COPIC
Better Medicine • Better Lives

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COPIC Policyholder Services

DISCLOSURE FORM CLAIMS-MADE POLICY
IMPORTANT NOTICE TO POLICYHOLDER

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT DESCRIBES SOME OF THE MAJOR FEATURES OF OUR CLAIMS-MADE POLICY FORM. READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

YOUR POLICY

Your policy is a claims-made policy. It provides coverage only for injury or damage occurring after the policy retroactive date (if any) shown on your policy and the incident is reported to your insurer prior to the end of the policy period. Upon termination of your claims-made policy an extended reporting period option is available from your insurer.

There is no difference in the kind of injury or damage covered by occurrence or claims-made policies. Claims for damages may be assigned to different policy periods, depending on which type of policy you have.

If you make a claim under your claims-made policy, the claim must be a demand for damages by an injured party and does not have to be in writing. Under most circumstances, a claim is considered made when it is received and recorded by you or by us. Sometimes, a claim may be deemed made at an earlier time. This can happen when another claim for the same injury or damage has already been made, or when the claim is received and recorded during an extended reporting period.

PRINCIPAL BENEFITS

This policy provides for defense and indemnification of covered claims arising from medical incidents or peer review incidents up to the maximum dollar limit specified in the policy.

The principal benefits and coverages are explained in detail in your claims-made policy. Please read it carefully and consult your insurance producer about any questions you might have.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS

Your claims-made policy contains certain exceptions, reductions and limitations. Please read them carefully and consult your insurance producer about any questions you might have.

RENEWALS AND EXTENDED REPORTING PERIODS

Your claims-made policy has some unique features relating to renewal, extended reporting periods and coverage for events with long periods of potential liability exposure. If there is a retroactive date in your policy, no event or occurrence prior to that date will be covered under the policy even if reported during the policy period. It is therefore important for you to be certain that there are no gaps in your insurance coverage. These gaps can occur in several ways. Among the most common are:

1. If you switch from an occurrence policy to a claims-made policy, the retroactive date in your claims-made policy should be no later than the expiration date of the occurrence policy.
2. When replacing a claims-made policy with a claims-made policy, you should consider the following:
    a. The retroactive date in the replacement policy should extend far enough back in time to cover any events with long periods of liability exposure, or
    b. If the retroactive date in the replacement policy does not extend far enough back in time to cover events with long periods of liability exposure, you should consider purchasing extended reporting period coverage under the old claims-made policy.
3. If you replace this claims-made policy with an occurrence policy, you may not have insurance coverage for a claim arising during the period of claims-made coverage unless you have purchased an extended reporting period under the claims-made policy. Extended reporting period coverage must be offered to you by law for at least one year after the expiration of the claims-made policy at a premium not to exceed 200% of your last policy premium.

CAREFULLY REVIEW YOUR POLICY REGARDING THE AVAILABLE EXTENDED REPORTING PERIOD COVERAGE, INCLUDING THE LENGTH OF COVERAGE, THE PRICE AND THE TIME PERIOD DURING WHICH YOU MUST PURCHASE OR ACCEPT ANY OFFER FOR EXTENDED REPORTING PERIOD COVERAGE.

COPIC
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COPIC Application for Medical Professional Liability Insurance

Supplement to the Colorado Health Care Professional Credentials Application (CHCPCA)

Claims-made policy

Please note: *Our underwriting process involves a thorough evaluation of your application and requires 7 to 10 business days on average to complete. Please consider this time frame when requesting a coverage effective date.*

With your completed application, you are required to submit the following information:

☐ Current declarations page which provides a retroactive date and indicates limits of liability for you and any entity for which you are requesting coverage.

☐ Written confirmation of the purchase of or your intent to purchase a reporting endorsement ("tail coverage") from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage. (This information MUST be obtained from your previous employer)

☑ Please check the following specialties that apply. **Note:** An additional application will be provided.

☐ ☐ ☐ ☐ ☐ ☐ N/A

☐ ☐ ☐ ☐ ☐ N/A

☐ If you are requesting coverage for your employed Allied Health Professional, a separate application is required.

☑ Current business letterhead and advertisements (including website material). BOULDERCOMMUNITY HOSPITAL .ORG

☐ Curriculum Vitae (C.V.)

☐ A loss run report. To obtain this information, please call your prior carrier(s) and request a currently valued loss run for the past five (5) years. (This information MUST be obtained from your previous employer)

☐ **A complete copy of the Colorado Health Care Professional Credentials Application signed and dated within the past ninety (90) days.**

Additional information may be requested.

COPIC
7351 E Lowry Boulevard, Ste. 400 ■ Denver, CO 80230
phone 720/858-6000 ■ *fax* 720/858-6004 ■ *toll free* 800/421-1834 ■ www.callcopic.com

APPLICANT DATA

1. Last name _____ First name _____ M.I. _____

2. DOB _____ 3. SSN _____ 4. Gender ☐ M ☐ F

5. Please select the mailing address you prefer for each of the following (see pages 4 to 6 of the CHCPCA):

Confidential documents (acknowledgement of incident report, claim correspondence):
☑ Office ☐ Office P.O. Box ☐ Residence ☐ Residence P.O. Box ☐ Admin ☐ Admin P.O. Box

Policy related documents (application, policy, endorsements, etc.):
☑ Office ☐ Office P.O. Box ☐ Residence ☐ Residence P.O. Box ☐ Admin ☐ Admin P.O. Box

If you are approved for coverage under a group policy, policy related documents will be sent to the address selected by the policyholder.

6. Personal/Confidential e-mail Address bch.org

COVERAGE REQUESTED

7. Requested Effective Date _____

8. Liability limits (check one) ☐ $500,000/$1.5 million* ☑ $1 million/$3 million ☐ $1.5 million/$3 million ☐ $2 million/$4 million ☐ Other: _____
*Subject to underwriting review

9. Practicing as (check one)
☐ Individual ☑ Joining Group ☐ Forming Group
☐ Locum tenens physician ☐ Slot physician ☐ Other: _____

10. Premium Payment Plan: Boulder Community Health has a contract in place with COPIC for the pymt plan
You have the option of choosing the payment plan that best meets your needs. Please note that only one option may be selected per policy.

☐ Quarterly (Four installments, three months apart)
☐ Semi-Annual (First half due at beginning, second half due in six months)
☐ Annual (Payment in full at beginning of policy year)

Mid-term policy changes and distributions will affect the actual installment amount.

11. List each professional corporation, association, partnership or other healthcare related entity in which you have an ownership:

Name	Description of Interest	% of Practice
N/A	N/A	

An additional entity application may be needed for the organization(s) listed above.

12. Please give the full names of all other physicians affiliated with any organization(s) or medical entities named in question #11, their specialties and the name of their current medical professional liability insurer. **All affiliated physicians must complete a separate application if organization or entity coverage is requested.** If extra space is needed, please attach additional sheets.

Name	Specialty	Current Insurer
N/A	N/A	N/A

13. Employer Name Boulder Community Health

14. Are you employed by a governmentally immune hospital or facility? ☐ Yes ☑ No

If "yes," please provide the name of the hospital or facility. N/A

If "yes," please indicate the number of hours you currently work per week on behalf of that hospital or facility. _____ # of hours per week

If "yes," do you work or provide professional medical services outside of or on behalf of anyone other than the governmentally immune hospital or facility identified above? ☐ Yes ☐ No

If "yes," please list here: _____

PROFESSIONAL LIABILITY INSURANCE

15. If your current insurance is claims-made, will "tail" coverage be purchased? ☐ Yes ☐ No ☐ N/A
    If "no," are you requesting prior acts coverage? ☐ Yes ☐ No
    Note: If you are requesting prior acts coverage, a separate Supplemental Prior Acts Application will be required by your Underwriter.

PRACTICE HISTORY

16. Percentage of your practice devoted to your Specialty 100 %
17. Percentage of your practice devoted to your Subspecialty _____ %

PRACTICE CHARACTERISTICS

18. List all hospitals at which you have or will have staff privileges in force for which you are requesting this COPIC coverage and indicate the type of privileges you hold at each:

Name of Hospital	Type of Privilege
Boulder Community Health	☐ Active ☐ Provisional ☐ Courtesy ☐ Pending ☑ Other
	☐ Active ☐ Provisional ☐ Courtesy ☐ Pending ☐ Other

Please explain any "pending or "other" answer here. If you explain a "pending" answer, please provide the date you initially applied for these privileges.
I will have privileges with BCH as soon as i begin working at BCH

If extra space is needed, please attach additional sheets.

19. If you made no entry in question #18 above, please provide details regarding your patients who require hospital care including the names and practice locations of all physicians who will follow them while hospitalized. If extra space is needed, please attach additional sheets.

20. List **all** entities to receive certificates of insurance (e.g., hospitals, HMOs, IPAs, etc.)

Name	Address (including city, state and zip code)
Boulder Community Health	Box 9019 Boulder, CO 80301

By adding a certificate holder's name and address to the above list, you give COPIC permission to allow the certificate holder to obtain your certificate of insurance.

21. Average number of hours worked per week ☐ 1-15 ☐ 16-20 ☐ 21-25 ☐ ≥ 26
    When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds.

22. Please describe all medical professional or business activities for which you are **not** requesting COPIC coverage. _____
    Do you maintain any other medical professional liability coverage? ☐ Yes ☐ No
    If "yes," please explain. _____

23. After the Requested Effective Date, including telemedicine work, do you plan to practice/consult outside Colorado in the next 12 months? ☐ Yes ☑ No
    If "yes," do you or will you maintain professional liability insurance for this exposure? ☐ Yes ☐ No
    Please describe the nature of your out-of-state practice and indicate the number of hours per week devoted to it. _____
    If extra space is needed, please attach additional sheets.
    (For purposes of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual patient as a result of transmission of individual patient data by electronic means." Telemedicine does not include an informal consultation provided without compensation or expectation of compensation, nor does it include those services described above which are rendered in a bona fide emergency.)

24. What percentage of your practice is devoted to aesthetic or cosmetic procedures? none % ☑ N/A

25. Do you provide "house call" services to patients other than hospice or palliative care patients? ☐ Yes ☑ No

If "yes," what percentage of your total practice is devoted to "house calls" for non-hospice or non-palliative care patients?_____ %

Note: *For purposes of this question, "house call" refers to the provision of professional medical services outside of a medical office or acute care setting.*

26. Do you practice "Concierge Medicine?" ☐ Yes ☑ No

Note: *For purposes of this question, "Concierge Medicine," also known as direct care, is a relationship between a patient and a healthcare provider in which the patient pays monthly or annual fees.*

If "no," please skip to question #27.

If "yes," what percentage of your practice is based on this model?_____ %

What is your current total patient count? _____

Do you continue to accept and bill insurance? ☐ Yes ☐ No

PROCEDURES PERFORMED

All "yes" answers require explanation. Please attach additional sheets, if necessary.

27. Do you perform bariatric surgery? ☐ Yes ☑ No

If "yes," please indicate the percentage of your time devoted to your bariatric practice. _____

28. Do you assist at surgery? ☐ Yes ☑ No

29. In your practice, do you perform procedures or use equipment not used by a majority of physicians in your specialty who practice in Colorado? ☐ Yes ☑ No

30. Do you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? ☐ Yes ☑ No

31. Do you perform surgery or obstetrical procedures at a location more distant than one hour's time or 50 miles from an office listed herein? ☐ Yes ☑ No

32. Do you perform surgery or obstetrical procedures in a surgical suite more distant than one hour's time or 50 miles from a hospital? ☐ Yes ☑ No

33. Do you perform obstetrical procedures? ☐ Yes ☑ No

34. If you answered "yes" to question #33, please indicate the average number of deliveries performed per year _____ and the average number of C-sections performed per year._____

If you answered "yes" to question #33, do you hold a current certification in Advanced Life Support in Obstetrics (ALSO)? ☐ Yes ☐ No

If "yes," please provide the expiration date._____

35. Do you practice in an Emergency Department (ED)? ☐ Yes ☑ No

If "yes," please indicate number of hours per week _____ and answer the following:

a. Do you only provide on-call coverage to the ED? ☐ Yes ☐ No
b. Do you provide ED specialty backup/consult only? ☐ Yes ☐ No
c. Do you work in the ED just to maintain hospital privileges? ☐ Yes ☐ No
d. Do you work in the ED for compensation for activities other than those described in 35 a, b, and c above? ☐ Yes ☐ No

36. Do you or will you perform office-based surgery utilizing conscious sedation, regional or general anesthesia? ☐ Yes ☑ No

If "yes," are you aware of and do you abide by the guidelines established by the Colorado Medical Board (CMB 40-12)? ☐ Yes ☐ No

37. Please identify below all "invasive" procedures you perform for which you were not resident trained or for which you do not hold hospital privileges. ☑ N/A

"Invasive" refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation.
If applicable, please list all such procedures:

Procedure	Resident-Trained?	Hospital Privileges?
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No

38. Do you perform:

Prenatal care beyond the first trimester?	☐ Yes	☑ No
Second-trimester abortions?	☐ Yes	☑ No
Elective home delivery?	☐ Yes	☑ No
Obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"?	☐ Yes	☑ No
For non-physicians you supervise or employ, the management of active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC) patients unless a responsible physician is physically on premises and immediately available for the entire course of care?	☐ Yes	☑ No
Breast biopsy by surgical incision?	☐ Yes	☑ No
Liposuction surgery using the tumescent technique?	☐ Yes	☑ No
Liposuction surgery using any technique other than tumescent?	☐ Yes	☑ No
Reduction of open fractures?	☐ Yes	☑ No
Treatment of undisplaced closed fractures?	☐ Yes	☑ No
Reduction of displaced closed fractures?	☐ Yes	☑ No
Intravascular absolute alcohol embolization except for renal pathology?	☐ Yes	☑ No
Rapid opiate detoxification?	☐ Yes	☑ No
Sclerotherapy (the injection of sclerosing agents) into the vertebral column?	☐ Yes	☑ No

"Undisplaced" refers to fractures in which a fracture line is visible, but the alignment of the bone has not been displaced. "Displaced" refers to fractures in which the alignment of the bone has been displaced, but the continuity of the bone has not been altered.

39. Please describe your practice (choose only one): ☐ Hospitalist ☐ Intensivist/Critical Care Specialist ☐ None of the above

If you answered "None of the above" to question #39, please skip the next two questions and proceed to question #42.

40. Please indicate the percentage of your total practice devoted to in-patient care of hospitalized patients. _____%

41. Please describe your practice's policy regarding continuity of care with patient "handoffs" at the end of shifts: _____

_____

_____

42. Do you recommend medical marijuana? ☐ Yes ☐ No

If "yes," please answer all of the following questions:

a. For all patients for whom you recommend medical marijuana, do you have a physician-patient relationship in which you have completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination? ☐ Yes ☐ No

b. For all patients for whom you recommend medical marijuana, are you available to provide follow-up care and treatment, including examination of the patient, to assess the efficacy of the medical marijuana? ☐ Yes ☐ No

c. For all patients for whom you recommend medical marijuana, do you specify the chronic or debilitating disease or condition and, if known, the cause or source of the disease or condition? ☐ Yes ☐ No

d. Do you maintain documentation of the subjective and objective information gathered from your examination of each patient which supports your diagnosis and recommendation for medical marijuana? ☐ Yes ☐ No

e. What percentage of your total practice is devoted to recommending medical marijuana?_____%

f. In the past 12 months, for how many patients have you recommended medical marijuana? _____

OTHER PERSONNEL TO BE COVERED

43. Will you/your entity employ or contract with any allied health practitioners who will work at any of your office locations?..... ☐ Yes ☑ No

If "yes," please provide the census information requested below. If you are practicing as part of a group practice, one person may complete this section if the information applies to all physicians in the group.

	# to be insured		# to be insured		# to be insured
Acupuncturists		Advanced Practice Nurses		Aestheticians	
Anesthesiologist Assistants		Child Health Associates		Clinical Nurse Specialists	
CRNA/Nurse Anesthetists		Cytotechnologists		Electrologists	
Embryologists		Emergency Med. Techs		Endermologists	
Laser Technicians		Microdermabrasionists		Nurse Clinicians	
Nurse Midwives		Nurse Practitioners		Optometrists	
Orthopaedic Physician Assistants		Perfusionists		Pharmacists	
Physician Assistants		Physicists		Physiologists	
Psychologists		Psychotherapists		Radiology Practitioner Assistants	
Surgical Assistants		Surgical Technicians			

The COPIC policy provides no individual coverage to any employee or independent contractor in any of these classifications working in your office unless he/she is specifically named on the Declarations Page. Please contact your underwriter for more information.

44. Please indicate if you employ or contract with an allied health practitioner or physician extender who performs any of the following procedures at any of your office locations:

Botox Injections	☐ Yes	☑ No	Laser Hair Removal	☐ Yes	☑ No
Chemical Peels	☐ Yes	☑ No	Micro-Dermabrasion	☐ Yes	☑ No
Collagen Injections	☐ Yes	☑ No	Micro-Pigmentation	☐ Yes	☑ No
Endermology	☐ Yes	☑ No			

If you answered "yes" to any of the procedures listed above, please attach a copy of the documentation of training for each person performing these procedures.

45. Do or will any of your employees practice at a location geographically separate from you? ..... ☐ Yes ☑ No

If "yes," please provide details on an additional sheet. Please include in your explanation the distance of the employee's separate practice location from your practice location and a summary of the employee's duties and responsibilities while practicing there. In addition, please explain how these employees are supervised consistent with their duties and the frequency of and methods by which that supervision occurs.

OTHER INFORMATION

All "yes" answers require an explanation. Please attach additional sheets, if necessary.

46. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? Note: You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs. ..... ☐ Yes ☐ No

47. Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry?..... ☐ Yes ☐ No

48. Have you ever been denied a medical license or been denied certification by a specialty board?..... ☐ Yes ☐ No

49. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, health plan, managed care organization or other medical review committee? ..... ☐ Yes ☐ No

50. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ..... ☐ Yes ☐ No

51. Has a professional liability carrier ever required that you accept a deductible or surcharged a policy issued to you?..... ☐ Yes ☐ No

CLAIMS INFORMATION

Important information regarding questions 52 through 54 (including sub-questions):

1. The word "claim" as used in questions 52 through 54 below refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to question 52, 53 or 54 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 7).

52. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? ☐ Yes ☐ No

53. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

   a. A request for records from a patient and/or attorney related to an adverse outcome? ☐ Yes ☐ No
   b. A letter from an attorney regarding your medical treatment of a patient? ☐ Yes ☐ No
   c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ☐ Yes ☐ No
   d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ☐ Yes ☐ No
   e. Any other circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No

54. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ☐ Yes ☐ No ☐ N/A*

**For purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

   a. If "yes," how many? _____ Please attach documentation of all such reports.
   b. If "no," please explain. Attach additional sheets, if necessary. _____

_____

_____

_____

_____

_____

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets, if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____

2. Date reported to insurance company: _____

3. Name of insurance company: _____

4. Date of incident and your treatment: _____

5. Allegations: _____

   _____

   _____

6. What is the present condition of the patient? _____

   _____

   _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... ☐ Yes ☐ No

8. Status of claim (check applicable answer):

   ☐ Suit threatened, no action taken
   ☐ Suit filed but dropped by claimant
   ☐ Summary judgment in your favor
   ☐ Suit settled out of court
   ☐ Court outcome in your favor
   ☐ Court outcome in favor of plaintiff:
   ☐ Awaiting mediation
   ☐ Awaiting court action

   a. Date claim paid: _____ Amount of Loss payment: Reserve Amount:

   b. Amount paid: $_____ $_____ $_____

   c. Did you want to settle this claim? ☐ Yes ☐ No

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No

   If "yes," amount was $_____

Signature: _____ Date: _____

Name (Printed): _____

During each policy year, COPIC intends to allocate some portion of your policyholder distribution monies to its Political Action Committee (PAC) or other accounts for the purpose of supporting Tort Reform in the State of Colorado. COPIC will allocate no more than $76 in a single policy year, and donate no more than $19 in any reporting period, if any policyholder distribution is declared by COPIC's Board of Directors.

If you object to this, please check this box. ..... ☐

Please Note:

Your consent to our making contributions to our PAC in your name will remain in effect until and unless you change your election by written notification to us. Depending upon future elective policy changes you make, it may be more than twelve months before we require that you complete another Renewal Application providing the option to opt out, but you may do so at any time with written notification. Your decision to opt out of the PAC will not affect any underwriting decision on your application. Donations are not tax-deductible.

Non-United States citizens are legally barred from contributing to a PAC. If you are not a United States citizen, you must check the box above.

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! I understand and agree that as a condition of being insured, I accept the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare and warrant that all answers and statements herein given are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and as such will be relied upon in the determination by the company to grant my liability insurance. If I or any other person making application or providing information on my behalf misstate or fail to disclose any pertinent information, my application may be declined. If my application is approved and it includes any misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC and/or its assigns may conduct a peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by Practice Quality, as COPIC may request or direct. I agree to abide by any recommendations arising from that review. For Colorado and Nebraska insureds only: I have been provided, understand, and will comply with the Participatory Risk Management Guidelines of COPIC.

I authorize any state board of medical examiners or licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC or its assigns. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC policy, I hereby consent to COPIC's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations, professional liability insurance carriers, and state and federal regulatory entities, including but not limited to boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank and to the fullest extent permitted by law, hereby release all providers of such information, including COPIC, its employees and agents, from any and all liability therefore. This release applies to the following information: my name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank.

I have received the Claims-Made Disclosure Notice. I understand that if my application for coverage is approved, the disclosures described in the Notice will apply to my coverage with COPIC.

Physician signature_____ Date _____

Please PRINT your name_____

WE SUGGEST YOU RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.

■ ■

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.