

**COREWELL HEALTH  
PHYSICIANS INSURANCE COMPANY  
(CHPIC)**

**PHYSICIAN MEDICAL PROFESSIONAL  
LIABILITY INSURANCE PROGRAM**

**Medical Staff Member Application  
and  
Participation Agreement**

**COREWELL HEALTH PHYSICIANS INSURANCE COMPANY  
APPLICATION AND PARTICIPATION AGREEMENT**

**PHYSICIAN MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM**

To participate in the insurance program, an eligible medical staff member must complete in full and sign this application and agreement which, in part, describes the terms of the risk management and loss prevention programs, and the common defense feature of the professional liability insurance provided.

**SECTION A: GENERAL INFORMATION**

**Contact Information**

Name of Applicant: \_\_\_\_\_ M.D./D.O./Other \_\_\_\_\_

**At which Corewell Health hospital(s) do you currently have privileges?**

Corewell Health Hospitals				
Place a check mark next to each hospital where you have staff privileges				
<input type="checkbox"/>	Big Rapids	<input type="checkbox"/>	Greenville	<input type="checkbox"/>
<input type="checkbox"/>	Blodgett	<input type="checkbox"/>	Grosse Pointe	<input type="checkbox"/>
<input type="checkbox"/>	Butterworth	<input type="checkbox"/>	Helen Devos	<input type="checkbox"/>
<input type="checkbox"/>	Dearborn	<input type="checkbox"/>	Lakeland	<input type="checkbox"/>
<input type="checkbox"/>	Farmington Hills	<input type="checkbox"/>	Ludington	<input type="checkbox"/>
<input type="checkbox"/>	Gerber	<input type="checkbox"/>	Niles	<input type="checkbox"/>
			Pennock	<input type="checkbox"/>
			Reed City	<input type="checkbox"/>
			Royal Oak	<input type="checkbox"/>
			Taylor	<input type="checkbox"/>
			Trenton	<input type="checkbox"/>
			Troy	<input type="checkbox"/>
			Watervliet	<input type="checkbox"/>
			Wayne	<input type="checkbox"/>
			Zeeland	<input type="checkbox"/>

**What is your level of Medical Staff Membership?**

<input type="checkbox"/>	Active	<input type="checkbox"/>	Ambulatory
<input type="checkbox"/>	Attending	<input type="checkbox"/>	Courtesy Staff with Privileges
<input type="checkbox"/>	Associate	<input type="checkbox"/>	Other?

Specialty/Type of Practice: \_\_\_\_\_

Medical License Number: \_\_\_\_\_ State: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Applicant's Email Address: \_\_\_\_\_ Gender: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Name of Practice/P.C./Partnership: \_\_\_\_\_

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

Office Manager/Contact Person: \_\_\_\_\_

Office Manager Phone: \_\_\_\_\_ Office Manager Email: \_\_\_\_\_

Main Office Address: \_\_\_\_\_ Suite/Building #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

Other office address(es): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Residence Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Res. phone number: \_\_\_\_\_

**COREWELL HEALTH PHYSICIANS INSURANCE COMPANY  
APPLICATION AND PARTICIPATION AGREEMENT**

**Education/Training**

	Facility	City, State	Start Date	End Date
Facility Medical School:	_____	_____	_____	_____
Residency:	_____	_____	_____	_____
Fellowship:	_____	_____	_____	_____

**Hospital Medical Staff Membership** (Please list both Corewell Health and Non-Corewell Health Facilities)

Hospital	Classification of Membership	Approximate % of Patients Admitted
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

1. Are you currently employed by any hospital?  Yes  No  
 If yes, please indicate the name of the hospital(s) \_\_\_\_\_  
 If yes, please provide the number of hours worked per week per your employment agreement. \_\_\_\_\_
  
2. For the coverage you are requesting from CHPIC, on average, what are your total hours worked including, but not limited to, hospital, office, home visits, nursing homes, etc. per week? \_\_\_\_\_  
*If you are employed by another hospital AND malpractice coverage is provided to you as part of your employment agreement, please do not include those hours in this total.*
  
3. Do you share or lease office space with another independently practicing physician?  Yes  No  
*(not as an employee, employer or independent contractor)* If Yes, please explain/provide name of physician:  
 \_\_\_\_\_

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4. Will you be insured by any other medical professional liability insurance program while this insurance is in effect?  
 No  
 Yes *If Yes, please attach proof of coverage from the other insurer and explain.*
  
5. Are you a member of Beaumont ACO, a physician and health system partnership?? . (For more information, visit [www.beaumont-aco.org](http://www.beaumont-aco.org))  
 No  Yes

**SECTION B: PROFESSIONAL INFORMATION**

**IF THE ANSWER TO ANY OF THE QUESTIONS IN SECTION B. IS YES, ATTACH SEPARATE DETAILED PARTICULARS.**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you licensed to practice medicine, dentistry or podiatry in the State of Michigan? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Please list each state and dates that you have ever been licensed and practiced in?    |                          |                          |

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3a. Please identify the current specialty that applies to your practice. (See Attachment 1 for listing)

	No Surgery	Minor Surgery	Major Surgery
Specialty: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subspecialty: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- |  | YES                      | NO                       |   |
|--|--------------------------|--------------------------|---|
| 3b. Has your scope of specialty changed? | <input type="checkbox"/> | <input type="checkbox"/> | If so, please attach an explanation with dates.                   |
| For example:                             |                          |                          | 1. OB/GYN and you no longer perform deliveries                    |
|  |                          |                          | 2. Orthopedic Surgeon and you no longer perform neck/back surgery |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 4. Have you ever had any State medical license or Federal narcotic license denied, revoked, suspended, restricted or voluntarily surrendered, or have you been subject to a consent order, probation or any conditions or limitations by any state licensing board? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had your driver's license suspended or revoked due to alcohol or substance abuse or other physical disability?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had or been treated for alcoholism, narcotics addiction or mental illness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been convicted of a felony or crime arising out of your medical practice?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever received a reprimand or been fined by any state licensing board?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been investigated by any payer, including the Federal Government, related to your billing and business practices?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been excluded from participating with any payer, including the Federal Government, related to your billing and business practices?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been convicted at the State or Federal level related to your billing and business practices?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a chronic illness or physical defect?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had any hospital staff or similar privileges refused?   | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION B: PROFESSIONAL INFORMATION (CONTINUED)**

**IF THE ANSWER TO ANY OF THE QUESTIONS IN SECTION B. IS YES, ATTACH SEPARATE DETAILED PARTICULARS.**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 14. Have you ever had any defined hospital staff or similar privileges restricted, modified, suspended or revoked, or voluntarily surrendered in lieu of the aforementioned actions being taken? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had your membership in a professional society refused, suspended or revoked?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a grievance filed against you with any licensing board or medical society?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had medical professional liability insurance refused, canceled or non-renewed within the last five years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. To your knowledge, is your license to practice currently under investigation?  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 19. Have you had a claim, received a "notice of intent" or been sued for medical professional liability within the last five years and/or do you have any outstanding claims, "notices of intent" or lawsuits? <i>(See attachment 4 for a supplemental claim form; complete a form for each claim/notice/suit)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If you have been claim free within the last five years, you are required to submit a loss run from your insurance carrier dated within the last 30 days.

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20. Is your practice currently recognized as a Patient Centered Medical Home (PCMH)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Does your office utilize Electronic Health Record (EHR) technology?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, what is the official name of the EHR Company? _____  |                          |                          |
| 22. Do you do stress testing in your office?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are you currently ACLS Certified? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span> |                          |                          |
| 23. Do you provide laboratory services in your office?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide the level of CLIA** certification your office holds.  |                          |                          |

\*\*Clinical Laboratory Improvement Amendments (CLIA) level of certification should be one of the following: Certificate of Waiver, Certificate for Provider Performed Microscopy (PPM) Procedures, Certificate of Registration, Certificate of Compliance or Certificate of Accreditation

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 24. Do you perform any procedure involving general or regional anesthetics?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you reduce fractures?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you practice in an emergency room, trauma, urgent care or surgical center?     | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, please explain: _____   |                          |                          |
| _____   |                          |                          |
| 27. Do you have an urgent care clinic or provide urgent care services in your office? | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION B: PROFESSIONAL INFORMATION (CONTINUED)**

**IF THE ANSWER TO ANY OF THE QUESTIONS IN SECTION B. IS YES, ATTACH SEPARATE DETAILED PARTICULARS.**

	YES	NO
28. Do you perform proctoscopy and/or sigmoidoscopy?	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you perform scopic procedures which penetrate the skin or enter into the body cavity? <i>(including, but not limited to, flexible sigmoidoscopy with biopsy, colonoscopy, gastroscopy, bronchoscopy)</i> If YES, please identify those scopic procedures:  _____	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you perform biopsies?	<input type="checkbox"/>	<input type="checkbox"/>
31. Do you perform kyphoplasty in your office? If yes, please provide evidence of appropriate training. Additional information may be requested.	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you perform any procedures in your office or other non-hospital facility that require the use of general or regional anesthetics or intravenous sedation? If YES, who administers? _____ AND, please attach evidence of license and appropriate training.	<input type="checkbox"/>	<input type="checkbox"/>
33. Do you deliver babies?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
34. On average, what are your total hours worked including, but not limited to, hospital, office, home visits, nursing homes, etc. per week? _____ <i>If reduced due to semi-retirement, partial disability, dependent care or pregnancy, please complete Section F.</i>		
35. Have you completed your postgraduate training within the last 3 years? <i>If YES, provide year completed _____ and complete Section H.</i>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
36. Do you perform any laser procedures in your office or other non-hospital facility?	<input type="checkbox"/>	<input type="checkbox"/>
37. Do you perform any dermatological procedures in your office or other non-hospital facility, including (but not limited to) Botox injections, chemical peels or Microdermabrasion? If YES, please attach a comprehensive list of all dermatology procedures.	<input type="checkbox"/>	<input type="checkbox"/>
38. Do you participate in any pharmaceutical testing, clinical trial or clinical research programs? If YES, please attach a description.	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
39. Do you perform any of the following services including, but not limited to, physical therapy/rehabilitation, sleep clinic, CT's, MRI's or medical spa in your office?	<input type="checkbox"/>	<input type="checkbox"/>
40. Do you engage in any "moonlighting" activity apart from your practice? If Yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
41. Do you practice medicine on the internet or via a telemedicine program? If YES, what is the website address and in what state(s)? _____	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
42. Do you practice Alternative/Supplemental Care in addition to your routine specialty in your office? If YES, please explain and attach certification.	<input type="checkbox"/>	<input type="checkbox"/>
43. If you are not a radiologist,		
a. Do you take and/or interpret your own X-rays or perform other imaging procedures? If YES, estimated number per year: _____	<input type="checkbox"/>	<input type="checkbox"/>
If YES, does a radiologist over-read your X-rays?	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION C: INFORMATION SECURITY & PRIVACY INSURANCE (Cyber)**

*Provides a comprehensive solution to privacy breaches and information security exposures, specifically tailored to the needs of physician groups.*

*Refer to the Summary for additional information on the Cyber policy.*

Coverage is only available if all physicians employed by your practice are insured with CHPIC. If all physicians are insured with CHPIC, then your group will be issued a separate policy at no additional premium. If not all are insured, then you can either 1) request a quote for coverage (subject to additional premium) by providing the information below or 2) reject coverage. Coverage under the Cyber policy is on a claims made basis. Consequently, in the event that the Cyber policy is cancelled or non-renewed, the physician or physician group should consider purchasing tail coverage, and CHPIC will provide a premium quote. Note that the cancellation or non-renewal of the medical professional liability insurance policy will also result in the cancellation or non-renewal of the Cyber policy, unless a separate Cyber policy is purchased

YES

NO *If NO and you would like this coverage for your group, please provide their names, insurers and limits (attach additional pages, if necessary) and we will provide you with the additional premium for the group. Otherwise, please check the box to reject the coverage offering:*

Reject Coverage

NAME	INSURER	LIMITS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

**You acknowledge and agree that any misrepresentation with respect to the above will nullify and void the information security and privacy liability insurance (Cyber) coverage issued by the Company in reliance upon this information.**

**COREWELL HEALTH PHYSICIANS INSURANCE COMPANY  
APPLICATION AND PARTICIPATION AGREEMENT**

**SECTION D: CURRENT MEDICAL PROFESSIONAL LIABILITY INSURANCE**

Insurance Co: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Policy Period: \_\_\_\_\_  
Retroactive Date: \_\_\_\_\_

**NOTE: Physicians who currently have claims made coverage will maintain the same retroactive date on your new policy as your current policy, regardless of your desired effective date.**

Coverage Form (please check):  Claims Made\*     Modified Claims Made     Occurrence

**DOCUMENTATION REQUIRED: A copy of your current insurance “face sheet” or policy declarations page evidencing retroactive date, limits, etc. MUST be attached to this application.**

*\*If Claims Made, you must complete Attachment 2 – page 15.*

Current Limit of Liability:  \$100,000 per claim/\$300,000 annual aggregate  
 \$200,000 per claim/\$600,000 annual aggregate  
 \$300,000 per claim/\$900,000 annual aggregate  
 \$1,000,000 per claim/\$3,000,000 annual aggregate  
 Other \_\_\_\_\_

**SECTION E: MEDICAL PROFESSIONAL LIABILITY COVERAGE REQUESTED**

1. Desired effective date of coverage: \_\_\_\_\_

2. Coverage Form:     Modified Claims Made     Claims Made

Modified Claims Made – provides coverage for claims based upon medical incidents that occurred while the insured participated in the program regardless of when the claim is made, even if reported after the physician leaves the program. This extended reporting period (“tail”) coverage will be provided automatically through policy renewal in future years. There will be no additional premium for this enhanced “tail” coverage.

Claims Made – provides coverage for claims reported to the insurer during that policy year which are based upon medical incidents that occurred subsequent to the effective date of coverage with the insurer issuing the policy. If the insurance is cancelled or non-renewed, there is no coverage for claims subsequently made unless extended reporting period (“tail”) coverage is purchased for an additional premium.

3. Primary Coverage:  \$100,000 per claim/\$300,000 annual aggregate \*  
 \$200,000 per claim/\$600,000 annual aggregate  
 \$300,000 per claim/\$900,000 annual aggregate  
 \$1,000,000 per claim/\$3,000,000 annual aggregate

4. Excess Coverage:

\$800,000 excess of \$200,000 per claim/\$600,000 aggregate Primary Coverage

Available only when \$200,000/\$600,000 limits are purchased from this Program and applies **only** to claims arising out of treatment at Corewell Health scheduled facilities. Subject to a \$1,000,000 total policy aggregate. In the event the \$600,000 annual aggregate limit of liability is exhausted, there shall not be any excess coverage.

*\*Limits of \$100,000 per claim/\$300,000 annual aggregate will be discontinued effective January 1, 2026.*

**SECTION F: PC/LLC/PARTNERSHIP COVERAGE**

Your Professional Corporation, Limited Liability Company or Partnership will be covered as an additional insured under medical professional liability at NO ADDITIONAL charge to you. The applicable policy limits will not be increased. In all cases, professional corporation, partnership and LLC coverage extends to the entity only for liability arising out of covered activities of insured physician.

Please provide the complete Professional Corporation, Limited Liability Company or Partnership name:

\_\_\_\_\_

\_\_\_\_\_

Please advise your relationship with a Medical Corporation/Professional Organization as one of the following:

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Sole Proprietor                      | <input type="checkbox"/> Employee               | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sole Practitioner (Incorporated)     | <input type="checkbox"/> Independent Contractor |                                      |
| <input type="checkbox"/> Sole Practitioner (NOT Incorporated) |   |                                      |

Please provide the number of physicians working at the Professional Corporation, Limited Liability Company or Partnership? \_\_\_\_\_

Please list all physicians employed by the Professional Corporation, Limited Liability Company or Partnership? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate the number of the following allied healthcare providers employed by your practice:

- |                       |                    |                     |                        |
|-----------------------|--------------------|---------------------|------------------------|
| ___ Nurse Anesthetist | ___ Nurse Midwife  | ___ Physician Asst. | ___ Nurse Practitioner |
| ___ Perfusionist      | ___ Surgical Asst. | ___ Nurse           | ___ Physical Therapist |
| ___ EMT-Paramedic     | ___ Medical Asst.  | Other: _____        |                        |

*NOTE: Certain allied healthcare providers may be required to purchase their own policy. (i.e. CNM's)*

***(Please continue to next page)***

**SECTION F: PC/LLC/PARTNERSHIP COVERAGE (CONTINUED)**

If you employ or otherwise supervise allied health professionals, such as physician assistants and nurse midwives, please complete the following chart identifying the allied health professionals employed by your PC, LLC or Partnership, and the level of supervision. Also include individuals who may not be employed by your PC, LLC or Partnership and whom you supervise.

Name	Licensure	Type of Supervision		
		General	Direct	Personal
<i>Ex: Jane Doe</i>	<i>Physician Assistant</i>		X	

**General supervision** means the services of the allied health professional are furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the services.

**Direct supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the services of the allied health professional. It does not mean that the physician must be present in the room when the allied health professional performs his or her services.

**Personal supervision** means a physician is in attendance in the room during the performance of the allied health professional’s services.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Do you supervise any healthcare providers other than those employed by your practice?<br>If YES, please list facility, specialty, licensure, number supervised and type of supervision:<br>_____        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you supervise any residents or interns in your office?<br>If YES, please list facility, specialty and number supervised: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you contract with any third party to provide medical services in your office?<br>If YES, please attach a description of the medical service provided including the name of the third party.          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you wish to purchase ADDITIONAL limits of liability for your medical organization? <b>There is an additional charge for this coverage.</b><br><i>If YES, please complete Attachment 3 – page 16.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION G: SUPPLEMENTAL APPLICATION FOR PART-TIME PHYSICIAN  
RATES AND STATEMENT OF ELIGIBILITY REQUIREMENTS**

Part-time status is verified, and attested to by a witness, upon the initial application and each renewal and may be verified, as requested, by the Program either through payroll records, periodic statement of hours worked or an on-site (office) audit.

A physician is eligible for part-time coverage if he or she satisfies general participation eligibility requirements and:

1. The physician must either:
  - a. be semi-retired to age (55 or older);
  - b. have reduced practice due to partial disability; or
  - c. have reduced practice due to pregnancy or dependent care
  - d. for any other reason, have reduced practice to 30 hours per week or less
  
2. I am eligible for part-time rates by virtue of Criteria \_\_\_\_\_  
*(Please insert the appropriate letter a, b, c or d from 1. above).*
  
3. On average, what are your total hours worked including, but not limited to, hospital, office, home visits, nursing homes, etc. per week? \_\_\_\_\_

I certify that I have read and understand the above part-time criteria.

I agree to cooperate and assist the program in verifying my part-time status.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION H: SUPPLEMENTAL APPLICATION FOR POST-TRAINING PHYSICIAN  
RATES AND STATEMENT OF ELIGIBILITY CRITERIA**

A physician is eligible for post-training rates if he or she satisfies general participation eligibility requirements and:

The physician must be entering private practice within three years of having completed his/her post graduate training (residency, fellowship or military service) without having had any previous practice.

I certify that I have read and understand the above post-training criteria and I state that I am eligible for such premium discount by virtue of having completed my \_\_\_\_\_ (training) at \_\_\_\_\_ (institution) on \_\_\_\_\_ (date).

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION I: RISK MANAGEMENT, LOSS ASSESSMENT AND COMMON DEFENSE**

I agree that I will adhere to the following program requirements:

1. To participate in the complimentary office assessment, including facility and patient record review.
2. Comply with risk management and quality assurance programs and recommendations made by any Corewell Health affiliated hospital or Corewell Health Physicians Insurance Company and to cooperate with each of them in achieving loss prevention and risk management objectives.

To accept defense counsel selected by Corewell Health Physicians Insurance Company for all claims against me. I understand that joint defense will be provided by counsel selected by Corewell Health Physicians Insurance Company should a claim be asserted against me and any Corewell Health affiliated hospital and/or other insured physicians. I also understand that separate counsel for me will be selected by Corewell Health Physicians Insurance Company if it determines that joint defense may not be appropriate in a given situation. In the event I desire to select independent co-counsel, the expense of that co-counsel will be borne by me.

3. To cooperate in the defense and investigation of all claims against or involving me.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***REMINDER.....***

**PLEASE ATTACH THE FOLLOWING DOCUMENTS TO THIS APPLICATION:**

- Please provide a list of your clinical privileges at all hospitals at which you hold staff privileges.
- Please provide a copy of your current insurance “face sheet” or policy declarations page.
- Please provide your complete loss history from current insurer dated within last 30 days, which should include a minimum of all claims reported since January 1, 2019
- Supplemental Claim Information Form (Attachment 4) for each notice of intent, claim or lawsuit, regardless of outcome.

*If any of these documents are unavailable, please attach an explanation.*

**SECTION J: AUTHORIZATION, CERTIFICATION AND ACKNOWLEDGEMENT**

Authorization: I authorize and release Corewell Health Physicians Insurance Company, its designee(s), their directors, or agents (herein called “insurer”) from all liability for obtaining information from individuals or institutions concerning me, my competence or qualifications and eligibility for the insurance program.

I also authorize and release the insurer from all liability for obtaining from any hospital any and all information regarding any proceedings or action taken by any hospital regarding appointment, reappointment and/or clinical privileges (including the grant, extension, reduction, suspension or termination thereof), utilization review or quality assurance information and any other information concerning my competence and qualifications that the insurer feels is pertinent. I also authorize insurer to share with Corewell Health and its affiliated hospitals any and all information it obtains in connection with reviewing my application and, if applicable, providing coverage to me that relates to my professional competence or conduct.

I consent to the release of all individuals from any liability who submit information at the request of the insurer to facilitate the assessment of my qualifications for insurance coverage which include my professional competence, character and ethics. I release from liability and hold harmless the insurer for acts in good faith and without malice in connection with the evaluation of my qualifications.

The authorization, release and consent set forth above apply to this application and any subsequent renewal application submitted by me or someone acting on my behalf.

Certification: I certify that all information provided in connection with this application is true, accurate and complete to the best of my knowledge. I understand that any material misrepresentation or omission in this application shall automatically void any and all coverage which may be issued to me.

I further certify that I meet the following eligibility requirements: (1) Corewell Health: active, attending, associate, courtesy with privileges or ambulatory medical staff; (2) valid Michigan license; (3) actively support and participate in risk management and quality assurance programs; and (4) participate in office assessments.

Acknowledgment: I acknowledge that I am obligated to notify the insurer, within thirty (30) days of the date of change, of any change in the scope of my practice, my clinical privileges at any institution, the procedures I perform, or other factors which may affect the risk under all policies by which I am insured.

**NOTE: THIS APPLICATION WILL NOT BE PROCESSED UNTIL IT IS FULLY COMPLETED. "FULLY COMPLETED" MEANS YOU HAVE FILLED IN ANSWERS TO ALL QUESTIONS, PROVIDED SEPARATE EXPLANATIONS WHERE NECESSARY, SIGNED IN THE APPROPRIATE PLACES, COMPLETED SUPPLEMENTARY CLAIM FORM FOR EACH OUTSTANDING CLAIM/LAWSUIT AND ALL CLOSED CLAIMS/LAWSUITS AND ATTACHED THE CURRENT DECLARATIONS PAGE FROM EXISTING INSURANCE CARRIER.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**ATTACHMENT 1: SPECIALTY CLASSIFICATION**

For classification assignment purposes, the following phraseology is defined:

1. The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (*other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia, proctoscopy, sigmoidoscopy, or laparoscopy*), and who do not ordinarily assist in surgical procedures.
2. The term "minor surgery" applies to general practitioners and specialists who perform minor surgery (*including obstetrical procedures not constituting major surgery*) or assist in major surgery on their own patients. Minor surgery will include laser procedures, catheterization, cardioelectrophysiology, endoscopy (other than proctoscopy or sigmoidoscopy) and vasectomies.
3. The term "major surgery" applies to general practitioners and specialists who perform surgery, other than minor surgery, and to those who assist at major surgery on other than their own patients. Tonsillectomies, adenoidectomies, hemorrhoidectomies, diagnostic D&C's and vacuum curettage abortions during the first trimester of pregnancy are considered major surgery.

**CLASSIFICATIONS:** (*Please mark all classifications which apply to your practice.*)

- |  |   |
|--|---|
| <input type="checkbox"/> Abdominal Surgery           | <input type="checkbox"/> Neurosurgery                               |
| <input type="checkbox"/> Aerospace Medicine          | <input type="checkbox"/> Nuclear Medicine                           |
| <input type="checkbox"/> Allergy                     | <input type="checkbox"/> Nutrition                                  |
| <input type="checkbox"/> Anesthesiology              | <input type="checkbox"/> OB/GYN                                     |
| <input type="checkbox"/> Bronco-Esophagology Surgery | <input type="checkbox"/> Obstetrical Surgery                        |
| <input type="checkbox"/> Cardiac Surgery             | <input type="checkbox"/> Occupational Medicine                      |
| <input type="checkbox"/> Cardiology                  | <input type="checkbox"/> Oncology                                   |
| <input type="checkbox"/> Cardiovascular Disease      | <input type="checkbox"/> Ophthalmology                              |
| <input type="checkbox"/> Colon & Rectal Surgery      | <input type="checkbox"/> Oral Surgery                               |
| <input type="checkbox"/> Dermatology                 | <input type="checkbox"/> Orthopedic Surgery                         |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Orthopedic Surgery – No Neck or Back       |
| <input type="checkbox"/> Emergency Medicine          | <input type="checkbox"/> Otolaryngology                             |
| <input type="checkbox"/> Endocrinology               | <input type="checkbox"/> Otorhinolaryngology                        |
| <input type="checkbox"/> Family Practice             | <input type="checkbox"/> Pathology                                  |
| <input type="checkbox"/> Forensic/Legal Medicine     | <input type="checkbox"/> Pediatrics                                 |
| <input type="checkbox"/> Gastroenterology            | <input type="checkbox"/> Pharmacology                               |
| <input type="checkbox"/> General Practice            | <input type="checkbox"/> Physical Medicine/Rehabilitation/Physiatry |
| <input type="checkbox"/> General Surgery             | <input type="checkbox"/> Plastic Surgery                            |
| <input type="checkbox"/> Geriatrics                  | <input type="checkbox"/> Plastic/Otorhinolaryngology Surgery        |
| <input type="checkbox"/> Gynecology (No OB)          | <input type="checkbox"/> Podiatry                                   |
| <input type="checkbox"/> Hand Surgery                | <input type="checkbox"/> Psychiatry                                 |
| <input type="checkbox"/> Head & Neck Surgery         | <input type="checkbox"/> Pulmonology                                |
| <input type="checkbox"/> Hematology                  | <input type="checkbox"/> Radiology                                  |
| <input type="checkbox"/> Infectious Disease          | <input type="checkbox"/> Rheumatology                               |
| <input type="checkbox"/> Intensive Care Medicine     | <input type="checkbox"/> Rhinology                                  |
| <input type="checkbox"/> Internal Medicine           | <input type="checkbox"/> Thoracic Surgery                           |
| <input type="checkbox"/> Laryngology                 | <input type="checkbox"/> Trauma Surgery                             |
| <input type="checkbox"/> Nephrology                  | <input type="checkbox"/> Urology                                    |
| <input type="checkbox"/> Neurology                   | <input type="checkbox"/> Vascular Surgery                           |

**ATTACHMENT 2: STATEMENT OF NO KNOWN INCIDENTS**

Physicians who currently have claims made coverage must sign and date the following Statement of No Known Incidents in order to maintain the same retroactive date on your new policy as your current policy.

**STATEMENT OF NO KNOWN INCIDENTS**

I am requesting claims made coverage with a retroactive date of: \_\_\_\_\_

My signature below confirms: As of the date hereof, I am not aware of any medical incidents which could reasonably result in a claim being made against me, arising out of the rendering or failure to render professional services on or after the retroactive date listed above. I have no knowledge of any request for medical records which might result in a claim. No prior professional liability carrier has refused coverage for, or declined to accept a report of a medical incident, threat of a claim, letter of intent, adverse result notice or attorney contract. Further, I have reported any and all previously received notices of intent or other assertions of claims to my current insurer.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**ATTACHMENT 3: ADDITIONAL PC/LLC/PARTNERSHIP LIMIT OF LIABILITY**

Professional Corporation, Limited Liability Company or Partnership coverage (“medical organization”) is available for an additional premium should you desire to purchase separate limits of liability for your medical organization. All physician, dentists, or podiatrist members and employees of your medical organization must obtain coverage with the same limits of liability through the program in order to purchase the additional limits. Only primary limits are available to the medical organization.

Do you wish to purchase ADDITIONAL limits of liability for your medical organization?

**There is an additional charge for the coverage.**

YES  NO

1. Please provide name of Professional Corporation, Limited Liability Company or Partnership:

\_\_\_\_\_

2. Please list all medical staff (each licensed, certified or registered physician, nurse, nurse practitioner, surgical assistant, physician’s assistant, certified nurse midwife or other allied health personnel you employ, sponsor or supervise\*) members who participate in the professional corporation, limited liability company or partnership (provide additional listing if needed).

Name	Licensure	Type of Supervision		
		General	Direct	Personal
<i>Ex: John Smith, M.D.</i>	<i>Physician</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>Ex: Jane Doe</i>	<i>Physician Assistant</i>		X	

**General supervision** means the services of the allied health professional are furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the services.

**Direct supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the services of the allied health professional. It does not mean that the physician must be present in the room when the allied health professional performs his or her services.

**Personal supervision** means a physician is in attendance in the room during the performance of the allied health professional’s services.

\*This list is for underwriting purposes only and does **not** result in coverage for those listed hereon.

**ATTACHMENT 4: SUPPLEMENTAL CLAIM INFORMATION FORM**

Copy this form as needed; a separate form must be completed for each claim, “notice of intent” or lawsuit reported.

1. Age and gender of patient: \_\_\_\_\_  
*(PLEASE DO NOT PROVIDE PATIENT NAME)*
2. Date of first consultation: \_\_\_\_\_
3. Physical condition and diagnosis on above date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Dates of treatment given and nature of same: \_\_\_\_\_  
\_\_\_\_\_
5. Date of claim, “notice of intent” or lawsuit and allegations made against you:  
\_\_\_\_\_
6. Disposition of claim (i.e. open, closed dismissed) and amount of judgement, reserves or settlement:  
\_\_\_\_\_  
\_\_\_\_\_
7. What professional liability insurance company, if any, is covering this claim on your behalf:  
\_\_\_\_\_
8. What limits: \$ \_\_\_\_\_ / \$ \_\_\_\_\_
9. Subsequent condition of patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Provide names of other physicians/hospitals, if any, involved in the claim, notice or lawsuit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Provide name and phone number of someone we contact for additional information about this claim, notice or lawsuit: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## **ATTACHMENT 5: INSTALLMENTS**

The program includes an installment payment option for payment of premium **if your premium is in excess of \$5,000 and you join the program between January 1 and June 30**. You have no obligation to elect the installment payment option, and if you wish, you may choose to pay 100 percent of your annual premium within 30 days of the effective date of your coverage for that policy year (the “Effective Date”). If you elect to pay the premium in one lump sum you will pay a lower cash discount base rate. If you choose the installment payment option, a slightly higher base premium rate will apply. The differential added to yield this higher rate is the time charge for the additional administrative costs associated with processing installment payments and also recognizes the delayed timing of cash flow.

If you elect the installment payment option, your premium, at the higher base rate applicable to this option, must be paid as follows:

- a) 40% of total annual premium for a policy year due and payable within 30 days of the Effective Date;
- b) 30% of total annual premium due and payable on or prior to 90 days after the Effective Date; and
- c) 30% of total annual premium due and payable on or prior to 180 days after the Effective Date.

You have no obligation to prepay any payment. If you elect the installment payment option, full payment of all the annual premium on or prior to the dates specified in paragraphs a) through c) above will be a condition precedent to coverage under the policy for you, and nonpayment of any of the foregoing amounts on or prior to ten days after the date on which written notice of cancellation is mailed to you, with postage fully prepaid thereon, will cause immediate termination of all of your coverage as of the date specified in the notice of cancellation as to all claims (*including covered expenses*) made on or after the date of cancellation specified in the notice of cancellation. If coverage has been terminated as described in this paragraph, later payments will not reinstate any such coverage.

**IF YOU ELECT THE INSTALLMENT PAYMENT OPTION, YOU ARE AGREEING TO ALL OF THE TERMS AND CONDITIONS SET FORTH IN THIS SECTION. YOUR SIGNATURE IS ALSO AN ACKNOWLEDGEMENT THAT YOU DESIRE TO PURCHASE INSURANCE COVERAGE FOR YOUR PROFESSIONAL ACTIVITIES, THAT ALL OF THE TERMS AND CONDITIONS OF YOUR PAYMENT OPTION SET FORTH IN THIS SECTION HAVE BEEN FULLY EXPLAINED TO YOU AND YOU UNDERSTAND AND AGREE TO ALL SUCH TERMS AND CONDITIONS.**

- I elect to pay my premium in full within 30 days of the Effective Date of my coverage.
- I elect to pay my premium through the installment option as described above.  
(Subject to eligibility and minimum premium of \$5,000)

*(Please note: If neither payment option is checked, then premium will be due in full within 30 days of the Effective Date of coverage)*

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date