

BERKLEY SELECT LLC

EMS Medical Director – GROUP PRACTICE Application Checklist

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION:

1. COPIES OF ALL EMS MEDICAL DIRECTOR CONTRACTS WITH MUNICIPALITIES OR OTHER ENTITIES INTENDED FOR COVERAGE, IF AVAILABLE
2. EMS DIRECTOR JOB DESCRIPTION

***NOTE:** The coverage for which you are applying is NOT intended to replace standard Medical Malpractice Insurance if you are a physician in private practice or are employed as a physician in addition to your duties as an EMS Medical Director. Please read the policy carefully.

Complete ALL areas of the application, indicating “N/A” when necessary.

Return the completed application to:

Lapre Scali & Company Insurance Services, LLC
c/o Thomas James
6200 Coors Blvd NW #K-3
Albuquerque NM 87120
Phone: 1-505-899-2068 or 1-866-577-7833
Fax: 1-505-217-0570
Email: tjames@laprescali.com

BERKLEY SELECT LLC

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Emergency Medical Services – Medical Directors – Group Practice

THE COVERAGE IS ON A CLAIMS MADE AND REPORTED BASIS.
PLEASE READ THE COVERAGE CAREFULLY.

(PLEASE TYPE OR PRINT IN INK)

1. Applicant's Name: _____
First Middle Initial Last

DBA: _____

City State Zip Code

This address is: Home Office

Phone: _____ Fax: _____

Email: _____ Website: _____

Tax ID: _____

2. Applicant is:
 Individual Corporation Professional Association Other: _____

Date of Incorporation: _____

3. Limits of Liability desired for Professional Liability:
 \$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000
 \$500,000/\$1,500,000 \$1,000,000/\$1,000,000 \$1,000,000/\$3,000,000
 Other: _____

4. a. Effective Date Desired: _____ 6b. Retroactive Date Desired: _____

5. How many EMS Medical Directors are associated with this entity/group? _____

6. Are the EMS Medical Directors
 employees _____
 independent contractors _____

to this entity/group?

BERKLEY SELECT LLC

EMERGENCY MEDICAL SERVICES MEDICAL DIRECTORS PROFESSIONAL LIABILITY CLAIM/CIRCUMSTANCE/ADMINISTRATIVE HEARINGS SUPPLEMENT

APPLICANTS INSTRUCTIONS:

- Complete one form for each claim or circumstance reported in the last ten (10) years involving you or your medical license.
- If space is insufficient to answer any question, use the reverse side or attach a separate sheet.
- Answer all questions.

(PLEASE TYPE OR PRINT)

1. Name(s) of individual(s) in the company named in the claim: _____
2. Name of claimant: _____
3. To what insurance company did you report this claim or incident? _____
 - 3a. Date of alleged error: _____
 - 3b. Date reported: _____
 - 3b. Date first notice received: _____
4. Present status of claim (check one): in suit open circumstance closed
 - 4a. If closed:
 - i. Total damages paid: \$ _____
 - ii. What is your percentage of the total settlement of all parties involved in this claim? _____ %
Total defense costs paid (including any deductible paid), if known: \$ _____
Indicate whether: court judgment out of court settlement.
 - 4b. If in suit or open: (Complete if known)
Amount asked in summons: \$ _____
Claimant's settlement demand: \$ _____
Defendant's offer for settlement: \$ _____
Insurer's loss reserve*: \$ _____
Defense costs paid to date: \$ _____
Your deductible that will apply to this claim: \$ _____
5. Description of claim (provide enough information to allow evaluation and attach a separate page if additional space is required). Alleged act, error or omission upon which claimant bases claim:

