



COOPERATIVE OF
AMERICAN PHYSICIANS

**APPLICATION FOR AN EMPLOYEE OR PERSON RELATED TO THE PRACTICE OF A
MEMBER OF THE COOPERATIVE OF AMERICAN PHYSICIANS, INC. (CAP) FOR
COVERAGE THROUGH MUTUAL PROTECTION TRUST (MPT)**

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

As the authorized person of this medical practice, I hereby request that MPT provide coverage to the person for whom this application is being submitted, pursuant to Part 1, Section 5 of the MPT Agreement, who is employed by or related to the practice of:

_____ or _____
(Member name) (Entity/Medical Group name)

Membership # _____ or Group # _____

Date of coverage desired (effective date): _____/_____/_____

Date of retroactive coverage desired: _____/_____/_____

This retroactive coverage period must be related to the practice of the Member or Entity identified above. A copy of a current declaration of coverage showing the retroactive coverage date must accompany this application for coverage. **PLEASE NOTE THAT IF RETROACTIVE COVERAGE IS APPROVED, THERE, WILL BE A ONE-TIME FEE CHARGED FOR THIS COVERAGE.**

Limits of liability* desired: Shared Separate
 \$1M/\$3M \$1M/\$3M
 \$2M/\$4M

*See page 9 for rates and an explanation of shared and separate limits. Separate limits are not available for all employee types.

How many hours does this employee/related person work per week? _____

Name of office contact person for employee matters:

Phone Number: (_____) _____

Fax Number: (_____) _____

E-mail Address: _____

PLEASE BE ADVISED:

- Until this application is approved, MPT will not provide any coverage to the Member physician(s) or the employee/related person for any Claim arising out of or related to any act, error, or omission of the employee/related person unless the employee/related person has other professional liability coverage with satisfactory limits of liability, as set forth in Part 1, Section 5.C of the MPT Agreement.

- If professional liability coverage is provided to this employee/related person, it will only apply to Professional Services provided for the practice of the Member(s) or Entity identified above. MPT will not provide any coverage for Claims that arise out of acts, errors or omissions of the employee/related person outside of the course and scope of that person's duties as an employee or person related to the practice of the Members(s).
- MPT reserves the right to discontinue coverage for this employee/related person with advance notice to the Member.

To be completed by the employee/person related to practice:

PERSONAL INFORMATION

1. Name: _____ 2. Job position: _____
3. Area of specialization: _____
(i.e., pediatrics, obstetrics, etc., if applicable)

NOTE: Please attach a copy of your Curriculum Vitae (CV) to this application..

4. Primary Office Location _____ Secondary Office Location _____
- _____
- Office Phone: () _____ Office Phone: () _____

5. Are you licensed, certified, or registered by a national or state agency? Yes No
- If yes, license/certification/registration number: _____

6. Has any disciplinary action ever been taken against your certification, licensure, or registration? Yes No
- If yes, please explain: _____
- _____

7. Have you ever been accused of having sexual relations with a patient or of treating a patient while under the influence of drugs and/or alcohol? Yes No
- If yes, please explain: _____
- _____

8. Are you currently in compliance with all continuing education requirements imposed by law for license, certificate, or registration renewal? Yes No

CLAIMS INFORMATION

1. Have you ever had a medical malpractice claim filed against you? Yes No

If yes, please complete a claim report form (page 7) for each claim or suit that has been made against you.

2. Are you aware of any incidents involving any patient care or treatment rendered by you or to which you were a party which could result in litigation involving you? Yes No

If yes, please complete a claim report form for each incident.

If additional forms are needed, please make copies or request more from MPT.

TRAINING AND WORK EXPERIENCE APPLICABLE TO YOUR PROFESSION

Name of Institution: _____

City/State: _____

Dates of Training: from: / / to: / /
month/year month/year

Degree/certification: _____ Specialization: _____

Name of Institution: _____

City/State: _____

Dates of Training: from: / / to: / /
month/year month/year

Degree/certification: _____ Specialization: _____

Note: Include professional work experience during the last seven (7) years.

<u>Dates of employment</u>	Physician or Facility	
_____ to _____	Address	
mo/yr mo/yr		
Phone Number: ()	City	State Zip

<u>Dates of employment</u>	Physician or Facility	
_____ to _____	Address	
mo/yr mo/yr		
Phone Number: ()	City	State Zip

<u>Dates of employment</u>	Physician or Facility	
_____ to _____	Address	

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If yes, indicate the types of medication furnished:

5. Please list your furnishing number if applicable. _____

6. Do you provide prenatal services? Yes No

If yes, up to what week? _____

7. Do you attend or assist at deliveries? Yes No

Please note:

All physician assistants and nurse practitioners are required to attend CAP's Risk Management Program within ninety (90) days of the effective date of their coverage. A schedule will be sent with our approval letter if this application is approved.

IMPORTANT FOR ALL PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS: A copy of written protocol between yourself and your supervising physician is on file in the office for referral if necessary at all times.

Yes No

If "No," MPT will not grant professional liability coverage to you.

CLAIM REPORT

(Photocopy as Needed)

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

4. Name of primary treating physician: _____

5. Your relationship to patient _____

6. Date of Incident: ____/____/____ 7. Location: _____

8. Insurance Carrier: _____ 9. Other Defendants: _____

10. 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: \$ _____

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

12. Condition and diagnosis at time of incident: _____

13. Dates and description of treatment rendered: _____

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

I understand that MPT will not provide professional liability protection services for Claims against me arising out of Professional Services, as described above, rendered to the above-named patient.

Signature of Employee/Related Person:

Date Signed:

REPRESENTATIONS AND WARRANTIES

Each of the undersigned represents, warrants and understands the following:

MPT will not provide any coverage for Claims arising out of the acts, errors or omissions of the employee/related person which occurred prior to the approval date of this Application, unless the employee/related person has other professional liability coverage with satisfactory limits of liability, as set forth in Exhibit B to the MPT Agreement.

We hereby warrant the truth, accuracy, and completeness of all statements contained in this Application. We understand that MPT will rely upon these statements and answers in making its decision to approve or deny this Application. No facts, events, acts, errors, omissions or circumstances known to the Member(s) and employee/related person have been withheld from the responses to the questions in this Application. We understand that if any facts have been withheld there will be no coverage for any Claims that may arise out of such withheld facts. We agree to notify MPT in a timely manner of any change to the information we have provided in this Application.

The Application for Coverage for an Employee or Person Related to a Member's Practice, if approved, will be incorporated by the reference into the MPT Agreement, and we agree to be bound by all the terms and conditions of the MPT Agreement.

This special application is deemed part of your membership in the Cooperative of American Physicians, Inc. (CAP) and professional liability protection through MPT. If approved, it is incorporated into such by this reference.

Signature of CAP Member or Authorized Representative

Date

Signature of Employee/Related Person

Date

**SCHEDULE OF ANNUAL RATES FOR
EMPLOYEES/PERSONS RELATED TO MEMBER'S PRACTICE
Effective January 1, 2007**

<u>Para-Professional</u>	<u>Shared Limit*</u>		<u>Separate Limit**</u>
	<u>\$1M/\$3M</u>	<u>\$2M/\$4M</u>	<u>\$1M/\$3M</u>
Acupuncturist	2,000	2,500	3,000
Chiropractor	2,000	2,500	3,000
Mental Health Professionals including:			
-Marriage and Family Therapist (MFT)	500	650	750
-Psychological Assistant	500	650	750
-Psychologist	700	900	1,050
-Licensed Clinical Social Worker (LCSW)	500	650	750
Nurse Practitioner	2,000	2,500	N/A
Occupational Therapist	350	450	525
Orthopedic Physician Assistant	800	1,000	1,200
Optometrist	1,000	1,250	1,500
Perfusionist	2,000	2,500	3,000
Pharmacist	300	375	450
Physical Therapist	350	450	525
Physician Assistant	2,000	2,500	N/A
***Podiatrist			
Employee Performing Cosmetic Procedures: including injections, lasers and permanent pigmentation	1,000	1,250	N/A
Estheticians performing microdermabrasion and light chemical peels	500	650	N/A

Full Time = More than 20 hours = full fee Part Time = Less than 20 hours = 50% fee

Minimum charge is one quarter (3 months) but no less than \$250 (Full Time).

Proration of charge is by the quarter; if coverage is provided during any part of quarter, charged is for the full quarter.

* A shared limit of liability for the employee/related person means that the MPT-covered CAP Member(s) is willing to share limits of liability with this employee/related person should a claim occur due to the acts, errors, or omissions of this person while he or she is acting within the course and scope of his or her duties as an employee or person related to the Member's practice.

** A separate limit of liability for this employee/related person means that the employee/related person has his or her own limits of liability which are separate from the MPT-covered CAP Member's limits of liability should a claim occur due to the acts, errors or omissions of this individual while this individual is acting within the course and scope of his or her duties as an employee or person related to the Member's practice.

***Rate available based upon scope of practice.