



Hello NYSPMA Members,

RE: Membership Benefit; Reduced Medical Malpractice Insurance Rates for Members

NYSPMA Leadership is excited to announce the association's relationship with Hilb Healthcare Group to develop an exclusive medical malpractice insurance program available only to members of the New York State Podiatric Medical Association. Hilb will be engaging with all medical malpractice insurance carriers that insure Podiatrists in New York to identify an appropriate partner for the Association that is best fit for Association members, giving due consideration to coverage types, customer service, and sponsorship for the Association.

Hilb has provided similar programs to large healthcare organizations in New York and nationally for over 20 years. With their long-term relationships and access to all markets, Hilb will be able to identify a carrier to partner with NYSPMA and respond to the insurance needs of members.

The goal of this NYSPMA initiative is to reduce annual premium costs for members without compromising coverage, while expanding the strength and benefits of NYSPMA membership. Participation is elective and for members who opt to not participate in this exclusive program, you can maintain your current policy or work with Hilb to help identify alternative medical malpractice insurance solutions.

Submission of documentation does not obligate participation or coverage, and any coverage selection may be made in response to a premium quote, once presented. Hilb will be requesting the following information from each interested member within the next thirty (30) days.

- Professional CV

-Podiatry License & Current Registration

-Current malpractice insurance declaration page

-Signature (authorizing the release of claims history to Hilb Healthcare)

FAQ

- 1. What type of policy will be provided? The current insurance marketplace in NY offers both occurrence and claims-made policies.
- 2. If I have a claims-made policy, will I have to purchase tail if I switch to the NYSPMA exclusive program? No, if you currently have a claims-made policy, all exposure will be transferred, and the carrier will provide retroactive coverage to avoid any gap.
- 3. Will I be able to maintain my current limits of liability? Yes, your current limits of liability will remain the same unless a change is requested.
- 4. If I am part time, will I still be able to maintain a part time policy with a premium that reflects my hourly status? Yes, your current status, whether you are part-time or full-time, will remain the same unless a change is requested.
- 5. Who can I contact with Questions? Questions may be submitted to <u>NYSPMA@hilbgroup.com</u>, or <u>melefante@hilbgroup.com</u>, or by calling 516.300.2028.



STATEMENT OF APPLICANT (Please read carefully before signing)

I fully understand that any fraudulent misstatements in or purposeful omissions from this application constitute cause for denial of coverage. All information submitted by me in the application is true to my best knowledge and belief.

In making this application for a quote for malpractice insurance coverage, I hereby release from liability all representatives of the New York State Podiatric Medical Association ("NYSPMA") and its officers, directors, staff, agents and consultants, for their acts performed in good faith and without malice in connections with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the NYSPMA or Hilb Healthcare Group, in good faith and without malice concerning and I hereby consent to the release of such information.

I hereby further authorize the Hilb Healthcare Group to communicate to other parties and to other persons or organizations with a legitimate interest therein any information concerning my application for malpractice insurance that it may have or acquire, and where such communication is made in good faith and without malice. I consent thereto and agree to hold NYSPMA and Hilb Healthcare Group and their authorized representatives free of liability thereof.

I understand and agree that I, as an applicant for malpractice insurance, have the burden of producing adequate information for proper evaluation of my claims history, professional competence, character, ethics and other qualifications.

Signature of Applicant

_____/____/____/____ Day Month Year