Lexington Clinic Initial Credentialing/Privileging Packet Instructions

MAGMUTUAL Insurance Company Malpractice Insurance Application

- On page 1, **please enter the name and expiration date of your current malpractice insurance carrier.**
- On page 2, answer all highlighted questions pertaining to demographic information, specialty and training information, malpractice claim information, disclosure questions, etc. **Attach any required explanations.**
- On page 3, answer all questions pertaining to adverse outcomes. **Attach any required explanations.**
- Sign page 4.

MAGMUTUAL®

3535 Piedmont Road NE, Building 14, Suite 1000 | Atlanta, GA 30305-1518
404-842-5600 | 1-800-282-4882 | fax 404-842-3481

Physician/Surgeon Application

This is an Application for Claims-made Coverage – Please Read Carefully

Policyholder Info

1. If my application is approved, my requested coverage effective date is: / / at 12:01 am.
2. Organization / Policyholder Name: New Lexington Clinic, PSC
3. Type: ☐ Solo Physician ☒ Physician Group ☐ Hospital Employed ☐ Other
4. Practice Location (please provide additional practice locations on a separate sheet) *see attached*

Address: Saint Joseph Hospital locations - see attached			Phone: 859-258-4000
City: Lexington	State: KY	Zip: 40504	County: Fayette

5. Billing Address ☐ Same as practice location ☒ Other (please provide below)

Address: 1030 South Broadway, Suite 4 Attn: Rebekah Walton			Phone: 859-258-4314
City: Lexington	State: KY	Zip: 40504	County: Fayette

6. Mailing Address ☐ Practice ☒ Billing ☐ Other (please provide below)

Address:			Phone:
City:	State:	Zip:	County:

7. Administrator Information ☐ Same as policyholder ☐ Other (please provide below)

Name: Rebekah Walton	Email: rwalt@lexclin.com	Phone: 859-258-4314

Policy Info

8. Do you want to add coverage for your organization? If yes: ☐ Yes ☒ No
   a. Will the organization share in the physician limits? ☒ N/A ☐ Yes ☐ No
   b. Do you want us to cover your organization's medical acts for the period you were insured with your current professional liability insurance company (i.e., Prior Acts Coverage)? If yes, please provide requested retroactive date: / / ☐ Yes ☒ No
9. Do you own a healthcare facility (e.g. medical spa or surgical suite)? If yes: ☐ Yes ☒ No
   a. Do you allow members outside of your organization to use this facility? ☒ N/A ☐ Yes ☐ No
   b. Name of facility c. Location of facility
   d. Do you maintain separate professional liability insurance coverage for this facility/ies? ☐ N/A ☐ Yes ☒ No
10. Do you employ and/or supervise any Advanced Practice Providers? If yes, please provide number and designation below. ☒ Yes ☐ No see attached

# Anes. Assts. (CRNA, PA, AA)	# Nurse Practitioners (NP)	Other #
# Physician Assistants (PA)	# Nurse Midwives (CNM)	Other Descr:

11. Is your organization owned by an Advanced Practice Provider? If yes, who: ☐ Yes ☒ No
12. a. Current Medical Professional Liability insurance company:
    b. Current policy expiration date: / /

Physician Info

13. First Name: Middle Name: Last Name: ☐ MD ☐ DO

14. Date of Birth: / / 15. NPI: 16. Email:

17. Phone: 18. Limits Requested: $1,000,000 Per Loss / $3,000,000 Annual Aggregate

19. a. Primary Specialty: b. Sub-specialty:

c. Has your practice ever expanded outside of your specialty and/or sub-specialty? ☐ Yes ☐ No

d. Do you perform any procedures not routinely performed by physicians in your specialty or sub-specialty? ☐ Yes ☐ No

20. Indicate surgeries performed (check all that apply):

☐ Minor Surgery ☐ Major Surgery ☐ Obstetrics ☐ Spine Surgery ☐ Bariatrics ☐ N/A

21. Residency completion date: / /

22. Did you successfully complete residency in the above listed primary specialty? ☐ Yes ☐ No

23. Have you ever had a claim that resulted in an indemnity payout greater than or equal to $25,000? If yes, what was the date of the most recent payment? / / ☐ Yes ☐ No

24. Do you provide medical services at any nursing home, correctional facility or other state institution? If yes, please explain: ☐ Yes ☑ No

25. Do you have any medical director responsibilities: If yes, please list name, type and location of facility: ☐ Yes ☐ No

26. Provide the following weekly averages:

a. Hours per week b. Patients per week c. Surgeries / Deliveries per week

27. Please answer the following questions about the physician listed in question 13:

a. Has your medical license or DEA certificate ever been denied, suspended, investigated, or limited in any way? ☐ Yes ☐ No

b. Have your privileges at any hospital, or contract(s) with any healthcare programs, ever been denied, surrendered, monitored, or otherwise restricted? ☐ Yes ☐ No

c. Have you ever been subject to a Consent Order (private or public) or other agreement with any state or federal licensing board or other governmental agency? ☐ Yes ☐ No

d. Has your medical professional liability coverage ever been cancelled or non-renewed? ☐ N/A ☐ Yes ☐ No

e. Have you had a claim or lawsuit filed against you, or have you ever been notified that a claim or lawsuit will be filed against you, alleging medical errors or omissions? ☐ Yes ☐ No

f. Do you have a criminal record or have you ever been criminally investigated? ☐ Yes ☐ No

g. Have you ever been treated or evaluated for: alcoholism; substance abuse; sexual misconduct; anger management; or any type of mental illness? ☐ Yes ☐ No

h. Have you ever been accused of billing errors or violations of Stark/anti-kickback laws, EMTALA, or HIPPA, by any government agency, government representative, or commercial payer? ☐ Yes ☐ No

If your answer to any of the above questions is "Yes", please give details on a separate, signed and dated sheet of paper.

28. Do you want us to cover your medical acts for the period you were insured with your current professional liability insurance company (i.e., Prior Acts Coverage)? ☐ Yes ☒ No

If yes, please answer "a" and "b" below.

a. Retroactive date: / /

b. To the best of your knowledge, have any of the following adverse patient outcomes occurred in your practice in the last two years which you have not already reported to your current professional liability insurance company:

i. Fetal distress during labor and delivery, newborn Apgar score less than six at either one or five minutes, or evidence of neurological or physical compromise of an infant? ☐ Yes ☐ No

ii. Any UNEXPECTED death (including stillbirths), organ failure (heart, liver, lung, kidney), or any significant neurological or functional deficit, or intractable pain, following surgery which were not present upon admission, which are not explained by the medical condition and/or general health of the patient? ☐ Yes ☐ No

iii. Any alleged failure or delay to diagnose a condition resulting in death or serious permanent disability, or any delayed communications of positive diagnostic imaging or pathology reports? ☐ Yes ☐ No

iv. Contact by an attorney either requesting records of a patient or notifying you that a malpractice action is being investigated or contemplated? ☐ Yes ☐ No

v. Any acute myocardial infarction, arrest, embolism, aneurysm, or cerebral vascular accident during or within 48 hours of surgery or 72 hours of an office visit? ☐ Yes ☐ No

vi. Any admission or return to the ER/OPD within 5 days of treatment due to complications from surgery resulting in serious temporary or permanent injury or death? ☐ Yes ☐ No

REPORT ANY "YES" RESPONSES FOR QUESTION 28b TO YOUR CURRENT INSURANCE COMPANY AND PROVIDE US WITH A COPY.

I choose to designate MAG Mutual Holding Company's Executive Chairman (currently Joseph S. Wilson, Jr., M.D.) or MAG Mutual Holding Company's Corporate Secretary (currently Benjamin H. Cheek, M.D.) as my proxy with the power to represent me and to vote my membership interest at any regularly called or special meeting of MAG Mutual Holding Company or in any other setting or proceeding where a vote of MAG Mutual Holding Company's members is taken. I understand that this proxy designation is valid for up to thirty-six (36) months from the date of my signature below. I further understand that this proxy designation is revocable at any time, and that I may revoke my proxy: (i) in writing to MAG Mutual Holding Company; (ii) by designating a new or substitute proxy; or (iii) by appearing personally at any member vote to cast my voting interest in person. **(You have the right to strike through this paragraph and thereby retain the right to vote your membership interest directly. Doing so will not affect MAG Mutual Insurance Company's coverage decision.)**

Furthermore, I hereby authorize my present and prior professional liability insurance carriers and any and all attorneys who have represented me in connection with any claim of professional liability to release to the Company upon its request all nonprivileged information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Company may have a bearing upon my acceptability to the Company as a professional liability risk. I acknowledge that this application may be used by the Company to underwrite coverage with MAG Mutual Insurance Company and/or Professional Security Insurance Company. Applications for Professional Security Insurance Company may be submitted only through a licensed, surplus lines broker or agent as Professional Security Insurance Company is an unauthorized insurer eligible to transact insurance in your state under applicable surplus lines insurance laws. I also authorize the Company or its duly authorized agents to provide a CERTIFICATE OF INSURANCE to interested parties.

I hereby declare that the statements and responses I have provided in this application are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that deliberate misstatements, which are deemed material or fraudulent, may be grounds for cancellation or denial of coverage in the event of a claim.

x _____ _____/_____/_____

Applicant's Signature Date

_____

Applicant's Name

Please attach:

1. The declarations page from your current policy
2. A curriculum vitae for each physician
3. A current dated 5-year loss run or NPDB report and any losses or incidents reported to your insurance company that are not reflected on your loss run.
4. Details for any "yes" answers in question 27
5. A copy of any claims reported as a result of a "yes" answer in question 28b.

FRAUD WARNINGS:

Notice to Alabama, Arkansas, District of Columbia, Louisiana, New Mexico, Rhode Island and West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Florida and Oklahoma Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilt y of a felony (of the third degree)*. *Applies in Florida only.

Notice to Kansas Applicants: A “fraudulent insurance act” means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Kentucky, New York, Ohio and Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing an y materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in New York only.

Notice to Maine, Tennessee, Virginia and Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in Maine only.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon Applicants: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Notice to Applicants of all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

List of CHI Saint Joseph Health Emergency Departments for ER providers of

New Lexington Clinic, P.S.C.

Saint Joseph Hospital
1 Saint Joseph Drive
Lexington, KY 40504

Saint Joseph East
150 N. Eagle Creek Drive
Lexington, KY 40509

Saint Joseph Berea
305 Estill Street
Berea, KY 40403

Saint Joseph Jessamine
1250 Keene Road
Nicholasville, KY 40356

Saint Joseph London
1001 Saint Joseph Lane
London, KY 40741

Saint Joseph Mount Sterling
225 Falcon Drive
Mount Sterling, KY 40353

Flaget Memorial Hospital
4305 New Shepherdsville Road
Bardstown, KY 40004