COOPERATIVE OF AMERICAN PHYSICIANS

APPLICATION FOR MEMBERSHIP

IMPORTANT: If you are filling out this application online, you must use Adobe Reader. Other applications such as Apple Preview will not work.

Application Checklist

The following documents will be used to process your application. Please submit the documents with your completed application.

- ☐ Current copy of your curriculum vitae (CV).
- ☐ Current copies of all office/practice letterhead stationery.
- ☐ Certificate of Insurance or Declaration Page from your current malpractice carrier.
- ☐ If you have completed a residency or fellowship within the past year, provide two references from your program, including one from the Chief of Service. Also, on Page 8 of this application, provide two additional references of your choice.

Please indicate whether you are a member of one of the following physician organizations for which Mutual Protection Trust (MPT) is the preferred medical professional liability coverage provider:

- ☐ Coastal Physicians Purchasing Group (CPPG)
- ☐ Medical Practice Purchasing Group (MPPG)
- ☐ Monarch Healthcare
- ☐ NAMM California/MD Ops, Inc.
- ☐ Scripps Mercy Physician Partners
- ☐ Sharp Community Medical Group
- ☐ SynerMed

Complete this application for any practice for which you want coverage.

Retain a copy of your completed application for your records.

Submit your completed application to:

COOPERATIVE OF AMERICAN PHYSICIANS

Cooperative of American Physicians, Inc.
Membership Underwriting Department
333 S. Hope St., 8th Floor
Los Angeles, CA 90071
Fax: 213-473-8773

If you have questions, call 800-252-7706

COOPERATIVE OF AMERICAN PHYSICIANS

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Personal Information

Last Name | First Name | Middle Name | ☐ MD ☐ DO

Other Names Used (AKA) | Date of Birth _____/_____/_____ | ☐ Male ☐ Female

Social Security No. _____-_____-_____ | Employer IRS No. _____-_____ | CA Medical License No. _____

Specialty Information

Specialty: _____

Do you want professional liability coverage for this specialty? ☐ Yes ☐ No

ABMS Certified? ☐ Yes ☐ No

Do you have plans to complete your Boards? ☐ Yes ☐ No

If yes, when do you plan to take your exam? Oral _____ Written _____

Subspecialty: _____

Do you want professional liability coverage for this subspecialty? ☐ Yes ☐ No

ABMS Certified? ☐ Yes ☐ No

Do you have plans to complete your Boards? ☐ Yes ☐ No

If yes, when do you plan to take your exam? Oral _____ Written _____

Coverage and Referral Information

Requested Date of Coverage: _____/_____/_____

Requested Coverage Limits: ☐ $1M/$3M ☐ $2M/$4M ☐ Other: _____

CURRENT CARRIER: _____

DO NOT CANCEL YOUR CURRENT INSURANCE UNTIL COVERAGE THROUGH MPT BEGINS.

How did you *first* hear about the Cooperative of American Physicians, Inc. (CAP)?

☐ Member Physician (Name): _____

☐ Joining Member/Group (Name): _____

☐ Finder (Name): _____

☐ Mail: Letter/Brochure ☐ Exhibit Attendance ☐ Advertisement ☐ Website

☐ Other: _____

COOPERATIVE OF AMERICAN PHYSICIANS

APPLICATION FOR MEMBERSHIP

Addresses

Primary Office Address	City	State	Zip Code
Contact Person (Name/Title)	Primary Office Phone	Primary Office Fax	
Secondary Office Address	City	State	Zip Code
Contact Person (Name/Title)	Secondary Office Phone	Secondary Office Fax	
Pager Number	E-mail Address	Website Address	
Home Address	City	State	Zip Code
Home Phone	Home Fax	Cell Phone	E-mail Address
Other Address	City	State	Zip Code

Temporary? ☐ Yes ☐ No If yes, until when?______/______/______ Phone ____________________

Please indicate the appropriate address:

Primary Correspondence: ☐ Home ☐ Primary Office ☐ Secondary Office ☐ Other

Billing Address: ☐ Home ☐ Primary Office ☐ Secondary Office ☐ Other

Best phone number and/or e-mail address at which to contact you: ________________________________

Practice History

List all locations where you have practiced since residency. Begin with the most recent location (include military service).

☐ Solo ☐ Employee ☐ Group: Group Name: ____

City________________________ State_______ Country____________ From ___/___ To Present

☐ Solo ☐ Employee ☐ Group: Group Name: ____

City________________________ State_______ Country____________ From ___/___ To ___/___

☐ Solo ☐ Employee ☐ Group: Group Name: ____

City________________________ State_______ Country____________ From ___/___ To ___/___

☐ Solo ☐ Employee ☐ Group: Group Name: ____

City________________________ State_______ Country____________ From ___/___ To ___/___

Please explain all gaps in practice:

Training Information

Note: If the current CV you submitted with this application contains training information, you may skip this page.

Medical School: From: Mo _____ / Year _____ To: Mo _____ / Year _____

Name _____

City _____ State _____ Zip Code _____ Country _____

Internship: From: Mo _____ / Year _____ To: Mo _____ / Year _____ Specialty _____

Name _____

City _____ State _____ Zip Code _____ Country _____

Residency: From: Mo _____ / Year _____ To: Mo _____ / Year _____ Specialty _____

Name _____

City _____ State _____ Zip Code _____ Country _____

Residency: From: Mo _____ / Year _____ To: Mo _____ / Year _____ Specialty _____

Name _____

City _____ State _____ Zip Code _____ Country _____

Fellowship: From: Mo _____ / Year _____ To: Mo _____ / Year _____ Specialty _____

Name _____

City _____ State _____ Zip Code _____ Country _____

Other: From: Mo _____ / Year _____ To: Mo _____ / Year _____ Specialty _____

Name _____

City _____ State _____ Zip Code _____ Country _____

APPLICATION FOR MEMBERSHIP

Practice Information

Please provide information on the practice for which you want coverage. For a new practice, please estimate.

Number of patients seen weekly: _____ Number of hours worked weekly: _____

Number of deliveries per month (if applicable): _____

Do you practice any form of complementary medicine? ☐ Yes ☐ No

Do you perform any procedures outside the scope of your medical specialty? ☐ Yes ☐ No

Do you perform any invasive procedures in the office? ☐ Yes ☐ No

Do you perform any cosmetic procedures? ☐ Yes ☐ No

If yes to above questions, describe the practice or procedures. Include type of anesthesia (local/general/sedation):

_____

Do you have medical professional liability coverage from another insurer for any part of your medical practice for which you are not requesting coverage from MPT? ☐ Yes ☐ No

Have there been any recent changes in your practice, or do you expect a change soon? ☐ Yes ☐ No

If yes, please provide a brief description of this practice: _____

With whom do you share call: _____

_____

Hospital Privileges

Hospitals and surgery centers where you currently practice (or are applying for privileges).	City	State	Status Active/Pending	Must Total 100%
			☐ A ☐ P	%
			☐ A ☐ P	%
			☐ A ☐ P	%
			☐ A ☐ P	%

Employees/Contracted Personnel (Independent Contractors)

State the number of personnel you employ and contract with (other than clerical, RNs, LVNs, Medical Assistants, and Techs) and list them by name and position in the space below or in the Remarks Section on Page 10.

☐ Nurse Practitioner #: _____ ☐ Physician Assistant #: _____ ☐ Other: _____ #: _____

_____

_____

Do you request MPT to provide medical professional liability coverage for these workers? ☐ Yes ☐ No

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Entity Information

Are you currently practicing with or are you joining an MPT-covered Entity or Member(s)? ☐ Yes ☐ No

If yes, please provide the name of the Entity or Member(s) and describe your affiliation: _____

_____

Status: ☐ Partner/Shareholder ☐ Employee ☐ Independent Contractor ☐ Office Sharing

If you answered YES to the above, you do NOT need to complete the remaining questions on this page.

Do you provide medical care, advice, or treatment to patients on behalf of any Entity? ☐ Yes ☐ No

"Entity" is defined as: Any Health Facility, medical sole proprietorship, medical partnership, medical corporation, medical group, medical clinic, unincorporated association of Heathcare Practitioners formed for the purpose of practicing medicine, and any other personal, professional or business enterprise with which the Member has any association or relationship.

If yes, please provide the names of all the Entities for which you provide professional services:

_____

_____

What is your role in the Entity(ies), e.g. owner, employee, independent contractor? _____

_____

Do two or more physicians provide patient care on behalf of the Entity(ies)**? ☐ Yes ☐ No

Is the Entity(ies) a surgicenter, laboratory or other type of facility**? ☐ Yes ☐ No

If yes, what type? _____

Are you requesting coverage for the Entity(ies)? ☐ Yes ☐ No

If you are requesting Entity coverage, a separate application for Entity coverage may be required.

Do you:

Provide facilities or equipment to direct Healthcare Practitioners? ☐ Yes ☐ No

Provide personnel or administrative services to direct Healthcare Practitioners? ☐ Yes ☐ No

Share or lease office space or share staff with direct Healthcare Practitioners? ☐ Yes ☐ No

Bill for any direct Healthcare Practitioners? ☐ Yes ☐ No

Please list any other known physicians and non-physician Healthcare Practitioners associated with this practice other than call coverage and locum tenens: _____

_____

_____

**Additional fees apply when Entities have Healthcare Practitioners who are not covered through MPT and/or are given a separate limit of liability. Additional fees also apply when coverage is provided to most facilities (e.g., surgicenters).

Professional Disclosure

Has any governmental agency ever suspended, revoked, or taken any other action against either your narcotics license or your license to practice medicine?	☐ Yes	☐ No
Have you ever used any intoxicant, narcotic, or other psycho-active drug to the extent that it either interfered with your ability to perform professional services or caused you to seek medical advice or treatment?	☐ Yes	☐ No
Do you have any health condition that may impede your ability to practice medicine or perform surgery, if applicable, now or in the future?	☐ Yes	☐ No
Have you ever pleaded "no contest" or been convicted of a crime other than a routine traffic violation?	☐ Yes	☐ No
Have you ever had privileges at any hospital or other institution reduced, revoked, restricted, suspended, or refused?	☐ Yes	☐ 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 medical professional liability insurance by any carrier?	☐ Yes	☐ No

If you have answered "yes" to any of the above questions, please explain below.

Remarks Section

Please use this section for questions asked which need clarification. Use additional remarks field on page 10 if necessary. Also, please attach appropriate documentation (e.g., MBC action report, notice of cancellation).

Insurance History

Current carrier:	Policy number:	Limits of liability (in millions): ☐ $1/3 ☐ $2/4 ☐ Other: ___/___	From: ____/____/____ To: ____/____/____
Prior carrier:	Policy number:	Limits of liability (in millions): ☐ $1/3 ☐ $2/4 ☐ Other: ___/___	From: ____/____/____ To: ____/____/____
Prior carrier:	Policy number:	Limits of liability (in millions): ☐ $1/3 ☐ $2/4 ☐ Other: ___/___	From: ____/____/____ To: ____/____/____

List all periods you practiced without malpractice coverage:

From: ____/____/____ To: ____/____/____ Reason: _____

Claims History

All questions on this page must be answered.

You will not have any coverage whatsoever for any known Claims* and any known incidents that may lead to a Claim or lawsuit. All lawsuits, claims or incidents that may lead to a Claim should be reported to your current malpractice insurer before terminating your existing policy.

Known Claims or Incidents:

1. Have any malpractice Claims ever been made against you? ☐ Yes ☐ No
   (This includes all cases that were dismissed or "dropped.")
2. If you answered "**Yes**" to Question 1:
   a. Total Number of Claims: _____
   b. Have all Claims been reported to your current/past malpractice insurer(s)? ☐ Yes ☐ No

Within the last three years, have any of the following events occurred (whether or not you believe you were at fault):

3. Have there been any incidents that may have resulted in injury, death, or damage to a patient and that may lead to a Claim against you? ☐ Yes ☐ No
4. Have there been any allegations of medical malpractice, any contentions of injury or death due to medical treatment, any written or oral threats of legal action, or any letters, written reports, or oral complaints about the medical care of your patient, including, but not limited to a patient of your current or former employees, independent contractors, associates, or any other person related to your practice? ☐ Yes ☐ No
5. Have you received from an attorney any subpoena or a request for medical records of a patient? ☐ Yes ☐ No
6. Have you been subpoenaed for deposition involving the medical care of a patient? ☐ Yes ☐ No

If you answered "Yes" to any of the questions on this page, please complete a Claim form for all such Claims, incidents, and contacts.

* For purposes of this application, a Claim is any notice of intent, demand for arbitration, lawsuit, cross-complaint, counterclaim or demand for payment for injury, death or damages to a patient.

Retroactive Coverage

By checking **"Yes"** below, you are applying for retroactive coverage. This coverage is also known as "prior acts" coverage or "nose" coverage. If you are not requesting retroactive coverage, please check **"No."**

If you are approved for retroactive coverage, you will receive a Certificate of Coverage with a specified Retroactive Date. Thereafter, you will be entitled to the medical professional liability coverage described in the MPT Agreement, Part 1, for any **unknown** incidents that may lead to a lawsuit or other Claim based on an Occurrence that takes place after the Retroactive Date so specified. Retroactive coverage is not available for any period during which you had no medical malpractice coverage or which you had occurrence-type coverage or which you provided professional services outside of California.

☐ **YES**, I hereby apply for retroactive coverage through MPT for any unknown incidents that may lead to a lawsuit or other Claim based on an Occurrence in California that takes place on or after my Retroactive Date. I represent that I have and will continue to maintain uninterrupted claims-made professional liability coverage for all Professional Services rendered during the retroactive coverage period for which I am now seeking retroactive coverage through MPT. I further represent that I will maintain my current professional liability coverage up to the Effective Date of coverage through MPT

The retroactive coverage period will be determined from your current certificate of insurance or declaration page.

☐ **NO**, I decline retroactive coverage through MPT.

Was tail coverage purchased? ☐ Yes ☐ No

If yes, please provide a copy of the tail coverage endorsement.

This Application for retroactive coverage is deemed part of your Application for Membership and is incorporated by this reference to the MPT Agreement.

By my signature on page 9 of this Application for Membership, I declare under penalty of perjury that the foregoing is true and correct.

References

Please provide names of four physicians (preferably CAP members) familiar with your practice who we may contact.

Name _____ Specialty _____ City _____ State _____

Phone _____ Fax _____ E-mail _____

Name _____ Specialty _____ City _____ State _____

Phone _____ Fax _____ E-mail _____

Name _____ Specialty _____ City _____ State _____

Phone _____ Fax _____ E-mail _____

Name _____ Specialty _____ City _____ State _____

Phone _____ Fax _____ E-mail _____

APPLICATION FOR MEMBERSHIP

California law requires that you disclose any and all information known to you that may influence our decision to approve or deny your application for coverage. You also are obligated to inform CAP of any information that becomes known to you between the date of your signature below and the date your coverage becomes effective that would change your answers on the previous page **(Retroactive Coverage)**. You may report any additional information to Membership Underwriting Department by calling 213-473-8600 or 800-252-7706.

Representations and Warranties

I guarantee the truth, accuracy and completeness of all statements and answers provided in this application. I understand that CAP will rely upon these statements and answers in making the decision to approve or deny this application. No facts known to me or known to any employees or other persons related to my practice have been withheld. I understand that if any material facts have been withheld, I will not be entitled to medical professional liability coverage for any Claim arising out of such withheld facts and such coverage may be rescinded. I agree to immediately notify CAP of any change to the statements and answers provided in this application. I acknowledge that coverage through MPT is governed by the MPT Agreement. I further understand that medical professional liability coverage does not become effective until this application has been approved, I have accepted the membership agreement, and payments have begun.

Arbitration

I agree that any dispute or controversy arising out of or in connection with this application shall be submitted to and resolved by binding arbitration in Los Angeles, California. The arbitration shall be conducted pursuant to the terms of the MPT Agreement, Part 2, Section 9.

References

I understand that in order to provide me with medical professional liability coverage, CAP must have reasonable access to all information concerning me. Therefore, I authorize and direct any government agency, medicalsociety, physician, hospital, insurance company, underwriter, insurance agent or credit reporting agent contacted by or on behalf of CAP to furnish any information concerning me which MPT may request.
I also agree that any person or organization that furnishes information to CAP pursuant to this authorization, together with the officers, directors, agents and employees of such person or organization, will not be liable to me for furnishing such information even though the information may be incomplete or incorrect.

In addition, I understand and agree that I have no right to receive any information regarding the basis or reasons for any decisions about my application.

I declare under penalty of perjury in the state of California that the information given in this application is true and correct and that I have fully disclosed all information requested.

_____ _____

Signature Date

_____

Print Name

Additional Remarks

COOPERATIVE OF
AMERICAN PHYSICIANS

APPLICATION FOR MEMBERSHIP
CLAIM FORM

Please Submit as Many Claim Forms as Needed

1. Name of Patient: _____

2. Age: _____ 3. ☐ Male ☐ Female

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

_____

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

7. Insurance Carrier: _____

8. Other Defendants: _____

9. Current Status:

☐ Incident Only ☐ 90 Day Notice ☐ Suit Filed ☐ Suit Served ☐ Arbitration

☐ Open Indemnity Reserve Amount: $_____ Expense Reserve Amount: $_____

☐ Closed Date Closed: _____/_____/_____

Method of Closing (if applicable):

☐ Dismissed ☐ Defense Verdict

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

☐ Judgment: Amount paid on your behalf: $_____ Total Judgment: $_____

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 after treatment (and dates of follow-up treatment): _____

_____

14. Describe the nature of the injuries your patient alleges were sustained: _____

_____

15. Please print your name: _____

COOPERATIVE OF AMERICAN PHYSICIANS

APPLICATION FOR MEMBERSHIP

ADDITIONAL CLAIM FORM

Please Submit as Many Claim Forms as Needed

1. Name of Patient: _____

2. Age: _____ 3. ☐ Male ☐ Female

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

_____

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

7. Insurance Carrier: _____

8. Other Defendants: _____

9. Current Status:

☐ Incident Only ☐ 90 Day Notice ☐ Suit Filed ☐ Suit Served ☐ Arbitration

☐ Open Indemnity Reserve Amount: $_____ Expense Reserve Amount: $_____

☐ Closed Date Closed: _____/_____/_____

Method of Closing (if applicable):

☐ Dismissed ☐ Defense Verdict

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

☐ Judgment: Amount paid on your behalf: $_____ Total Judgment: $ _____

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 after treatment (and dates of follow-up treatment): _____

_____

14. Describe the nature of the injuries your patient alleges were sustained: _____

_____

15. Please print your name: _____