

II. EDUCATIONAL BACKGROUND

If Additional Space Is Needed, Please Use Supplemental Form

A. MEDICAL SCHOOL

[Grid for Name of School]

NAME OF SCHOOL

[Grid for City and State]

CITY

STATE

[Grid for Country]

COUNTRY

[Grid for Degree, Completed From, and To dates]

DEGREE

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM?

[YES] [NO]

If no, please explain: _____

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS. (i.e., Residency Specialty Training, Anesthesia Residency Training, etc.)

If more than one Specialty completed please enter each specific specialty.

1. [Grid for Name of Hospital/Facility]

NAME OF HOSPITAL/FACILITY

[Grid for City, State, and Country]

CITY

STATE

COUNTRY

[Grid for Specialty Type Completed]

SPECIALTY TYPE COMPLETED

[Grid for Completed From and To dates]

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

2. [Grid for Name of Hospital/Facility]

NAME OF HOSPITAL/FACILITY

[Grid for City, State, and Country]

CITY

STATE

COUNTRY

[Grid for Specialty Type Completed]

SPECIALTY TYPE COMPLETED

[Grid for Completed From and To dates]

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

C. HAVE YOU PARTICIPATED IN ANY ADDITIONAL TRAINING? (i.e., Fellowship, etc.)

[YES] [NO]

1. [Grid for Name of Hospital/Facility]

NAME OF HOSPITAL/FACILITY

[Grid for City, State, and Country]

CITY

STATE

COUNTRY

[Grid for Specialty Type Completed]

SPECIALTY TYPE COMPLETED

[Grid for Completed From and To dates]

COMPLETED FROM

MM

YYYY

TO

MM

YYYY

C. INDICATE THE AVERAGE WEEKLY HOURS OR PATIENTS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE. (If you practice in multiple states, please identify the following information for each state.)

Please provide whole numbers (no ranges i.e., > <). If "none" please enter "0" (zero) in the space provided below.

PATIENTS SEEN PER WEEK

HOURS PER WEEK

WALK-IN PATIENTS PER WEEK

D. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- Abortions
- Acupuncture
 - Therapeutic/Local Anesthetic
 - General Anesthetic
- Angiography
- Angioplasty
- Arthroscopy
- Arteriography
- Assisting In Major Surgery
 - Own Patients Only
 - Own & Other Than Own Patients
- Blepharopigmentation
- Blepharoplasty - Brow Lifts
 - Cosmetic % Of Total Practice
 - Reconstruction % Of Total Practice
- Botox % Of Total Practice
- Breast Implants
 - Cosmetic % Of Total Practice
 - Reconstruction % Of Total Practice
- Bronchoscopy
- Bronco-Esophagology
- Cataract Surgery
- Cryosurgery (Other Than External Lesions)
- ERCP
- D & C
- Phenol Facial Peels
- Diagnostic Embolization
- Anesthesia -General/Spinal/Caudal
 - Pulse Oximetry
 - End Tidal CO2 Analyzer
- Hair Transplants
 - Scalp Excision/Transplantations
 - Plug Technique/Minigraph
- Laproscopic Cholecystectomy
- Laproscopy
- Laser Surgery
- Liposuction
- Lymphangiography
- High Velocity/Low Amplitude (HVLA) on patients 18 years of age or older
- High Velocity/Low Amplitude (HVLA) on patients younger than 18 years of age
- % Osteopathic Manipulation Therapy on patients 18 years of age or older
- % Osteopathic Manipulation Therapy on patients younger than 18 years of age

- Lithotripsy
- Major Gynecological Surgery
- Myelography
- Mammograms
- Needle Biopsy
- Nerve Blocks
 - Lumbar Epidural Steroid
 - Paraspinal
 - Sciatic
 - Facet
 - Paravertebral
 - Peripheral
 - Myofascial
 - Occipital
 - Triggerpoint Injection
 - Intrathecal Pumps
 - Spinal Cord Stimulators
- Phlebography
- Pnuemoencephalography
- Radial/laser keratotomy
- Radiation/X-Ray Therapy
- Radiopaque Dye
 - Non-Ionic Only
- Shock Therapy
- Sigmoidoscopy
 - 60 cm or less
 - Greater Than 60 cm
- Colonoscopy
- Polypectomy
- Gastrointestinal Endoscopy
- Biopsy(Endoscopic)
- Peritoneoscopy
- Laser Therapy (Endoscopic)
- Laser Therapy (Non-Endoscopic)
- Pacemakers
 - Permanent
 - Temporary

- Silicone Injections
- Skin Flaps/Grafts
 - Cosmetic % Of Total Practice
 - Reconstruction % Of Total Practice
- Oxidation Therapy
- Prolotherapy
- Chelation Therapy
- Electromagnetic Therapy
- Rectal Ozone Therapy
- Swan-Ganz Catheterization
- Right Heart Catheterization (Other Than CVP Lines)
- Left Heart Catheterization
- Tubal Ligations
- Vasectomies
 - Own Patients Only
 - Own & Other Than Own Patients
- Weight Control Therapy/Surgery % Of Total Practice
 - Medication - Weight Control
 - Gastric Bubble
 - Gastric Stapling
 - Other(Type): _____
- Prenatal Practice
 - See Patients During The First & Second Trimester
 - See Patients To Term But Do Not Perform Delivery
 - See Patients To Term And Perform Delivery
- Normal Obstetrical Deliveries
 - How Many Per Year? _____
- Cesarean Sections
 - How Many Per Year? _____
- Other Medical Techniques
 - List Procedures (Do not restate your specialty)
 - _____
 - _____
 - _____

If you devote more than 25% of your practice to OMT, please answer both questions below:

1. Do you have an informed consent discussion with all your patients regarding your choice of OMT? YES NO
2. Please describe the use of x-ray or imaging technology used in your practice (i.e., is this required prior to manipulation etc.)

E. INDICATE THE PERCENTAGE OF YOUR TOTAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Plastic (reconstruction only)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Cardiac	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Orthopedic (including back)
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Plastic (cosmetic enhancement only)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Vascular	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Orthopedic (not including back)
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Hand	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Neurosurgery	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Ophthalmology
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Traumatic	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Obstetrics	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Urology
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Thoracic	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Gynecology	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Other (Describe): _____
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % Otorhinolaryngology		_____

F. IN THE LAST TEN (10) YEARS,

- Have you discontinued major surgical procedures, performance of Obstetrics, or any other medical activity? YES NO
 If **yes**, list procedures/activities, **date** discontinued and reason for discontinuing. _____

Date: MM - YYYY
- Have you ever been a representative of a Pedicle Screw Manufacturer?
 If yes, please **attach** an explanation. YES NO
- Have you performed weight control surgery or prescribed weight control medication? YES NO
 - If **yes**, what percentage of your practice (% of patient care) **was** devoted to prescribing anorectic drugs?
 < 1 % 1 % - 10 % 11 % - 50% > 50%
 - If **yes**, what percentage of your practice (% of patient care) **was** devoted to performing weight control surgery?
 < 1 % 1 % - 10 % 11 % - 50% > 50%
- Do you have ownership interests in a weight control clinic? YES NO
- If **yes**, what is the name of the weight control clinic with which you are affiliated: _____

G. IF YOU USE SILICONE GEL/SALINE BREAST IMPLANTS, DO YOU USE THE MANUFACTURER'S INFORMED CONSENT FORMS IN ADDITION TO YOUR NORMAL INFORMED CONSENT PROCEDURE? YES NO

H. DO YOU SERVE IN A HOSPITAL EMERGENCY ROOM FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE? YES NO

- If yes, number of hours per month:
- If yes, are the hours you work in the ER the minimum number of hours required to maintain hospital privileges?
 If you have emergency room activities which are covered by another professional liability insurance policy, complete question I. YES NO

I. WILL YOU BE PERFORMING ACTIVITIES WHICH WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY? YES NO

If **yes**, complete the following: Employee Independent Contractor Resident/Fellow Faculty

Practice name and location(s): _____

Name of Carrier: _____

J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP THE MEDICAL PROTECTIVE COMPANY BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE. _____

V. ADDITIONAL PROFESSIONAL INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

1. Do you perform surgery on professional athletes? YES NO
 If **yes**, what percentage of your practice is devoted to performing surgery on professional athletes? %
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
2. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? YES NO
 If **yes**, include a copy of the indemnification agreement provided by the pharmaceutical company.
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
3. Do you treat or review treatment of federal prison inmates? YES NO
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
4. Do you treat non-federal prison inmates? YES NO
 If **yes**, what percentage of your practice is devoted to treating non-federal inmates? %
 Does this facility have a law library? YES NO
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
5. Do you use a collection agency which has the authority to file collection suits without your knowledge? YES NO
6. Do you practice as a Medical Director at a blood bank? YES NO
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
7. Do you devise or review plant/employer safety standards? YES NO
 (1) What products are manufactured by the company? _____

 (2) Company name: _____ Location: _____
 (If you are covered by other insurance for this activity, please complete Section IV, question 1.)
8. 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, medical license or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? YES NO
 If **yes**, please explain and indicate the date(s): _____ Date: -
 _____ MM YYY Y
9. Have you had any professional liability insurance declined, refused, canceled or non-renewed? YES NO
 If **yes**, please indicate the reason and the date(s): _____ Date: -
 _____ MM YYY Y
10. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? YES NO
 (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)
 If **yes**, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type of Illness: _____
 Duration of Illness: - To -
 MM YYY Y MM YYY Y
 Treating Physician (Name & Address): _____

VI. PRACTICE ORGANIZATION INFORMATION

If Additional Space is Needed, Please Use Supplemental Form

A. PRACTICE ORGANIZATION:

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status
 Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

Solo Unincorporated/Sole Proprietor

Entity Name:

Employment Status

Sole Proprietor Employee Shareholder/Partner Independent Contractor Other

Date Joined/Formed: -
 MM YYY Y

If Other, please explain: _____

A. PRACTICE ORGANIZATION: (continued)

Please check the boxes that best describe your practice affiliation(s) and "x" applicable boxes under Employment Status
Note (1): TO SECURE ENTITY COVERAGE PLEASE CONTACT YOUR AGENT TO COMPLETE AN ENTITY APPLICATION FOR CONSIDERATION

Solo Incorporated-No employed or contracted physicians

Entity Name

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/formed: MM - YYYY

If Other, please explain:

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Individual, Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? YES NO

If yes, do you have any employed or contracted physicians associated with your practice? YES (1) NO

If no, do you wish to share your individual policy limits with your solo corporation? YES NO

If yes, and you desire to share your individual policy limits, please initial here.

Note: To qualify for shared limit solo corporation coverage, you must have no physician employees or physician independent contractors.

** If you desire separate policy limits or you do not qualify for "solo corporation" coverage, please contact your agent to complete a separate entity application for consideration. **

Multi-Shareholder Corporation, Partnership, Limited Liability Company

Entity Name:

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/formed: MM - YYYY

If Other, please explain:

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? YES (1) NO

Hospital Industrial Government-Branch:

Entity Name:

Employment Status

Employee Shareholder/Partner Independent Contractor Other Date Joined/formed: MM - YYYY

If Other, please explain:

Is this entity or employer currently insured with The Medical Protective Company? YES NO

If yes, please provide The Medical Protective Company Corporation or Partnership policy and group number, if known:

Policy #: Group #: Sub-Group#:

If no, do you desire coverage for this entity? YES (1) NO

VIII. CLAIMS/SUIT INFORMATION FORM

(Please make copies if additional forms are needed)

If making additional copies, please enter applicant's name here: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION

1. Patient/Claimant Information:

Grid for LAST NAME

LAST NAME

Grid for FIRST NAME

FIRST NAME

AGE: [][] Gender: Male Female

2. Date of treatment and/or surgery, which led to the allegations against you. [][] - [][][][]

MM YYYY

3. Date claim/incident notice received [][] - [][][][]

MM YYYY

4. Date claim reported to prior insurer [][] - [][][][]

MM YYYY

5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit: _____

6. Disposition or current status of claim or suit: OPEN CLOSED

If Closed, Date of Closing/Settlement or award: [][] - [][][][]

MM YYYY

7. Indicate case value established by carrier, if known: \$ [][][] , [][][] , [][][]

8. Defending Insurance carrier name: _____

CARRIER NAME

9. Claim file number, if known: _____

CLAIM NUMBER

10. Was this matter closed with your consent? YES NO

Was a suit filed? YES NO

Was payment made? YES NO

If no, was claim or suit withdrawn? YES NO

If yes, indicate total amount of settlement or award: \$ [][][] , [][][] , [][][]

Amount paid on your behalf: \$ [][][] , [][][] , [][][]

11. Nature of allegations in the claim or suit: _____

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

12. Please provide a narrative description of the medical facts: (must include, but not limited to the type of treatment and/or surgery; your involvement): _____

Multiple horizontal lines for narrative description

IX. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS, DATING BACK TO COMPLETION DATE OF FORMAL TRAINING. LIST CURRENT INSURER FIRST

1. _____ Insurer	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY to MM - DD - YYYY
2. _____ Insurer	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY to MM - DD - YYYY
3. _____ Insurer	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	MM - DD - YYYY to MM - DD - YYYY

Please explain any gaps in coverage back to your start date of practice: _____

B. COVERAGE DESIRED

1. Occurrence
2. Claims-Made Coverage without Prior Acts Coverage
3. Claims-Made Coverage with Prior Acts Coverage *(A copy of current declaration page showing current retroactive date must be attached)*

IF 1 OR 2 ARE SELECTED FROM THE ABOVE 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 (copy of tail is attached)
 An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying for with The Medical Protective Company if offered, will not provide prior acts coverage.

Initial Here

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 or the additional expense associated with an "extension contract" or "tail coverage."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M.

This date cannot be earlier than the expiration date of your current policy.

Annual policy terms will begin and end on the same month and day.

From: MM - DD - YYYY 12:01 a.m.

To: MM - DD - YYYY 12:01 a.m.

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:

(Not required for occurrence policies or Claims-Made without prior acts)

MM - DD - YYYY 12:01 a.m.

E. LIMITS DESIRED: [] , [] , [] per occurrence/per claims made

[] , [] , [] annual aggregate

Note: Requested limits may not be available from this company

X. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my: Employer OR Named Third Party (Include Name&Address) _____

both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g., termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's Home Office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Note: This assignment is continuous until we receive your written request to revoke your request. Third party finance company assignments must be renewed each year. Do not use this form to assign a third party finance company. Third party finance companies must submit a copy of your signed finance agreement, including your assignment of rights, with their request for cancellation.

XI. STATE STATUTORY REQUIREMENT

NOTE: ALL NEW JERSEY APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

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

Initial Here

XII. PLEASE READ AND SIGN

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) offered me a premium quote; 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 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.

Date Signed: - -
MM DD YYYY

Signature

Print Name

When would you like your quote delivered? - -
MM DD YYYY

