

# BERKLEY SELECT LLC

## EMS PHYSICIAN SUPPLEMENT – GROUP PRACTICE

**PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION:**

1. PROOF OF MEDICAL MALPRACTICE INSURANCE IF THE APPLICANT ALSO IS A PRACTICING PHYSICIAN\*
2. CURRENT CURRICULUM VITAE
3. LICENSE NUMBERS FOR ALL STATES IN WHICH APPLICANT IS LICENSED TO PRACTICE MEDICINE

**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.

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

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**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](mailto:tjames@laprescali.com)

1. Applicant's Name: \_\_\_\_\_  
First Middle Initial Last DBA

Address: \_\_\_\_\_  Home  Office

City State Zip Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Website: \_\_\_\_\_

2. Social Security #: \_\_\_\_\_ Tax ID: \_\_\_\_\_

3. Date of Birth: \_\_\_\_\_  Male  Female

4. Is the applicant a licensed physician in Good Standing?  Yes  No

License #	State	Expiration Date	% Of practice in this state

5. Practitioner DEA Number: \_\_\_\_\_

6. Medical Specialty Information:

6a. Principal Medical Specialty in which you practice: \_\_\_\_\_ 6b. % of practice time: \_\_\_\_\_

6c. Sub-Specialty in which you practice: \_\_\_\_\_ 6d. % of practice time: \_\_\_\_\_

6e. Currently Held Board Certifications and Dates: \_\_\_\_\_

6f. Medical School and Year Graduated: \_\_\_\_\_

6g. Residency Information/Additional Training: \_\_\_\_\_

6h. Fellowship Training: \_\_\_\_\_

7. Name of Hospital/Facility: \_\_\_\_\_ Name of Hospital/Facility: \_\_\_\_\_

Name

Name

City State Zip Code

City State Zip Code

Specialty: \_\_\_\_\_

Specialty: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_  
mo./yr. mo./yr.

From: \_\_\_\_\_ To: \_\_\_\_\_  
mo./yr. mo./yr.

Completed:  Yes  No

Completed:  Yes  No

8. Are you employed outside of your duties as an EMS Medical Director?  Yes  No

8a. If "Yes," check the appropriate boxes:  Hospital Emergency Department  Urgent Care Facility  
 Faculty  Other: \_\_\_\_\_

8b. Duties: \_\_\_\_\_  
 Full-Time  Part-Time

8c. Do you carry Physician's Medical Malpractice Insurance for the above duties?  Yes  No

If Yes, attach a copy of the certificate of insurance or indicate if coverage/indemnification is provided to you by your employer. NOTE: If you are a general/family practice physician, proof of insurance is REQUIRED.

If "No," please provide an explanation.

**NOTE: The rendering of medical services outside your capacity as an EMS Medical Director is specifically excluded from coverage for which you are applying.**

9. Do you currently carry insurance as an EMS Medical Director?  Yes  No  
If "Yes," please provide a copy of your policy declarations.

10. Have you:

10a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association?  Yes  No

10b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No

10c. Ever been treated for alcoholism or drug addiction?  Yes  No

10d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  Yes  No

10e. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? (not allowed in MO)  Yes  No

10f. Ever had your hospital privileges denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?  Yes  No

10g. Had any malpractice claim or suit brought against you within the past ten (10) years? **If "Yes," please complete the Claim/Circumstance/Administrative Hearings Supplement for each claim/suit brought against you in the past and submit complete copies of all office/hospital records, summons and complaint, etc.**  Yes  No

10h. Had any professional liability and/or Employment Practices Liability claims or incidents made against you, the applicant, or anyone proposed for this insurance?  Yes  No

If "Yes," how many? \_\_\_\_\_  
If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

10i. Been made aware of any facts or circumstances, which might give rise to a medical malpractice, professional liability or Employment Practices Liability claim or complaint?  Yes  No

If "Yes," how many? \_\_\_\_\_  
If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

10j. Been made aware of any charges, inquiries, investigations, grievances or other administrative or disciplinary hearings?  Yes  No

If "Yes," how many? \_\_\_\_\_  
If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

**SIGNATURE SECTION AND OTHER INFORMATION**

**NOTE:** Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

**THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.**

**THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.**

**THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.**

**THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.**

**THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.**

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**FRAUD WARNING (Applicable in Tennessee and Washington): 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 AND DENIAL OF INSURANCE BENEFITS.**

**APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.**

\_\_\_\_\_  
Signature of Principle (must be owner, partner, or officer)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Principle (must be owner, partner, or officer)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date