

# PHYSICIAN ASSISTANTS ANNUAL OCCURRENCE RATE TABLES

## OKLAHOMA

CLASS P1		FULL TIME	
LIMIT		OCCURRENCE	
\$100,000/\$300,000	\$	2,230	
\$200,000/\$600,000	\$	3,011	
\$250,000/\$750,000	\$	3,234	
\$500,000/\$1,000,000	\$	3,802	
\$1,000,000/\$6,000,000	\$	4,683	

PART TIME	
OCCURRENCE	
\$	1,450
\$	1,957
\$	2,102
\$	2,471
\$	3,044

CLASS P2		FULL TIME	
LIMIT		OCCURRENCE	
\$100,000/\$300,000	\$	2,788	
\$200,000/\$600,000	\$	3,764	
\$250,000/\$750,000	\$	4,043	
\$500,000/\$1,000,000	\$	4,754	
\$1,000,000/\$6,000,000	\$	5,855	

PART TIME	
OCCURRENCE	
\$	1,812
\$	2,447
\$	2,628
\$	3,090
\$	3,806

CLASS P3		FULL TIME	
LIMIT		OCCURRENCE	
\$100,000/\$300,000	\$	3,345	
\$200,000/\$600,000	\$	4,516	
\$250,000/\$750,000	\$	4,850	
\$500,000/\$1,000,000	\$	5,703	
\$1,000,000/\$6,000,000	\$	7,025	

PART TIME	
OCCURRENCE	
\$	2,174
\$	2,935
\$	3,153
\$	3,707
\$	4,566

CLASS PS	
LIMIT	OCCURRENCE
\$1,000,000/\$6,000,000	\$ 150

### Physician Assistant Rating Classes

**Class P1:** A physician assistant who carries out responsibilities generally performed by a qualified licensed physician and who practices under the direction and supervision of a licensed physician to assist the physician in the diagnosis and treatment of patients. A physician assistant with any exposure to an operating room for Observation Only.

**Class P2:** A physician assistant who practices any of the following:  
 1. Assisting a licensed physician who is qualified to perform surgery – any practice exposure in an operating room other than for observation with a general practitioner/ (10 hours a week or less) to trauma/emergency room procedures or responsibilities; 3. Obstetrics practice or exposure limited to prenatal or postnatal care; and 4. Assisting a qualified licensed physician in Anesthesiology.

**Class P3:** A physician assistant who is involved in any of the following:  
 1. Assisting an orthopedic surgeon, neurosurgeon, OB/GYN surgeon, cardiovascular surgeon and/or plastic surgeon in surgery in an operating room other than for observation; 2. Practicing or any exposure (more than 10 hours a week) in trauma/emergency room procedures or responsibilities; 3. Contact or exposure with Obstetrics including delivery room responsibilities; 4. Contact or exposure with cardiac catheterization labs; and 5. Assisting in Cosmetic/Aesthetic procedures.

**Class PS:** Students currently enrolled and attending an American Academy of Physician Assistants approved physician assistant program.

# PHYSICIAN ASSISTANTS ANNUAL CLAIMS MADE RATE TABLES OKLAHOMA

CLASS P1		FULL TIME			
LIMIT	1st Year	2nd Year	3rd Year	4th Year	
\$100,000/\$300,000	\$ 813	\$ 1,543	\$ 1,986	\$ 2,027	
\$200,000/\$600,000	\$ 1,098	\$ 2,083	\$ 2,681	\$ 2,736	
\$250,000/\$750,000	\$ 1,179	\$ 2,237	\$ 2,880	\$ 2,939	
\$500,000/\$1,000,000	\$ 1,386	\$ 2,631	\$ 3,386	\$ 3,456	
\$1,000,000/\$6,000,000	\$ 1,707	\$ 3,240	\$ 4,171	\$ 4,257	

PART TIME		1st Year	2nd Year	3rd Year	4th Year
	\$ 528	\$ 1,003	\$ 1,291	\$ 1,318	
	\$ 714	\$ 1,354	\$ 1,743	\$ 1,778	
	\$ 766	\$ 1,454	\$ 1,872	\$ 1,910	
	\$ 901	\$ 1,710	\$ 2,201	\$ 2,246	
	\$ 1,110	\$ 2,106	\$ 2,711	\$ 2,767	

CLASS P2		FULL TIME			
LIMIT	1st Year	2nd Year	3rd Year	4th Year	
\$100,000/\$300,000	\$ 1,016	\$ 1,928	\$ 2,483	\$ 2,534	
\$200,000/\$600,000	\$ 1,372	\$ 2,603	\$ 3,352	\$ 3,421	
\$250,000/\$750,000	\$ 1,473	\$ 2,796	\$ 3,600	\$ 3,674	
\$500,000/\$1,000,000	\$ 1,732	\$ 3,287	\$ 4,234	\$ 4,320	
\$1,000,000/\$6,000,000	\$ 2,134	\$ 4,049	\$ 5,214	\$ 5,321	

PART TIME		1st Year	2nd Year	3rd Year	4th Year
	\$ 660	\$ 1,253	\$ 1,614	\$ 1,647	
	\$ 892	\$ 1,692	\$ 2,179	\$ 2,224	
	\$ 957	\$ 1,817	\$ 2,340	\$ 2,388	
	\$ 1,126	\$ 2,137	\$ 2,752	\$ 2,808	
	\$ 1,387	\$ 2,632	\$ 3,389	\$ 3,459	

CLASS P3		FULL TIME			
LIMIT	1st Year	2nd Year	3rd Year	4th Year	
\$100,000/\$300,000	\$ 1,219	\$ 2,314	\$ 2,980	\$ 3,041	
\$200,000/\$600,000	\$ 1,646	\$ 3,124	\$ 4,023	\$ 4,105	
\$250,000/\$750,000	\$ 1,768	\$ 3,355	\$ 4,321	\$ 4,409	
\$500,000/\$1,000,000	\$ 2,078	\$ 3,945	\$ 5,081	\$ 5,185	
\$1,000,000/\$6,000,000	\$ 2,560	\$ 4,859	\$ 6,258	\$ 6,386	

PART TIME		1st Year	2nd Year	3rd Year	4th Year
	\$ 792	\$ 1,504	\$ 1,937	\$ 1,977	
	\$ 1,070	\$ 2,031	\$ 2,615	\$ 2,668	
	\$ 1,149	\$ 2,181	\$ 2,809	\$ 2,866	
	\$ 1,351	\$ 2,564	\$ 3,303	\$ 3,370	
	\$ 1,664	\$ 3,158	\$ 4,068	\$ 4,151	

## Physician Assistant Rating Classes

**Class P1:** A physician assistant who carries out responsibilities generally performed by a qualified licensed physician and who practices under the direction and supervision of a licensed physician to assist the physician in the diagnosis and treatment of patients. A physician assistant with any exposure to an operating room for Observation Only

**Class P2:** A physician assistant who practices any of the following:

1. Assisting a licensed physician who is qualified to perform surgery – any practice exposure in an operating room other than for observation with a general practitioner/family practice or general surgeon;
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3. Obstetrics practice or exposure limited to prenatal or postnatal care; and
4. Assisting a qualified licensed physician in Anesthesiology.

**Class P3:** A physician assistant who is involved in any of the following:

1. Assisting an orthopedic surgeon, neurosurgeon, OB/GYN surgeon, cardiovascular surgeon and/or plastic surgeon in surgery in an operating room other than for observation;
2. Practicing or any exposure (more than 10 hours a week) in trauma/emergency room procedures or responsibilities;
3. Contact or exposure with Obstetrics including delivery room responsibilities;
4. Contact or exposure with cardiac catheterization labs; and
5. Assisting in Cosmetic/Aesthetic procedures.



**PA Protect®**  
**Malpractice Insurance For**  
**Physician Assistants**

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- 1) Please print a copy of this cover sheet & application to your desktop printer.
- 2) Complete this hard copy by hand, answering all questions
- 3) Sign, date and either:
  - a. Mail your completed application providing your credit card information OR with check payable to:  
**CM&F Group, Inc., 99 Hudson Street, 12th Floor,**  
**New York, NY 10013**
  - OR
  - b. Fax your signed and completed application providing your credit card information (per the application) to  
CM&F Group, Inc. at (212) 233.8919
- 4) Once your application is processed, you will be notified by email within 5-7 business days of confirmation of coverage. Your payment -- whether by check or credit card -- will NOT be processed until your coverage has been approved.
- 5) **Please complete the following and submit this page, along with your completed application & payment form:**

How did you hear about PA Protect®?

AAPA  Yes  No

Other \_\_\_\_\_

Fax or Mail Completed Application To:  
**CM&F Group, Inc.**  
99 Hudson Street, 12th Floor  
New York, New York 10013-2815  
(212)233-8911 (800)221-4904  
Fax (212)233-8919 pa@cmfgroup.com

If previously covered with Medical Protective, please  
enter policy number \_\_\_\_\_

## THE MEDICAL PROTECTIVE COMPANY HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION - PA

### I. Coverage Information

#### A. Coverage Desired:

*\*Please note that requested policy types may not be available in all states.*

- Occurrence coverage
- Claims-Made coverage without Prior Acts coverage
- Claims-Made coverage with Prior Acts coverage
- Convertible Claims-Made coverage **PLEASE CALL FOR MORE INFORMATION**

#### B. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been purchased.
- An extended reporting endorsement has not and will not be purchased.

\* Please be advised that if you do not purchase tail coverage (an extended reporting endorsement) from your current insurer where you are insured under a Claims-Made policy, this will result in an uninsured exposure for any claims which may arise as a result of professional services rendered or which should have been rendered while insured by your current insurer's policy. If you do not purchase tail coverage from your current insurer understand that the policy for which you are applying with The Medical Protective Company, if offered, will not provide prior acts coverage.

**Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage.**

#### C. Retroactive date shown on my current Claims-Made policy is: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (This date is not a requirement for Occurrence or Claims-Made without prior acts policies.) MM DD YYYY

#### D. Desired Limits:

*\*Please note that requested limits options may not be available in your state.*

- \$100,000/\$300,000                       \$200,000/\$600,000                       \$250,000/\$750,000
- \$500,000/\$1,000,000                       \$1,000,000/\$3,000,000                       \$1,000,000/\$6,000,000
- \$2,000,000/\$6,000,000 **(VA Only)**

#### E. Are you an Indiana resident electing to participate in the Indiana Patient Compensation Fund?

Yes  No                      If yes, coverage provided will have limits of \$250,000/\$750,000.

#### F. Are you a Louisiana resident electing to participate in the in the Louisiana Patient Compensation Fund?

Yes  No                      If yes, coverage provided will have limits of \$100,000/\$300,000.

#### G. Are you a New Mexico resident electing to participate in the New Mexico Patient Compensation Fund?

Yes  No                      If yes, coverage provided will have limits of \$200,000/\$600,000

## II. General Information

Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

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A.

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Suffix

\_\_\_\_\_  
Date of Birth MM/DD/YYYY

\_\_\_\_\_  
Professional License Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Apartment/Suite #

\_\_\_\_\_  
City

\_\_\_\_\_  
County

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
State of Practice

\_\_\_\_\_  
National Provider Identifier # (Optional)

\_\_\_\_\_  
Business Phone

\_\_\_\_\_  
Business Fax

\_\_\_\_\_  
Residence/Cell Phone

E-mail Address: \_\_\_\_\_

B. Requested Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

## III. Practice Information

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A. Please indicate all that apply to your current professional practice.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hospital (Inpatient Unit)   | <input type="checkbox"/> Med Spa/Day Spa      | <input type="checkbox"/> Nursing Home/LTC                    |
| <input type="checkbox"/> Hospital (Outpatient Unit)  | <input type="checkbox"/> Psychiatric Facility | <input type="checkbox"/> Home Health Care                    |
| <input type="checkbox"/> Urgent Care Facility  | <input type="checkbox"/> Surgi-Center         | <input type="checkbox"/> Family Practice                     |
| <input type="checkbox"/> Trauma Center   | <input type="checkbox"/> School/Health Dept   | <input type="checkbox"/> Specialty/Physician Office/Facility |
| <input type="checkbox"/> Correctional Facility   | <input type="checkbox"/> ER > 10 Hours/Week   | <input type="checkbox"/> ER < 10 Hours/Week                  |
| <input type="checkbox"/> OR (Cardiovascular/Thoracic, Neurological, OB/GYN, Plastic Surgeon) |   |  |
| <input type="checkbox"/> OR (All Other)  | <input type="checkbox"/> Other: _____         |  |

B. Please indicate all that apply to your professional services.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Family General Medicine | <input type="checkbox"/> Psychiatric               | <input type="checkbox"/> Emergency Unit  |
| <input type="checkbox"/> Emergency Medicine      | <input type="checkbox"/> OB/GYN                    | <input type="checkbox"/> Trauma Center   |
| <input type="checkbox"/> Orthopedics             | <input type="checkbox"/> Dermatology               | <input type="checkbox"/> Surgi-Center    |
| <input type="checkbox"/> Cardiovascular/Thoracic | <input type="checkbox"/> Anesthesia Administration | <input type="checkbox"/> Neurological    |
| <input type="checkbox"/> Cosmetic/Aesthetics     | <input type="checkbox"/> Assisting in Surgery      | <input type="checkbox"/> Plastic Surgery |

C. Please indicate your Physician Assistant Rating Class: for Class definitions please see below:

Class P1    Class P2    Class P3    Class PS

Class Description:

**Class P1:** A physician assistant who carries out responsibilities generally performed by a qualified licensed physician and who practices under the direction and supervision of a licensed physician to assist the physician in the diagnosis and treatment of patients. A physician assistant with any exposure to an operating room for **Observation Only**

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**Class PS:** Students currently enrolled and attending an American Academy of Physician Assistants approved physician assistant program.

**D. As a Physician Assistant I practice:**  Full Time  Part Time (24 hours/week or less)

**E. Is your professional designation/certification currently valid?**  Yes  No

Please provide date of expiration:  /  /   
MM DD YYYY

**F. Are you member of a Professional Association(s)?**  Yes  No

If yes, please list membership affiliation(s) \_\_\_\_\_

**G. Have you completed the AAPA approved risk management course?**  Yes  No

If yes, please attach a copy of the certificate to your application as proof of completion.

#### IV. Additional Practice Information

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**A. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, healthcare license or reimbursement privileges, refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?**

Yes  No If yes, please attach a separate sheet with full particulars including date(s).

**B. Has any professional liability insurance company ever declined, refused, canceled or non-renewed your coverage?**

**NOTE: MISSOURI RESIDENTS DO NOT RESPOND.**  Yes  No

If yes, please indicate the date(s) and explain: Date  /  \_\_\_\_\_  
MM YYYY

**C. Have you ever been accused of sexual misconduct of any kind?**  Yes  No

If yes, please indicate the date(s) and explain: Date  /  \_\_\_\_\_  
MM YYYY

**D. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty?**

(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics or other controlled substances, etc).

Yes  No \*If yes, please complete Medical Condition Supplemental form

#### V. Loss Information

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**Please complete the Loss Information Supplement for each written request, incident, claim or suit that has NOT been covered by a Medical Protective policy.**

Report professional liability and malpractice related matters, including but, not limited to board complaints, etc.

For Questions A and B below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim, suit, received a written request for treatment records arising out of the rendering or failure to render professional services? \_\_\_ Yes \_\_\_ No If yes, how many? \_\_\_\_\_

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but it is not limited to, the following:

- Amputation - Death - Loss of major organ function - Loss of Vision - Permanent neurological injury
- Permanent damage to a patient related to an injury during the delivery of a child

\_\_\_ Yes \_\_\_ No If yes, how many? \_\_\_\_\_

## VI. Professional Liability Coverage

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A. Please list your prior professional liability insurance, if any.

Insurance Carrier	Coverage Type (Occurrence or Claims Made)	Policy Number	Limits	Effective Date(s)	Retro Date
_____	_____	_____	_____	_____	_____

## VII. Important Notice – Representations, Authorizations, Releases and Notices

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WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

## VIII. Notes and Agreements

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Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the company. I agree to notify the company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) my application has been accepted by the Company; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer, credit card payment or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the company any information regarding me, which the company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

\_\_\_\_\_  
Applicant's Signature

Date Signed: \_\_\_ / \_\_\_ / \_\_\_  
MM DD YYYY

\_\_\_\_\_  
Print Name

**PREMIUM PAYMENT OPTIONS**

**PREPAYMENT REQUIRED**

Check or money order enclosed.  Charge premium to credit card.

I authorize CM&F Group, Inc. to charge the premium to my:  VISA  MASTERCARD

Credit Card Account Number: \_\_\_\_\_ Expiration Month and Year: \_\_\_\_ / \_\_\_\_

Print name exactly as it appears on card: \_\_\_\_\_

**THIRD PARTY CREDIT CARD AUTHORIZATION** Please complete the following (if payer other than applicant):

CHARGE TO:  VISA  MASTERCARD

Credit Card Account Number: \_\_\_\_\_ Expiration Month and Year: \_\_\_\_ / \_\_\_\_

Card Member Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**MAIL OR FAX COMPLETED APPLICATION & PAYMENT INFORMATION TO:**

**CM&F Group, Inc.**

99 Hudson Street, 12th Floor, New York, NY 10013-2815

212.233.8940 1.800.221.4904 FAX: 212.233.8919 pa@cmfgroup.com

# The Medical Protective Company Loss Information Supplement

Please make additional copies if needed.

**Applicant's Name** \_\_\_\_\_

Note: Additional documentation may be requested at the Company's discretion.

**A. Is the matter related to**  **A** or  **B** **from the Loss Information Section?** (Check only one)

**B. Patient/Claimant Information:**

\_\_\_\_\_

Last Name	First Name	Age
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**C. Date of treatment and/or surgery, which led, or could lead, to allegations against you:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

**D. Date notice received (if applicable):** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

**E. Has this matter been reported to your current or former insurer?**  **Yes**  **No**

**If yes, date reported to your current or former insurer?** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

**Current or former insurer name** \_\_\_\_\_

**If no, please explain** \_\_\_\_\_

**F. Name of all other doctor(s), hospital(s) or healthcare provider(s), if any, involved:**

\_\_\_\_\_

**G. Current status:**  **Open**  **Closed**

If open, indicate dollar value established by insurer: \$ \_\_\_\_\_

**If closed:** 1. Date of closing: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

2. Was Payment Made?  **Yes**  **No**

a. If yes, did you consent to the settlement?  **Yes**  **No**

b. Total amount of settlement or award: \$ \_\_\_\_\_

c. Total amount of settlement or award paid on your behalf: \$ \_\_\_\_\_

**H. Nature of allegations or potential allegations:**

Condition Treated \_\_\_\_\_

Treatment Provided \_\_\_\_\_

Alleged Negligence \_\_\_\_\_

Alleged Injury \_\_\_\_\_

**Please provide narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_