



## WVMIC Professional Liability Insurance

### How to apply for your renewal term

Complete, sign and submit the enclosed application for insurance at least 45 days prior to the effective date of coverage. The application should be received as early as possible since policy renewal is subject to underwriting review. Please be certain that the following items are included with your completed application.

- Updated CV (if changes have occurred since last year's renewal)
- Letterhead
- Explanation of any "Yes" answers
- Current copy of Medical License
- Current copy of DEA License
- Company loss run for any pending claims showing current reserves (unless a WVMIC claim)
- Narrative of any pending claims (unless a WVMIC claim)
- Company loss run for any claims closed in the past year (since last year's renewal showing outcome of case)

Additional information may be requested by the WVMIC Underwriting Department.

Thank you for your interest in the West Virginia Mutual Insurance Company.

Please submit applications to:

Mailing address:

West Virginia Mutual Insurance Company  
P.O. Box 3697  
Charleston, WV 25336-3697

For questions call: 304-343-3000  
888-998-7642

Physical address:

West Virginia Mutual Insurance Company  
Attn: Underwriting Department  
500 Virginia Street, East, Suite 1200  
Charleston, WV 25301



500 Virginia Street, East, Suite 1200  
 Charleston, WV 25301  
 P.O. Box 3697  
 Charleston, WV 25336-3697

Tel: 304.343.3000  
 Toll-Free: 888.998.7642  
 Fax: 304.342.0985  
[www.wvmic.com](http://www.wvmic.com)

**RENEWAL APPLICATION FOR PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

Re-application is hereby made for medical malpractice liability insurance. The declarations contained herein are made as a representation on which the renewal policy is to be issued. Please print or type legibly.

**PART I NAME AND ADDRESS**

Name: \_\_\_\_\_

Corporation/Business Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Medical Specialty: \_\_\_\_\_ % of Practice \_\_\_\_\_

Subspecialty: \_\_\_\_\_ % of Practice \_\_\_\_\_

If any of the following questions are answered "yes" please provide a complete explanation on a separate sheet and attach copies of any information that is applicable. When providing your explanation please clarify whether or not the event(s) have already been reported to West Virginia Mutual Insurance Company. Incomplete information will delay the processing and release of your renewal quotation and of your renewal policy.

Do you desire to change your limits of liability at renewal?  Yes  No

**IN THE PAST TWELVE MONTHS HAVE YOU;**

1. Assisted in surgery on your own patient?  Yes  No

2. Assisted in surgery on the patients of others?  Yes  No

3. Had any claim or suit for alleged medical malpractice made against you **other than those already reported to the WV Mutual Insurance Company?**  Yes  No

4. Had any claim or suit for alleged malpractice that resulted in payment by you, or on your behalf by any insurance company **other than WV Mutual Insurance Company**  Yes  No

5. Obtained knowledge of any claims that might be made against you?  Yes  No

6. Had any of the following denied, suspended, restricted, revoked or voluntarily surrendered for any reason:

A. Any state medical license?  Yes  No

B. License to prescribe or dispense medicine?  Yes  No

C. Hospital privileges?  Yes  No

7. Undergone psychiatric treatment?  Yes  No

8. Been treated for alcohol or narcotics addictions?  Yes  No

9. Been treated or diagnosed with any chronic illness or physical defect?  Yes  No

**If you answered "Yes" to questions 7, 8, or 9 a statement from your attending physician is required for each.**

10. Been convicted of any misdemeanor or felony other than a minor traffic violation?  Yes  No

11. Appeared before any Professional Standards/Quality Assurance Review Committees?  Yes  No

12. Appeared before the Board of Medical Examiners or Medical Licensure Board?  Yes  No

13. Had any changes in your practice that you have not previously reported to the WV Mutual Insurance Company?  Yes  No  
 (such as: specialty, type of practice, number or type of diagnostic or surgical procedures performed, employment, moonlighting activity, hours practiced per week, hospital privileges or their status, percentage of practice or admissions at the hospitals where you have privileges, ancillary personnel, office location(s), mailing address, phone numbers, etc.)

**I hereby declare that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and that I have not willfully concealed or misrepresented any material fact or circumstances concerning this insurance or the subject thereof:**

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**PART II PRACTICE INFORMATION**

Do you perform minor surgery?  Yes  No

Add brief description (i.e., other than sutures, toenail removal, etc.) \_\_\_\_\_

Do you perform major surgery?  Yes  No

Add brief description \_\_\_\_\_

Please check any of the following procedures that you perform:

- |  |  |
|--|--|
| <input type="checkbox"/> Abdominoplasty – Tummy Tuck                                 | <input type="checkbox"/> Endoscopy   |
| <input type="checkbox"/> Abortions - Elective  | <input type="checkbox"/> ERCP  |
| <input type="checkbox"/> Acupuncture   | <input type="checkbox"/> Fluoroscopy   |
| <input type="checkbox"/> Adenoidectomy   | <input type="checkbox"/> Face Lifts  |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal                            | <input type="checkbox"/> Face Lifts – Mini (done with laser) _____ % of Practice |
| <input type="checkbox"/> Angiography   | <input type="checkbox"/> Fracture Reductions                                     |
| <input type="checkbox"/> Angioplasty   | <input type="checkbox"/> Open  |
| <input type="checkbox"/> Appendectomy  | <input type="checkbox"/> Closed  |
| <input type="checkbox"/> Assisting in major surgery – own patients only              | <input type="checkbox"/> Gastrointestinal Endoscopy                              |
| <input type="checkbox"/> Assisting in major surgery – own & other than own patients  | <input type="checkbox"/> Hip Nailings  |
| <input type="checkbox"/> Bariatric Surgery – Laparoscopic                            | <input type="checkbox"/> Hyperbaric Medicine                                     |
| <input type="checkbox"/> Bariatric Surgery – Non-Laparoscopic                        | <input type="checkbox"/> Laparoscopy   |
| <input type="checkbox"/> Biopsy – Endoscopic   | <input type="checkbox"/> Laser Surgery   |
| <input type="checkbox"/> Blepharoplasty – Cosmetic _____ % of Practice               | <input type="checkbox"/> Liposuction   |
| <input type="checkbox"/> Blepharoplasty - Reconstruction _____ % of Practice         | <input type="checkbox"/> Lithotripsy   |
| <input type="checkbox"/> Botox   | <input type="checkbox"/> Mammograms  |
| <input type="checkbox"/> Breast Implants   | <input type="checkbox"/> Myelography   |
| <input type="checkbox"/> <input type="checkbox"/> Cosmetic _____ % of Practice       | <input type="checkbox"/> Norplant Insertion/Extraction                           |
| <input type="checkbox"/> <input type="checkbox"/> Reconstructive _____ % of Practice | <input type="checkbox"/> Obstetrics  |
| <input type="checkbox"/> Breast Reduction  | <input type="checkbox"/> Prenatal  |
| <input type="checkbox"/> Bronchoscopy  | <input type="checkbox"/> Postnatal   |
| <input type="checkbox"/> Cataract Surgery  | <input type="checkbox"/> Deliveries  |
| <input type="checkbox"/> Catheterization   | <input type="checkbox"/> Organ Transplant  |
| <input type="checkbox"/> <input type="checkbox"/> Arterial                           | <input type="checkbox"/> Pain Management   |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac                            | <input type="checkbox"/> <input type="checkbox"/> Medicine Only                  |
| <input type="checkbox"/> <input type="checkbox"/> Diagnostic                         | <input type="checkbox"/> Nerve Block   |
| <input type="checkbox"/> <input type="checkbox"/> Left Heart                         | <input type="checkbox"/> Implants  |
| <input type="checkbox"/> Chelation Therapy   | <input type="checkbox"/> Radiofrequency Procedures                               |
| <input type="checkbox"/> Chemonucleolysis  | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Cholecystectomy   | <input type="checkbox"/> Pedicle Screws for Spinal Surgery                       |
| <input type="checkbox"/> Cholecystectomy / Laparoscopic                              | <input type="checkbox"/> Permanent Pacemaker                                     |
| <input type="checkbox"/> Colonoscopy   | <input type="checkbox"/> Polypectomy   |
| <input type="checkbox"/> Cryosurgery (other than external lesions)                   | <input type="checkbox"/> Radiation/ X-Ray Therapy                                |
| <input type="checkbox"/> D&C   | <input type="checkbox"/> Radiopaque Dye Injection                                |
| <input type="checkbox"/> Dermatological Surgery:                                     | <input type="checkbox"/> Renal Dialysis  |
| <input type="checkbox"/> <input type="checkbox"/> Chemical Peels                     | <input type="checkbox"/> Sclerotherapy   |
| <input type="checkbox"/> <input type="checkbox"/> Chemabrasion                       | <input type="checkbox"/> Shock Therapy   |
| <input type="checkbox"/> <input type="checkbox"/> Dermabrasion                       | <input type="checkbox"/> Spinal Surgery  |
| <input type="checkbox"/> <input type="checkbox"/> Hair Transplants                   | <input type="checkbox"/> Teleradiology _____ % of Practice                       |
| <input type="checkbox"/> <input type="checkbox"/> Silicone Injections                | <input type="checkbox"/> Thyroidectomy   |
| <input type="checkbox"/> <input type="checkbox"/> Tumescent Liposuction              | <input type="checkbox"/> Tonsillectomy   |
| <input type="checkbox"/> <input type="checkbox"/> Other: _____                       | <input type="checkbox"/> Tubal Ligation  |
| <input type="checkbox"/> Elective Plastic Surgery                                    | <input type="checkbox"/> Vasectomy   |
| <input type="checkbox"/> Encephalography   | <input type="checkbox"/> Weight Control Medication _____ % of Practice           |
| <input type="checkbox"/> Endoscopic Laser Therapy                                    | <input type="checkbox"/> Other Procedures: _____                                 |

**SPECIFIC CONSENT TO CONSIDERATION OF THE APPLICATION FOR INSURANCE**

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release WV Mutual Insurance Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

**I acknowledge that acceptance into the Company’s insurance program is not a right of every licensed physician who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company’s Underwriting Committee.**

**Applicant’s Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**AGREEMENTS & NOTICES**

**Notice to 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 Kentucky Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose on misleading , information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Ohio Applicants:** 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.

**Notice to 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, denial of insurance benefits, and civil damages.

**Applicant’s Signature:** \_\_\_\_\_ **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 liability. Below is an Authorization to Release Information form which requires your signature. Please read carefully.

**AUTHORIZATION TO RELEASE INFORMATION**

The undersigned applicant for insurance by WV Mutual Insurance Company (the “Company”) hereby authorizes his/her present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his/her acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he/she is or has been a member; all hospitals in which he/she now holds, had held or has applied for staff privilege; the State Board of Medicine or Board of Osteopathy for the state in which he/she is licensed; any other state in which he/she has practiced or resided; and any and all physicians having information regarding the undersigned to release to the Company upon its request for information any such person or entity may have which, in the judgment of any such person, or entity of the Company, may have a bearing upon his/her acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, the Company, its directors, officers, employees and agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing the information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the undersigned original.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## SUPPLEMENTAL CLAIMS INFORMATION FORM

Please complete a Supplemental Claims Information Form for each case indicated on the application. You may photocopy this form if needed. All requested information must be provided 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. 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

7. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed but dropped by claimant Date \_\_\_\_\_
- Summary judgment in your favor Date \_\_\_\_\_

Court outcome in your favor:  Jury verdict  Directed verdict Date \_\_\_\_\_

Court outcome in favor of plaintiff:  Jury verdict  Directed verdict Date \_\_\_\_\_

Verdict Amount \_\_\_\_\_

Suit settled out of court

A. Date claim paid: \_\_\_\_\_

B. Amount paid on your behalf: \$ \_\_\_\_\_

C. Did **you** want to settle this claim?  Yes  No

Claim is currently pending

Reserve Amount \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (printed) \_\_\_\_\_