MEDICAL PROFESSIONAL LIABILITY ASSOCIATION

# REGULAR AND INDUSTRY ASSOCIATE MEMBERSHIP APPLICATION

## PART A | GENERAL INFORMATION

**1 Name of Applicant Organization** (Insurance Company) ____________________

**Date of Application** ____________________

**Name of Parent/Holding Co.** ____________________

**2 Corporate Address**

____________________
Mailing Address
____________________
Mailing City, State, Zip+4

____________________
Street Address (if different from mailing)
____________________
City, State, Zip+4

**3 Phone Number and Fax Number**

P ____________ F ____________

Please include all digits necessary for dialing from the United States

**Website Address** ____________________

**4 Company Executives or Chief MPL Professionals**

____________________
Name
____________________
Title

____________________
Name
____________________
Title

**Designated Representative to the MPL Association**[1]

____________________
Name
____________________
Title
____________ Phone ____________ Email

**Alternate Representative to the MPL Association**

____________________
Name
____________________
Title
____________ Phone ____________ Email

[1] The designated representative to the MPL Association is the individual who will receive a copy of all member mailings/emails distributed on a one-per-member basis, including administrative mailings (i.e. dues renewal notices, member surveys, etc.) and other important member program notices or alerts. All other contacts listed here will not receive mailings from the MPL Association unless requested or approved by the designated representative.

## PART B | INSURANCE COMPANY INFORMATION

**1 Date Chartered** ____________________ **Date Licensed** ____________________

**2 State Domiciled** ________ **State(s) Licensed to Operate** ____________________
(Enter 2 Letter Abbreviation)

**3 Ownership**

- ☐ Stock-Public
- ☐ Mutual
- ☐ Non-Insurance Trust
- ☐ Stock-Private
- ☐ Reciprocal or Exchange
- ☐ Other (Specify) ____________________

**4 Type/Structure**

- ☐ Admitted
- ☐ Trust
- ☐ Self-Ins. Plan
- ☐ Mutual Indemnification Org.
- ☐ RRG
- ☐ Captive
- ☐ Other (Specify) ____________________

**5 MPL Direct Written Premium** $ ____________ **As of Year End** ____________

**6 Total Assets** $ ____________ **As of Year End** ____________

**7 Number in Force**

| | | | | | |
|---|---|---|---|---|---|
| ______ | MDs/DOs | ______ | Advanced Practice Providers | ______ | Hospitals/Institutions |
| ______ | Interns/Residents | ______ | Allied Health Professionals | ______ | Clinics or Non-Hospital Facilities |
| ______ | Hospitalists | ______ | Podiatrists | ______ | Medical/Professional Groups |
| ______ | Dentists | ______ | Chiropractors | ______ | Other Entities |
| ______ | Oral Surgeons | ______ | Other Healthcare Providers (Specify) | | |

**8 Policy/Coverage Types Offered**

| Type | % of Policies | Type | % of Policies |
|---|---|---|---|
| Claims Made | ______ | CM/Prefunded Tail | ______ |
| Occurrence | ______ | Discretionary | ______ |
| Other (Specify) | | Other (Specify) | |

**9 What is your current official standing with your primary regulator (jurisdiction in which the company is domiciled)?** (Please attach a copy of the communication, if possible)

**10 Who comprises your Board of Directors, MPL Governing Body and/or Committee that helps direct your business?**

| Individual | Number | Individual | Number |
|---|---|---|---|
| Physician | ______ | Dentist | ______ |
| Hospital Admin | ______ | Other H/C Provider | ______ |
| Attorney | ______ | Managers | ______ |
| Other (Specify) | ______ | | |

**11 Who conducts the day-to-day insurance operations of the organization?**

☐ Company Employees ☐ Brokerage ☐ Attorney-In-Fact ☐ Service Company

Name of Company ____________

Do you operate on a basis other than admitted?

☐ Yes ☐ No If Yes, please explain ____________

## PART C | NARRATIVE

**Please explain if Physicians, Dentists, Hospital Administrators, or other Healthcare Professionals are involved in the day-to-day operations within the following areas:**

(Please be as detailed and specific as possible and use a separate sheet, if necessary.)

**Underwriting** ____________

**Claims Administration** ____________

### Risk Management

Besides reviewing your external risk management operations, also include the level of internal risk management education of your staff.

### General Management and Oversight

Please also include any resources that your company commits or budgets specifically for patient safety education of your insureds, and/or any ongoing activities demonstrating commitment to patient safety. If these are not currently available, does your company have plans to incorporate resources in the future?

### To Whom Do Your Profits Flow?

### Provide a Summary of Your Organization's Philosophy of Operation

Describe how your company**:**

- Encourages involvement by healthcare providers.
- Displays a unique focus which reflects knowledge, passion, and commitment to operate a successful medical liability insurance company that supports the quality delivery of healthcare and practice of medicine.
- Has supported tort (judicial) reform in the past and its current position on such issues.

### Supporting Documents to Include (if available)

- Most recent annual report to insurance department or stockholders (yellow book).
- Most recent audited financial statements (if not included in annual report).
- Organizational chart.
- Copy of organization bylaws.
- Listing of the members of Board of Directors or MPL governing body or committee.
- Sample specimens of current policy form or forms.

## PART D | AUTHENTICATION

Signature of Individual Completing Application

Date

Name (Print)

Title

Phone

Email