please check type of coverage (**Occurrence or Claims-made**) and the limits of liability desired.

☐ **Occurrence** (Limits indicated are the only limits available and are for Each Claim and All Claims)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,000,000

OR

☐ **Claims-made** (Limits indicated are Each Claim and All Claims)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $300,000/$900,000 ☐ $500,000/$1,000,000

C. Insurance History for Previous Three Years

	Current Year	First Prior Year	Second Prior Year
1. Insurance Company:			
Coverage Form:	☐ Claims-made ☐ Occurrence	☐ Claims-made ☐ Occurrence	☐ Claims-made ☐ Occurrence
Policy Period:			
Limits of Liability Per Claim/All Claims:			

If your current insurance is written on a Claims-made form, it is necessary to purchase a Reporting Endorsement (tail coverage) from your present insurer or Prior Acts (nose coverage) from TMLT to reduce the chances of having a gap in coverage.

2. Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer for all of your previous exposures? Yes ☐ No ☐

If no, are you requesting Prior Acts (nose coverage) from TMLT? Yes ☐ No ☐

III. PRIOR ACTS COVERAGE

If you are not requesting Claims-made coverage, including Prior Acts, from TMLT, skip to page 4, Section IV.

NOTE: The following two questions in this section apply to your ***past*** Claims-made coverage and need to be answered for the entire time period following your retroactive date.

A. Have any of your physicians practiced outside the state of Texas? Yes No

If yes, please list below the physician(s) name(s), state(s), date(s) and the percentage of practice for each year.

B. Has your Claims-made policy ever included coverage for any other Entity? Yes No

If yes, please explain below and attach a copy of any endorsement providing coverage for such other individual (including locum tenens) or Entity. Each is subject to separate underwriting consideration.

C. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered by any of your associates or members) which you have reason to believe may lead to a claim or suit against your Entity? Yes No

D. Have any incidents (which have not yet resulted in a claim or suit) been reported on behalf of the Entity to another insurance carrier? Yes No

E. Have any incidents, claims or suits been reported to another insurance carrier by any of your current or former members or associates on their own behalf which have not been reported on behalf of the Entity? Yes No

F. Has your Entity received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, complaint, summons, citation or other legal process or notification? Yes No

If you answered yes to C, D, or E above, you must provide details below. Report all incidents identified under C or E to your current insurance carrier. Doing so does not necessarily eliminate the need for the Reporting Endorsement (tail coverage).

Patient Name	Date of Incident	Date incident report sent to insurance carrier (provide copies)

IV. UNDERWRITING AND RATING INFORMATION

A. List the names and medical specialties of all individual Physicians/Surgeons who are shareholders or partners.

	Physician Name	Medical Specialty
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

B. Does the Entity Employ ☐ Supervise ☐ Contract ☐
with any other licensed physicians? (not shareholders/partners) Yes ☐ No ☐

C. Does the Entity Employ ☐ Supervise ☐ Contract ☐
with midwives or any individuals who administer anesthesia, other than licensed physicians? Yes ☐ No ☐

If yes to B or C, list below.

Name	Specialty	Insured By	Limits of Liability

D. Indicate number of professional licensed personnel in each category employed or supervised by the Entity.

	Insured by	Limits of Liability
_____ RNs		
_____ LVNs		
_____ Lab/Radiology Techs		
_____ PAs		
_____ Nurse Practitioners		
_____ LPTs		
_____ Other		

E. Does the Entity own or operate any:

- ____ hospital
- ____ ambulatory surgery facility
- ____ minor emergency clinic
- ____ clinic with bed and board facilities
- ____ laboratory
- ____ x-ray facility
- ____ sanatorium
- ____ other business enterprise

If yes, provide details on page 5.

F. CLAIM INFORMATION

How many professional liability claims have **ever** been brought against the Entity?
This includes notice of intent to sue, written demand from patient or lawsuit. #_____
Complete the information for all claims/suits on page 6.

AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding. **I understand any policy issued by TMLT will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMLT any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: Texas Medical Board; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability and/or Premises Liability Coverage. I further authorize TMLT and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

This application incorporates by reference the terms and conditions of TMLT's HIPAA-HITECH Business Associate Agreement (reviewable at www.tmlt.org/appdocs), copies of which will be provided to me upon request. By signing and accepting below, I consent to the terms and conditions of these documents and agreements.

By submission of this application, or by acceptance of coverage from TMLT, I hereby release TMLT and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

Physician's Signature	Printed Name	Date Signed

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

Coverage will not be considered until this application is completed, signed and dated. Failure to provide complete information and/or attachments as requested will cause delay.

VI. ADDITIONAL DETAILS (Please use this area if additional space is needed for answers to any questions.)

PAGE NUMBER	QUESTION NUMBER	ANSWER AND/OR DETAILS

VII. CLAIM/SUIT INFORMATION

If additional space is required, please photocopy this form as needed. PLEASE TYPE OR PRINT IN BLACK INK. Note: Additional documentation may be requested by the Underwriting Department.

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration

Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year