

APPLICATION FOR OTHER RELATED
PERSONS (ORP) COVERAGE

This portion is to be completed by the MPT Member or Group administrator:

As an authorized person of this medical practice, I hereby request that MPT provide coverage as specified in Article VIII, Section 8(e) of the MPT Agreement to the person for whom this application is being submitted, who is employed by or related to the practice of:

(Member/Group name and CAP/Group #)

Date Coverage Desired: _____

Expected Duration of Coverage: _____

Describe the Scope of Practice for ORP: _____

Name of office contact person for employee
matters: _____

Phone Number: () _____

Fax Number: () _____

Email: _____

Please be advised:

- Until this application is approved, MPT will not provide any coverage to the MPT Member(s) or the employee/related person for any act, error, or omission of the employee/related person.
- If professional liability coverage is provided to this employee/related person, it will only be for practice related to the practice of the MPT Member(s). If this individual has a practice separate from the practice of the MPT Member(s), MPT will not provide coverage for that activity.

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✓ APPLICATION CHECKLIST:

The following documents are required to effectively process your application:

- Current copy of your Curriculum Vitae (CV).**

Please complete this application according to any practice for which you want coverage.

PERSONAL INFORMATION

Last Name	First Name	Middle Name	<input type="checkbox"/>	M.D.
			<input type="checkbox"/>	D.O.
E-Mail Address		Pager Number		
California Medical License No.	Social Security Number	Date of Birth		

PROFESSIONAL DISCLOSURE

Has any governmental agency ever investigated, suspended, revoked or taken any other action against either your narcotics license or your license to practice medicine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever used any intoxicant, narcotic or other psycho-active drug to the extent that it either has interfered with your ability to perform professional services or caused you to seek medical advice or treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever pleaded "no contest" or been convicted of a crime other than a routine traffic violation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever had privileges at any hospital or other institution reduced, revoked, restricted, suspended or refused?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Has any professional liability carrier ever terminated, restricted or modified your coverage (e.g., reduced limits; applied a deductible, surcharge or co-payment), or have you ever been denied professional liability insurance by any malpractice carrier?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If you have answered "yes" to any of the above questions, please explain fully on a separate page.				

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CLAIMS HISTORY

YOU WILL HAVE NO COVERAGE FROM MPT FOR ANY KNOWN CLAIMS OR INCIDENTS THAT MAY LEAD TO A CLAIM OR LAWSUIT. ALL CLAIMS OR INCIDENTS THAT MAY LEAD TO A CLAIM OR LAWSUIT SHOULD BE REPORTED TO YOUR CURRENT MALPRACTICE INSURER BEFORE TERMINATING YOUR EXISTING POLICY. (COVERAGE FOR ANY SUCH LAWSUITS, CLAIMS, OR INCIDENTS UNDER YOUR CURRENT MALPRACTICE INSURANCE POLICY DEPENDS UPON THE TERMS OF THAT POLICY.)

Definitions: A Claim is a demand for money from a patient or on a patient's behalf, a 90-day notice of intention to sue, a lawsuit, a counterclaim, or a demand for arbitration.

An Incident is any injury, death, or damage to a patient with whom you are or were involved that may lead to a claim, whether or not you believe you were at fault. Incidents include any contentions of malpractice or injury, any threat of legal action, or any letters or written reports complaining about the medical care of a patient with whom you or your employees, associates, or any other person related to your practice were involved.

1. Have any malpractice Claims ever been made against you? Yes No
2. Number of Claims _____
3. Have all Claims been reported to your current/past malpractice insurer(s)? Yes No
4. Number of Incidents or threats _____
5. Have all Incidents and threats been reported to your current/past malpractice insurer(s)? Yes No

If you answered "yes" to any of the above questions, please complete a Claim Form for each Claim or Incident.

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DISCLOSURES

REPRESENTATIONS AND WARRANTIES: I hereby warrant the truth of all statements and answers contained in this application. I have not withheld any facts about my professional practice which are reasonably calculated to or may influence the judgment of Mutual Protection Trust in considering this application. I understand that if I have withheld any material facts concerning the risk exposure of my professional practice and MPT is made aware of my lack of disclosure, I will have no coverage for any claims that may arise due to my lack of disclosure and my coverage with CAP-MPT may be rescinded. I agree to notify CAP-MPT in a timely manner of information regarding an open claim or incident as it becomes available to me. I acknowledge that coverage through MPT is governed by the MPT Agreement. I understand and agree that I have no right to receive any information regarding the basis or reasons for any decision about my application. I further understand that my professional liability coverage does not become effective until my application has been accepted.

AGREEMENT TO CONDITIONS OF COVERAGE: I acknowledge that I am an "Other Person Related (ORP) to the Practice of the MPT Member," as set forth in Article VIII of the MPT Agreement. I acknowledge that I do not have Membership status with the Cooperative of American Physicians, Inc./Mutual Protection Trust (CAP-MPT) and that my coverage from MPT depends on the Member's continuing agreement with MPT for such coverage.

As an Other Person Related to the Practice of an MPT Member, I agree that my interests in the defense and indemnity of any claim for which I seek coverage from MPT do not conflict with that of the Member or of the entity.

I agree to abide by the terms of Article VIII of the MPT Agreement (a copy of which I have received and read). I understand that I am covered by MPT only for my medical services rendered for the Member or entity. I also understand that coverage will be denied if my activities fall within the stated exclusions in Article VIII, Section 5 of the MPT Agreement.

I further understand that upon termination of my services with the Member or Entity, I will have tail coverage from MPT for claims arising out of those services provided on behalf of the Member or Entity.

REFERENCES: I authorize and direct any government agency, medical society, physician, hospital, insurance agent or company contacted by or on behalf of MPT to furnish any information concerning me or my medical practice which MPT may request. This authority extends to the release of information regarding professional liability coverage and claims. I also agree that any person or organization, together with the officers, directors, and agents, will not be liable in any way for furnishing such information even though the information may be incomplete or incorrect.

I authorize CAP-MPT to release information relative to my application to the individual or group under whose Membership I am covered as an Other Related Person as noted above.

Signature: _____ Date ____/____/____

Print Name: _____

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CLAIM FORM
Photocopy as Needed

INFORMATION REGARDING A LAWSUIT, CLAIM OR DEMAND FOR ARBITRATION OR
INCIDENTS WHICH COULD LEAD TO THE SAME

1. Name of Patient: _____ 2. Age: _____ 3. Sex _____

4. Your relationship to patient (i.e., attending physician, primary surgeon, asst. surgeon, etc.):

5. Date of Incident: ___/___/___ 6. Location: _____

7. Insurance Carrier: _____ 8. Other Defendants: _____

9. Present Status: Open Closed ___/___/___
Date

Incident Only 90 Day Notice Suit Filed Suit Served Arbitration

Method of Closing:

Dismissed

Defense Verdict

Settled Amount paid on your behalf: \$ _____ Total Settlement: \$ _____

Judgment- Amount paid on your behalf: \$ _____ Total Settlement: \$ _____

10. Patient's allegations or circumstances brought to your attention: _____

11. Condition and diagnosis at time of incident: _____

12. Dates and description of treatment rendered: _____

13. Condition of patient subsequent to treatment (and dates of follow-up treatment): _____

