PIAA
Our Expertise Is Medical Liability.
Our Passion Is Quality Healthcare.

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Membership Application
(Regular or Industry Associate)

PART A - GENERAL INFORMATION

1. Name of Applicant Organization _____ Date of Application _____

2. Corporate Address

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

_____ Physical Location Street Address, if different
_____ Physical City, State, Zip+4

3. Main Telephone Number* _____ Main Fax Number* _____ Website Address _____

*please include all digits necessary for dialing from the United States

4. Please Provide the Names of those who lead your MPL business:

(Example: Jane Smith, Chief Executive Officer or
John Doe, Vice President, Risk Management)

_____ Name _____ Title

_____ Name _____ Title

Designated Representative to PIAA[1] _____ Name

_____ Title _____ Email _____ Telephone

Alternate Representative to PIAA _____ Name

_____ Title _____ Email _____ Telephone

5. States/Countries of Insurance Operations: _____

6. State/Province/Country of Company Domicile: _____

7. Year Commenced Operations: _____

8. Sponsoring Organization(s), if any: _____

[1] The designated representative to the PIAA 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 PIAA unless requested or approved by the designated representative.

9. PART B - INFORMATION FOR PRIMARY INSURER (APPLICANT)

1. Method Of Ownership:
   _____ Stock Insurance Company - Publicly Traded
   _____ Stock Insurance Company - Closely Held _____
   _____ Mutual Insurance Company (By Whom)
   _____ Reciprocal Exchange
   _____ Mutual Indemnification Organization
   _____ Non-Insurance Company Trust
   _____ Other (Specify) _____

   Does your organization own or manage any other companies that also provide MPL insurance?
___ Yes ___ No If Yes, please provide company name(s): _____

2. Lines of Insurance - Please indicate all lines of insurance written (include aggregate annual gross written premium for all companies within your organization that provide MPL insurance):

	Lines of Business	Direct Written Premium (US $Mil)	Total Admitted Assets	Number of Insureds
_____	Medical Prof Liability – Physicians	_____	_____	_____
_____	Dental Prof Liability	_____	_____	_____
_____	Professional Corporations	_____	_____	_____
_____	Hospital/Institutional Liability	_____	_____	_____
_____	Other Healthcare Professionals (Specify) _____	_____	_____	_____
_____	Other Healthcare Liability (Specify)_____	_____	_____	_____
_____	Other (Specify) _____	_____	_____	_____
	TOTAL	_____	_____	_____

3. Policy/Coverage Types Offered:

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

4. 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.

_____

_____

5. 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)	_____		

6. Who Conducts the Day-to-Day Insurance Operations of the Organization?

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

Name of Company: _____

Do you operate on a basis other than admitted? ___Yes ___No
If Yes, please explain: _____

_____

7. 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):*

a) **Underwriting**:

b) **Claims Administration**:

c) **Risk Management**: *(Besides reviewing your external risk management operations, please also include the level of internal risk management education of your staff.)*

d) **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?)

e) **To Whom Do Your Profits Flow**?

f) **Provide a Summary of Your Organization's Philosophy of Operation**
Please 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; and*
- *has supported tort (judicial) reform in the past and its current position on such issues.*

g) Supporting Documents to include (if available):
i. Most recent annual report to insurance department or stockholders (yellow book).
ii. Most recent audited financial statements (if not included in annual report).
iii. Organizational chart.
iv. Copy of organization bylaws.
v. Listing of the members of Board of Directors or MPL governing body or committee.
vi. Sample specimens of current policy form or forms.

PART C - AUTHENTICATION

_____
Signature of Individual Completing Application

_____ _____
Name and Title Date

_____ _____
Telephone Email