PLICO Inc. 226 Dean A. McGee Suite 200 Oklahoma City, OK 73102 · P.O. Box 1838 Oklahoma City, OK 73101-1838
Accounting (405) 815-4824 · Claims (405) 815-4802 · Underwriting (405) 815-4801 · Risk Mgmt (405) 815-4803 · Fax (405) 815-4900

ERRORS AND OMISSIONS FOR SELECTED ADMINISTRATIVE HEALTHCARE SERVICES COVERAGE APPLICATION

This policy provides claims-made coverage. Please read the entire policy carefully.

This insurance covers **bodily injury and pecuniary loss** as a result of Administrative Services Only. Administrative Services include Case Management, Chart Review, Consulting Expert Services, Credentialing, Expert Witness Services, Independent Medical Examinations, and Medical Director Services.
The endorsement does not cover fiduciary liability or liability for professional services to a patient being treated by you.

I. GENERAL INFORMATION

Name of Individual Applicant: _____

Mailing Address (Principal Practice Address):

_____

_____

PLICO Policy #: _____ Date of Birth: _____

Work phone: _____ Work email:_____

Cell phone: _____Personal mail: _____

II. COVERAGE REQUEST

Requested Effective Date: _____

III. ENTITY/FACILITY INFORMATION

Entity/Facility #1

Entity/Facility Name (provide both the legal and d/b/a name, if applicable):

_____

Entity/Facility Address: _____

Describe the type of entity/facility and the services provided by. Please attach a copy of the contract.

_____

_____

Does the entity/facility provide insurance coverage for your services? If yes, attach a copy of the Certificate or other verification to this application.

_____

Prior Acts Date (Retroactive Date): _____

Entity/Facility #2

Entity/Facility Name (provide both the legal and d/b/a name, if applicable):

_____

Entity/Facility Address: _____

Describe the type of entity/facility and the services provided by you. Please attach a copy of the contract.

_____

_____

Does the entity/facility provide insurance coverage for your services? If yes, attach a copy of the Certificate or other verification to this application.

_____

Prior Acts Date (Retroactive Date): _____

Entity/Facility #3

Entity/Facility Name (provide both the legal and d/b/a name, if applicable):

_____

Entity/Facility Address: _____

Describe the type of entity/facility and the services provided by you. Please attach a copy of the contract.

_____

_____

Does the entity/facility provide insurance coverage for your services? If yes, attach a copy of the Certificate or other verification to this application.

_____

Prior Acts Date (Retroactive Date): _____

List any additional entities or facilities on a separate sheet.

IV. CLAIMS AND DISCIPLINARY INFORMATION

Has any claim ever been made against you arising from any duty described in Section III.?

Yes_____ No_____
If yes, complete the Supplemental Claim Information Form for each claim and attach 5 years of current value loss runs.

Are you aware of any incidents, arising from any of the duties described in Section III, which may result in a claim against you?

Yes _____ No _____

Have you ever had any license, certification, or privileges revoked, suspended or restricted, or have you been subject to any disciplinary proceeding, been reprimanded by an administrative agency, professional association or peer review committee?

Yes _____No_____
If yes, provide details:_____

_____

V. NOTICES AND AGREEMENTS

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted. I agree to notify the Company of any material changes to the information contained in this Application or its attachments.

I UNDERSTAND that the statements and answers herein will be relied upon by PLICO and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE any professional societies, prior, or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to PLICO, or to the Oklahoma State Medical Association (Association) upon the request of either. I authorize the use of a copy of this authorization in place of the original.

In order to facilitate the risk management program, I authorize **PLICO** to provide the Association with any records and information concerning claims arising under any policy or insurance issued in connection with this application.

I declare that to the best of my knowledge and belief I have reported all known incidents, claims, and suits to my previous or current carrier(s), and that I have no knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit, and no knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last 10 years that have not been reported to the applicable insurance company or risk transfer entity (self-insured retention plan).

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

Signature_____

Printed Name_____

Date_____

APPLICABLE IN ARKANSAS

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and civil penalties.

APPLICABLE IN OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Please send the application & supporting documentation to PLICO Business Development, *protect@plico.com* or fax to 405.815.4900.

Thank you for requesting Selected Administrative Healthcare Services Coverage. Evidence of coverage will be furnished to you by email or fax.