COVERYS®

Emergency Physician Risk Management Credit Addendum

Reset Form

- ❑ Medical Professional Mutual Insurance Company
- ❑ ProSelect Insurance Company
- ❑ ProSelect National Insurance Company, Inc.

PART I - APPLICANT INFORMATION			
First Name	Middle Initial	Last Name	Policy Number

PART II - GENERAL QUESTIONS

Failure to return this credit application by the effective date of this policy will result in loss of credit for the policy period.

I hereby apply for the Emergency Physician's Risk Management Credit from the regular premium for my medical malpractice insurance policy to be issued by Coverys. In making this application, I certify the following:

1. I am a full-time emergency physician (greater than 21 hours per week) with an unrestricted license to practice medicine in _____. I have no other practice outside of the Emergency Department.

2. I understand that in order to be eligible for the credit, I must pass a qualifying risk management educational program sponsored by the Massachusetts College of Emergency Physicians (MACEP) with a score of 90% or better. Every 4 years, I must retake the educational program to retain the credit. The MACEP program is offered online and can be accessed at their website (www.macep.org). I also understand that I must work in an Emergency Department that submits to a Coverys risk management appraisal that satisfactorily meets the criteria of the appraisal developed collaboratively by MACEP and Coverys.

3. I am insured as an emergency physician, not performing major surgery, and I have unrestricted clinical privileges in emergency medicine at the following healthcare facility(ies):

   _____

   _____

   _____

4. I understand and agree that if it is determined that any of the representations made in paragraphs 1 through 3 above are untrue that I will be immediately disqualified from any risk management credit to which this application applies, and I will be ineligible for any risk management credit for a minimum of two policy years following such disqualification.

   I also understand and agree that the credit is subject to consistent adherence to Coverys risk management protocols, positive claims history, and underwriting discretion.

I HEREBY CERTIFY UNDER THE PAINS AND PENALTIES OF PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE AND THAT THEY ARE MADE BY ME IN ORDER TO RECEIVE A CREDIT ON MY OTHERWISE APPLICABLE PREMIUM FOR MEDICAL MALPRACTICE INSURANCE COVERAGE.

MARYLAND APPLICANTS: WE ARE NOTIFYING YOU THAT THE BINDER OR POLICY YOU HAVE JUST AGREED TO PURCHASE IS SUBJECT TO A 45 DAY UNDERWRITING PERIOD BEGINNING ON THE EFFECTIVE DATE OF YOUR COVERAGE. YOUR COVERAGE MAY BE CANCELLED DURING THE UNDERWRITING PERIOD IF YOUR RISK DOES NOT MEET OUR UNDERWRITING STANDARDS. IF WE DECIDED TO CANCEL THE BINDER OR POLICY, WE WILL SEND YOU A WRITTEN NOTICE OF CANCELLATION ADVISING YOU OF THE REASON(S) FOR THE CANCELLATION AND THE DATE ON WHICH YOUR POLICY WILL BE CANCELLED.

Signature of Applicant _____ Date _____