Professional Program Insurance Brokerage is a
Division of SPG Insurance Solutions, LLC ©2024

Thank you for your trust in PPIB to support you with your Insurance needs. We're thrilled to do business with you and help protect what matters most to you. To get started, please follow these steps:

How to Submit Application

1. Complete Application -- Fill out the required information on the next few pages.
2. Save Application -- Once completed, save a copy to your computer so you can email it.
3. Sign Application -- Ensure it is signed by the business owner, either electronically or printed and signed.
4. Submit Application -- Send signed application to **submissions@ppibcorp.com.**

What to Expect Next?

After receiving your application, we will send you a confirmation email acknowledging receipt.

Within 3-5 business days, one of our insurance experts will reach out to you with any follow-up questions or a quote, depending on the status of your submission.

If you need the quote expedited, please indicate this when you submit your application via email.

If you need further assistance with the application, or have additional questions, please feel free to contact us at:

PHONE:
415.475.4300
877.655.0123

FAX:
415.475.4303

Submissions: submissions@ppibcorp.com

Let's Get Started

Fill Out Application on Next Page

MEDICAL DIRECTOR PROFESSIONAL LIABILITY APPLICATION

SECTION I: GENERAL INFORMATION

1. Applicant Name (First, Last): ____________________
2. Email Address: ____________________ Phone Number: ____________________
3. Your Mailing Address: ____________________
   City: ____________________ State: __________ Zip Code: __________
4. Primary Business Address: ____________________
   City: ____________________ State: __________ Zip Code: __________
   Type of Facility: ____________________
5. How many facilities do you oversee? ____________________
6. Check type of Medical Designation: ☐ MD ☐ DO ☐ Ph.D. ☐ NP ☐ PA ☐ Other: __________
7. Annual Gross Income from Medical Director Operations only: $____________________
8. Do you currently have Medical Malpractice insurance? ☐ Yes ☐ No
   a. If Yes, indicate below:
   Insurer: *Liability Limits:* *Exp. Date:*
   ____
9. Do you currently have insurance for Medical Director Oversight? ☐ Yes ☐ No
   a. If Yes, indicate below:
   Insurer: *Liability Limits:* *Exp. Date:* *Premium:* *Retro Date (if applicable)*
   ____

SECTION II: OVERSIGHT QUESTIONS

1. Name ALL entities for which you are a Medical Director **(i.e. Sam's Laser, SF Fire Department)**:

2. Do you oversee any operations in a state other than your home state? ☐ Yes ☐ No
   a. If Yes, confirm you have appropriate licensing for each state in which you are operating. ☐ Yes ☐ No
3. Do you have any % of ownership of any of the facilities that you are overseeing? ☐ Yes ☐ No
   a. If Yes, does the facility have a separate primary professional liability (malpractice) policy in place with at least $1M per claim and $3M aggregate limits? *(Provide copy)* ☐ Yes ☐ No
4. Do you provide any Direct Patient Care as a Medical Director? ☐ Yes ☐ No
   a. If Yes, what percentage of your Medical Director time is spent doing Direct Patient Care? __________%
   b. Describe: ____________________
5. All locations and Medical Professionals must have professional liability (malpractice) insurance for all services provided. Do you agree to make this a contractual requirement for being a Medical Director? ☐ Yes ☐ No
6. Have you signed a contract making you ***solely*** responsible for the acts of the professionals you oversee? ☐ Yes ☐ No
   a. If Yes, send a copy of the contract.
7. Do you have any oversight of MDs, DOs or PAs? ☐ Yes ☐ No

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SECTION III: GENERAL OPERATIONS OF FACILITIES YOU OVERSEE

**** Select All Descriptions that Apply ****

Aesthetics / Cosmetic Facilities

- ☐ Clinics
- ☐ Weight Loss Clinics
- ☐ Cryotherapy Centers
- ☐ Medical Spas / Day Spas Cosmetic / Plastic Surgery

Civic Facilities

- ☐ Fire Departments
- ☐ EMT / EMS
- ☐ Police Departments
- ☐ Correctional Facilities
- ☐ Private Emergency First Responders
- ☐ Federal / State / City / County Departments (other than listed above)

Business / Educational Facilities

- ☐ Occupational Health
- ☐ Staffing Firms
- ☐ School Districts
- ☐ Educational Facilities
- ☐ Private Business Facilities
- ☐ Medical / Billing Consulting
- ☐ Workers Compensation Carrier Consults

Care Facilities

- ☐ Family Clinics
- ☐ Physical Therapy
- ☐ Home Health
- ☐ Occupational Therapy Centers
- ☐ Adult Day Care
- ☐ Addiction Rehab Facilities
- ☐ Memory Care
- ☐ Psychiatric Hospitals / Facilities
- ☐ Counseling & Psychology Centers
- ☐ Non-Medical Assisted Living Facilities
- ☐ Hospice / Palliative Care Facilities
- ☐ Hospitals Including Emergency Services
- ☐ Nursing Homes, Skilled Nursing Facilities, Long Term Care Facilities

Specialized Medicine

- ☐ Sexual Health Clinics
- ☐ Fertility Clinics
- ☐ Abortion Clinics
- ☐ Podiatry Clinics
- ☐ Wound Care Facilities
- ☐ Kidney Dialysis Centers
- ☐ Oncology Clinics
- ☐ Chiropractic Facilities
- ☐ Pain Management Clinics
- ☐ Pediatric Focused Care Facilities
- ☐ Surgicenters / Outpatient Surgery
- ☐ Clinics utilizing Psilocybin, Ketamine Therapy, DMT or any other psychedelics

Diagnostics

- ☐ Sleep Centers
- ☐ Laboratories
- ☐ Radiology Centers

Other

- ☐ Cannabis Dispensaries
- ☐ Other: ______________________________________

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SECTION IV: OPTIONAL COVERAGES

If this section does not apply, check here ☐

1. Do you want coverage for License Action Reimbursement? ☐ Yes ☐ No — If Yes, Indicate Limit: ☐ $25K ☐ $50K
2. Do you want coverage for HIPAA Defense? ☐ Yes ☐ No — If Yes, Indicate Limit: ☐ $250K ☐ $500K
3. Do you need coverage for any guest medical director(s)? ☐ Yes ☐ No
   a. If Yes, provide name(s): ______________________________
4. Do you have an Additional Insured (AI) who needs to be listed on your policy? ☐ Yes ☐ No
   a. AI Name: ______________________________
   b. Address: ______________________________ Business Location #: __________
   c. Does the AI require the following? ☐ Primary / Non-Contributory Wording ☐ Waiver of Subrogation
   d. Interest of Additional Insured? ☐ Managing Services Organization (MSO) ☐ Billing / Office Entity ☐ Government Entity ☐ Other: ______________

SECTION V: HISTORY

Note - ALL questions must be answered. Failure to disclose claims history could invalidate coverage.

1. Have you ever had professional liability (malpractice) insurance refused, declined, canceled or accepted on special terms? ☐ Yes ☐ No
   a. *If Yes, describe:*
2. Has any liability suit, arbitration or other claim proceeding been brought against you or your business for any alleged malpractice? ☐ Yes ☐ No
   a. *If Yes, describe:*
3. Do you have knowledge of an event, circumstance, or occurrence prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No
   a. *If Yes, describe:*
4. Has your license or certificate ever been investigated, limited, revoked, suspended, refused, canceled or voluntarily surrendered by, or to, any state or federal licensing board or regulatory agency? ☐ Yes ☐ No
   a. *If Yes, describe:*
5. Have you ever been charged or convicted of a criminal offense? ☐ Yes ☐ No
   a. *If Yes, describe:*
6. Have you ever been treated for substance abuse or chemical dependency? ☐ Yes ☐ No
   a. *If Yes, describe:*

MEDICAL DIRECTOR PROFESSIONAL LIABILITY APPLICATION

SECTION VI: ATTESTATION

On Behalf of ALL operations, I confirm:

1. Claims from 'Failure to Diagnose' will be EXCLUDED from the insurance policy.
2. No medical / lab director coverage will be offered for any service unless specifically endorsed on to the policy and a premium is paid.
3. All facilities I oversee have a separate professional liability (malpractice) insurance policy in place to cover the legal entity(ies) providing services.
4. I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy.
5. I understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.
6. I authorize and consent to investigation of information of my business including authorization to every person or entity, public or private, to release the company, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application but shall include any other sources of information deemed relevant by the Company as may be authorized by law.
7. If I am aware of any claim or incident that could arise from any time prior to today, while working as the medical director, I must advise underwriters at this time.
8. The liability policy applied for will apply only to CLAIMS MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is canceled or terminated, whichever comes first or as otherwise provided by the policy.
9. I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY APPLICANT WITHIN 30 DAYS PRIOR TO BINDING (60 DAYS FOR RENEWALS). SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE INSURANCE COMPANY.

______________________________ APPLICANT SIGNATURE

______________________________ TITLE

______________________________ DATE SIGNED

______________________________ REQUESTED EFFECTIVE DATE

LIABILITY LIMIT REQUESTED:

☐ $1M / $3M ☐ Other: ______________