

PHYSICIAN & SURGEON PROFESSIONAL LIABILITY INSURANCE APPLICATION

All questions must be answered completely. If the answer to any question is "NONE" or "NOT APPLICABLE", so state. Upon receiving a copy of your final application from us, the application and all supplemental forms must be signed and dated by the applicant. If your most recent policy is "Claims Made" and you desire to continue coverage back to your "Initial Effective Date" (also known as "Retroactive Date"), please request Prior Acts coverage and submit proof of continuous Claims Made coverage with your final application. (The Declarations Page of your most recent policy is adequate proof.)

Please attach:

- ~ A copy of your curriculum vitae.
- ~ A copy of your current declaration page.

GENERAL INFORMATION

1) Applicant Name:	Last	First	MI
2) Date of Birth	License #	- Expiration	SS#:
3) Addresses:			
OFFICE			
Address		State	Zip
City		Fax	
Phone		E-Mail	
County			
BILLING			
Address		State	Zip
City		Fax	
Phone		E-Mail	
County			
4) Type of Practice (check all that apply):			
<input type="checkbox"/> Individual/Unincorporated	<input type="checkbox"/> Partnership	<input type="checkbox"/> Industrial Employee	
<input type="checkbox"/> Hospital Employee	<input type="checkbox"/> Professional Corporation	<input type="checkbox"/> Government Employee or Contractor	
<input type="checkbox"/> Independent Contractor	<input type="checkbox"/> Individual/Incorporated		
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Other	
5) Broker Name:			
Broker Address:			

COVERAGE HISTORY

1) Is your current coverage:	<input type="checkbox"/> Claims Made Coverage	<input type="checkbox"/> Occurrence Coverage
2) If your current coverage is Claims Made Coverage:		
a) What is the Retroactive (Initial Effective) Date used by the present carrier?		(mm/dd/yy)
b) Did you, or are you planning to, purchase tail coverage from the present carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

3) List professional liability coverage carried for each of the past 5 years. If none, state "NONE".			
Insurance Carrier	Limits of Liability (Each Medical Incident/Aggregate)	Type of Coverage (Claims Made of Occurrence)	Effective Date/Expiration Date
	<input type="checkbox"/> \$500K/\$1.5M Mandatory List if Other:	<input type="checkbox"/> Claims Made Coverage <input type="checkbox"/> Occurrence Coverage	
	<input type="checkbox"/> \$500K/\$1.5M Mandatory List if Other:	<input type="checkbox"/> Claims Made Coverage <input type="checkbox"/> Occurrence Coverage	
	<input type="checkbox"/> \$500K/\$1.5M Mandatory List if Other:	<input type="checkbox"/> Claims Made Coverage <input type="checkbox"/> Occurrence Coverage	
4) Has your professional liability coverage been canceled, nonrenewed or declined by a previous carrier or by the present carrier?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain:			

COVERAGE REQUESTED

1) Requested Effective Date of this policy:		(mm/dd/yy)	
2) Type of coverage: (Check the blocks that apply). If you check Claims Made Coverage, be certain to give us a requested Initial Effective (retroactive) date. All applicants must have the same type of coverage.			
Type of Coverage	Applicant	Corporation, Partnership Or Association (Entity Coverage)	Applicant's or entity's Professional Employees
Claims Made	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
What Initial Effective Date do you request for the Claims Made Coverage?			
None	N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3) Limits Requested: (Select limits requested) NOTE: All entities to be covered by this policy shall carry the same limits.			
Each Medical Incident/Aggregate	<input type="checkbox"/> \$500,000/\$1,500,000		
4a) List the Corporation, Partnership, or Association name(s) if such coverage is required above:			
4b) List all officers, stockholders, partners, members, etc., of the entity(ies) identified in 4(a):			
5) Whether Professional Employee Coverage is desired or not, please identify all Professional			

Employees that you employ or supervise.			
Nurses	#	Nurse Midwives	#
Physicians Assistants	#	Nurse Anesthetists	#
Nurse Practitioners	#	Lab and/or X-Ray Techs	#
Other:	#		
6) Are there any of the above listed employees for whom coverage is not desired? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the names of employees to be excluded.			

PRACTICE HISTORY

1) In chronological order, please list all locations where you have practiced in the past 5 years.					
Location	State				% of Practice
2) Please note and explain any period you did not practice.					
3) If you are not currently licensed, has an application for license been made? <input type="checkbox"/> No <input type="checkbox"/> Yes (State:)					
4) Schooling Information:					
Medical School:					
Date of Graduation:					
First Year of Residency:					
Residency:					
Date of Graduation:					
Type of Residency:					
5) Are you ECFMG Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
6) How many hours do you work per week?					
7) How many scheduled patients do you see per week? How many Walk in patients do you see per week?					
8) Does your practice include treatment or review of inmates at a prison or jail? <input type="checkbox"/> Yes <input type="checkbox"/> No					
9) List each institution where you have admitting privileges and estimate the number of patients admitted within the lat year.					
Do You have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Institution	Type of Privileges*	Number of Patients			

10) Do you use a collection agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, does it have the authority to file a collection suit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

UNDERWRITING INFORMATION

1) What is your Specialty?			
Sub-Specialty?			
2) What is the nature of your practice?			
3) Are you Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specialty:		
	Sub-Specialty:		
4) If you are not Board Certified, are you Board Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Specialty:		
	Sub-Specialty:		
5) What changes have occurred in your practice specialties/procedures, etc., over the past two years?			
6) Please list any procedures that are not normally within the realm of your specialty, but in which you are trained and credentialed to perform:			
7) Courses you've taken or credits you've received via training to qualify you to perform procedures identified above?			
8) How many category 1 (CME) credits have you earned in the last three years?			
9) Please indicate the percentage of time you devote to any of the following surgical specialties (if any):			
%	Specialty	%	Specialty
	Abdominal		Neoplastic
	Cardiac		Otology
	Cardiovascular		Otorhinolaryngology
	Colon & Rectal		Plastic
	Gastroenterology		Thoracic
	Gynecology		Traumatic
	Hand		Urological
	Head & Neck		Vascular
	Laryngology		Other:
If Other, describe:			

10) Please indicate the percentage of your practice which includes the following (percentages should total 100%).	
%	NO SURGERY – includes incision of boils and superficial abscesses, suturing of skin and superficial fasciae, and similar minor procedures encountered in a formal family-type practice. Administration of anesthesia by topical or by means of local infiltration is also included
%	MINOR SURGERY – Includes above and general practitioners and specialists performing normal vaginal deliveries and assisting in major surgery on their own patients.
%	MAJOR SURGERY – Includes above and general practitioners and specialist performing vasectomies, appendectomies, Cesarean sections, tonsillectomies, adenoidectomies, and assisting in major surgery on other than their own patients.
11) What surgeries, if any, are performed in a setting other than an inpatient facility?	
12) In addition, please check any of the following <i>specific</i> surgical procedures and/or medical techniques you perform:	
Abortions (Trimesters): <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd	<input type="checkbox"/> Lasers – List types used:
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Needle Biopsy of Internal Organs
<input type="checkbox"/> Arteriography	<input type="checkbox"/> Paracentesis
<input type="checkbox"/> Catheterization-arterial, cardiac, or diagnostic other than urethral or routine venous catheterization.	<input type="checkbox"/> Radiopaque Dye/Isotope Injections into blood vessels, lymphatics, sinus tracts and fistulae.
<input type="checkbox"/> Cryosurgery	<input type="checkbox"/> Phlebography
<input type="checkbox"/> Diskography	<input type="checkbox"/> Pneumatic or Mechanical Esophageal Dilation
<input type="checkbox"/> Electroconvulsive Therapy	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Hair Transplants	<input type="checkbox"/> Radial Keratotomy
<input type="checkbox"/> Laparoscopy (Peritoneoscopy)	<input type="checkbox"/> Sex – Reassignment Surgery
<input type="checkbox"/> Myelography	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Weight Control Surgery Telemedicine	
Endoscopic Procedures <input type="checkbox"/> For viewing only <input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography <input type="checkbox"/> For viewing, biopsy and/or removal of objects, stones, etc. List types of endoscopic procedures you perform:	Elective Cosmetic Surgery <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Breast Surgery- What type? <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Dermabrasion/Chemabrasion <input type="checkbox"/> Suction-assisted lipectomy <input type="checkbox"/> Other:
13) Do you practice as an emergency room staff physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per month?	
14) Do you practice in a free-standing urgi-care or ambulatory care center? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15) Do you practice in a free-standing abortion clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16) Has your practice included and/or will your practice include use of an experimental drug, equipment or procedure during the time period for which coverage is requested? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give details:	
17) What percentage of time (not including peer review for credentialing purposes) is spent on reviewing another physician's or health care professional's patient care in exchange for a fee?	

PERSONAL HISTORY

1) Have you ever been the subject of an investigation or disciplinary proceeding by any government agency (e.g., State Medical Board, DEA), professional society, or a professional review board of a hospital, HMA, PPO, IPA, etc.? Or are you aware of any incident that could lead to such an action?
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If yes, please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Have you or any of your employees ever had any licensing board or professional ethics body require you to surrender your license or found you guilty of a violation of ethics code, professional misconduct, unprofessional conduct, incompetence or negligence in any state of country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your, or any employee's license to practice medicine or permit to prescribe or dispense drugs ever been denied, revoked, suspended or in any way limited?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, please give details:	
4) Is your, or any employee's, license under investigation in this or any other state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Please give details:	
5) Have you, or any of your employees, ever received notification from a hospital of intent to restrict, suspend, revoke or deny staff privileges or had your privileges denied, suspended or in any way restricted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, please give details:	

CLAIM HISTORY

1) Have you ever been involved in a suit or stated demand for damages arising out of a medical incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Do you have any knowledge of any occurrence or circumstance likely to result in a malpractice claim or suit against you (or any corporation, association or partnership for which you are making application) on or after the effective date of any policy issued, or on or after the requested initial effective date (retroactive date) if prior acts coverage is being requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered yes to either of the above questions, please complete the "Supplemental Claim Information" at the bottom of this application.	

CLAIMS SUPPLEMENTARY FORM

(Please make copies if necessary as a separate form is required for each claim.)

Please Print or Type

1. _____
Applicant's Name

2. _____
Insurance Carrier covering this claim

3. _____
Name of Patient Age at Treatment

4. _____
Date(s) of treatment related to this Claim

5. _____
Date this Claim was filed against you

6. To inform us about your diagnosis and treatment, please attach any of the following that you deem relevant:

Pertinent office records, history and physical, admission note, operative note (if any), pathology report (if any), discharge summary, narrative report.

Note: Attachment of this information is not mandatory, but may assist in our evaluation.

7. Patient Allegations and Outcome:

8. Indicate claim status: Pending Closed

9. If closed, was this by: Settlement Court proceedings

10. If by settlement, what was the amount? \$ _____.

11. If by court proceedings, what was the amount/result? \$ _____.

12. Please give us your comments on the case. Please indicate type of treatment, result of treatment and your involvement. Any additional information will help to expedite the process of obtaining a premium quotation.

Applicant Signature

Date

AGREEMENT, AUTHORIZATION and REPRESENTATION

I, the undersigned, hereby make application for Professional Liability Insurance.

I agree: (a) to implement and comply with reasonable risk management and incident reporting programs for my private practices; (b) to actively participate in risk management and incident reporting programs in effect at any facility(ies) in which I practice or for any group of which I am a member; (c) to report claims and incidents as required by such programs and to Company in accordance with policy terms; and (d) to allow the program coordinator(s) for such programs and/or Company to perform such inspections as may be necessary for the evaluation of potential liability exposures and claims.

I agree to provide updated information to Company of changes in the status of any licensure or staff privileges or of changes in medical techniques or procedures I perform within 30 days of such changes. I understand that failure to do so may result in policy cancellation.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organization, institutions or persons that may have any record or knowledge concerning any of the statements made and answers given herein to release such information to Company upon request. I authorize the use of a copy of this authorization in place of the original.

I hereby represent that, if I am requesting Prior Acts coverage, I have no knowledge of any professional liability claims which have been asserted against me or any corporation, association or partnership for which I am making application or of any occurrence or circumstance likely to result in such a claim, on or after the requested initial Effective Date of Prior Acts Coverage.

Report any incidents involving serious injury including, but not limited to: brain injury, unexpected death, blindness (in one or both eyes), significant burns (including overexposure to radiation), significantly diminished life expectancy, injury to the spinal cord, significant sensory and motor loss, or loss of a significant portion of an arm or leg. Please give a brief description of each such claim, occurrence or circumstance. Please note that no coverage will be provided under the applied-for-policy, for any such claim, occurrence or circumstance permitted to be reported to your current insurance provider*. (*Insurance provider includes any self-insurance, or any other financial mechanism, whether public or private, established for the purpose of paying awards, judgments or settlements for loss or damages against any insured entitled to participate in such mechanism).

I understand that if claims-made coverage under any policy issued is terminated at any time, an extended reporting period (tail) may be purchased where elected in writing within the period stated in such policy.

The information contained herein is true, complete and correct to the best of my knowledge, information and belief. I understand and agree that any policy Company may issue will be issued in reliance upon the representations made in the Application. I also understand that this Application, including the above Agreement, Authorization and Representation, will become a part of any policy so issued. I understand that failure to provide a true and accurate response to any of the information requested herein may result in the denial of claims under any policy so issued.

Upon acceptance by Company, this Application, including the above Agreement, Authorization and Representation, will be made a part of any policy issued.

Any person who knowingly and with intent to defraud any insurance company or other person 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 subjects such person to criminal and civil penalties.

Applicant Signature

Date