310 East 4500 South, Suite 600
Salt Lake City, Utah 84107-3993
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# APPLICATION FOR INDEPENDENT CORPORATION/PARTNERSHIP PROFESSIONAL LIABILITY INSURANCE

PLEASE TYPE OR PRINT RESPONSES AND ANSWER ALL QUESTIONS. COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETE.

**COVERAGE REQUESTED TO COMMENCE 12:01 AM ON ______________________________(MO/DAY/YR)**

**1. CORPORATION/PARTNERSHIP COVERAGES** **Policy Number** ______________________
(For UMIA use only)

Please check type of coverage desired:

☐ Vicarious ☐ Non-vicarious

Do you desire "Prior Acts" coverage? ☐ Yes ☐ No

If "Yes," on what date do you desire the Prior Acts coverage to commence?______________________

Billing Mode Desired:

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

(Only the monthly billing mode carries an interest charge)

**2. NAME AND ADDRESS OF CORPORATION/PARTNERSHIP**

______________________________________________
Name

______________________________________________
Address City State Zip Telephone

______________________________________________
President/Director

______________________________________________
Business Manager/Administrator

Please identify the name, address and telephone number of any satellite offices.

______________________________________________
Name Address City State Zip Telephone

______________________________________________
Name Address City State Zip Telephone

______________________________________________
Name Address City State Zip Telephone

**3. SHAREHOLDERS/PARTNERS**

Please list all shareholders or partners of the corporation or partnership. Include specialty, current insurer, and expiration date of current professional liability

______________________________________________
Name Specialty Insurer Exp. Date

______________________________________________
Name Specialty Insurer Exp. Date

______________________________________________
Name Specialty Insurer Exp. Date

______________________________________________
Name Specialty Insurer Exp. Date

______________________________________________
Name Specialty Insurer Exp. Date

## 4. PHYSICIAN EMPLOYEES

Please list all physician employees of the corporation or partnership. Include specialty, current insurer, and expiration date of current professional liability policy.

| Name | Specialty | Insurer | Exp. Date |
|---|---|---|---|
| Name | Specialty | Insurer | Exp. Date |
| Name | Specialty | Insurer | Exp. Date |
| Name | Specialty | Insurer | Exp. Date |
| Name | Specialty | Insurer | Exp. Date |

## 5. ANCILLARY PERSONNEL

Please list all professional employees of the corporation or partnership. Include the degree/title and insurer for each.

| Name | Degree/Title | Insurer |
|---|---|---|
| Name | Degree/Title | Insurer |
| Name | Degree/Title | Insurer |
| Name | Degree/Title | Insurer |
| Name | Degree/Title | Insurer |

## 6. PRACTICE INFORMATION

Do you operate any hospital, sanitarium, clinic with bed facilities, laboratory or business enterprise other than X-ray or pathological laboratory?

## 7. CLAIM INFORMATION

Has a claim or suit for alleged malpractice been brought against the applicant in the past ten years? ☐ Yes ☐ No
Please give details on a separate sheet.

## 8. INSURANCE INFORMATION

Is the professional association, partnership or business currently insured?

| Company Name | Limit of Liability | Policy Number |
|---|---|---|

Has any insurer canceled, declined coverage or refused renewal for any similar insurance? ☐ Yes ☐ No
If "Yes" give complete details on a separate sheet.

Does the professional association, partnership or business currently contract with an HMO or PPO which requires you to hold them harmless or indemnify them with the contract? ☐ Yes ☐ No

All agreements or contracts, including hold harmless agreements and agreements to assume the liability of others are specifically excluded from coverage under the insurance applied for herein.

I certify that all information is true and correct and I authorize release and exchange of information involving either underwriting or claims matters between all prior insurance carriers and the Utah Medical Insurance Association.

Signature - President/Partner　　　　　　　　　　　　　　　　　　　　　　　　Date