

THE MEDICAL PROTECTIVE COMPANY
Physician Professional Liability Insurance Application

I. GENERAL INFORMATION

If additional space is needed, please use the Supplemental Form.

A. _____
 LAST NAME FIRST NAME MIDDLE NAME DEGREE

DATE OF BIRTH (M/D/Y) _____ SOCIAL SECURITY NUMBER _____

B. OFFICE LOCATIONS (List Principal Location First)

1. _____
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY % OF PRACTICE

2. _____
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY % OF PRACTICE

3. _____
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY % OF PRACTICE

C. HOSPITALS WHERE YOU PRACTICE. LIST PRINCIPAL LOCATIONS FIRST.

1. _____
 HOSPITAL CITY STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

2. _____
 HOSPITAL CITY STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

3. _____
 HOSPITAL CITY STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

4. _____
 HOSPITAL CITY STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

D. HOME ADDRESS

_____ SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY

E. PREFERRED MAILING ADDRESS: OFFICE # _____ HOME OTHER (BELOW)
(FROM B ABOVE)

OTHER ADDRESS: _____
 STREET ADDRESS CITY STATE ZIP

() BUSINESS PHONE () BUSINESS FAX E-MAIL ADDRESS

II. EDUCATIONAL BACKGROUND

A. MEDICAL SCHOOL

_____ NAME OF SCHOOL CITY STATE COUNTRY DEGREE MM/DD/YY COMPLETED

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

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS.

If you are currently in a residency or fellowship program, please enter your anticipated residency/fellowship ending date here: _____

Your Medical Protective Company policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.

1. _____
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

2. _____
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

3. _____
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

ADDITIONAL TRAINING (FELLOWSHIP, ETC.)

4. _____
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

C. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? Yes No

D. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS? Yes No

If "yes", how many category 1 credit hours? _____

E. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE PAST TWELVE (12) MONTHS? Yes No

F. IF YOU ANSWERED YES, DID THE COURSE PROVIDE ALL OF THE FOLLOWING:

A minimum of three category 1 continuing medical education (CME) hours;
Provide the CME hours through an approved national / regional medical education sponsor; and
Strictly adhere to a risk management (loss prevention) curriculum? Yes No

Please attach your completion (attendance) certificate from the CME program.

III. PRACTICE INFORMATION

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? Yes No
(If this is covered by another professional liability insurance policy, complete question IV. I.)

IF YES, WHICH STATE(S) _____

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE

1. STATE _____ LICENSE# _____ 3. STATE _____ LICENSE# _____

2. STATE _____ LICENSE# _____ 4. STATE _____ LICENSE# _____

5. PENDING LICENSE? Yes No PENDING STATE _____ TEMPORARY LICENSE# _____

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST.

CITY _____ STATE _____ SPECIALTY _____ FROM MONTH/YEAR TO MONTH/YEAR _____

CITY _____ STATE _____ SPECIALTY _____ FROM MONTH/YEAR TO MONTH/YEAR _____

CITY _____ STATE _____ SPECIALTY _____ FROM MONTH/YEAR TO MONTH/YEAR _____

D. TO WHICH STATE/LOCAL MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG?

IV. RATING INFORMATION

A. WHAT IS YOUR PRESENT SPECIALTY? _____ SUB-SPECIALTY? _____

What percentage of your practice is devoted to your specialty? _____ Subspecialty? _____

Are you permanently retired from the practice of clinical medicine? Yes No

B. AMERICAN BOARD CERTIFIED? Yes No _____
SPECIALTY BOARD DATE CERTIFIED

IF NO, ARE YOU BOARD ELIGIBLE? Yes No

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS? _____

C. INDICATE THE AVERAGE WEEKLY NUMBERS, 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.)

PATIENTS SEEN PER WEEK _____ HOURS PER WEEK _____ WALK-IN PATIENTS PER WEEK _____

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

- | | | |
|--------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> ABORTIONS | <input type="checkbox"/> LAPAROSCOPIC CHOLECYSTECTOMY | <input type="checkbox"/> BIOPSY (ENDOSCOPIC) |
| <input type="checkbox"/> ACUPUNCTURE | <input type="checkbox"/> LAPAROSCOPY | <input type="checkbox"/> PERITONEOSCOPY |
| <input type="checkbox"/> THERAPEUTIC/LOCAL ANESTHETIC | <input type="checkbox"/> LASER SURGERY | <input type="checkbox"/> LASER THERAPY (ENDOSCOPIC) |
| <input type="checkbox"/> GENERAL ANESTHETIC | <input type="checkbox"/> LIPOSUCTION | <input type="checkbox"/> PACEMAKERS UNDER GENERAL ANESTHESIA |
| <input type="checkbox"/> ANGIOGRAPHY | <input type="checkbox"/> LYMPHANGIOGRAPHY | <input type="checkbox"/> SILICONE INJECTIONS |
| <input type="checkbox"/> ANGIOPLASTY | <input type="checkbox"/> LITHOTRIPSY | <input type="checkbox"/> SKIN FLAP/GRAFTS |
| <input type="checkbox"/> ARTHROSCOPY | <input type="checkbox"/> MAJOR GYNECOLOGICAL SURGERY | COSMETIC _____% OF PRACTICE |
| <input type="checkbox"/> ARTERIOGRAPHY | <input type="checkbox"/> MYELOGRAPHY | RECONSTRUCTION _____% OF PRACTICE |
| <input type="checkbox"/> ASSISTING IN MAJOR SURGERY | <input type="checkbox"/> NEEDLE BIOPSY | <input type="checkbox"/> SWAN-GANZ CATHETERIZATION |
| <input type="checkbox"/> OWN PATIENTS ONLY | <input type="checkbox"/> NERVEBLOCKS | <input type="checkbox"/> RIGHT HEART CATHETERIZATION (OTHER THAN CVP LINES) |
| <input type="checkbox"/> OWN & OTHER THAN OWN PATIENTS | <input type="checkbox"/> LUMBAR EPIDURAL STEROID | <input type="checkbox"/> LEFT HEART CATHETERIZATION |
| <input type="checkbox"/> BLEPHAROPIGMENTATION | <input type="checkbox"/> PARASPINAL | <input type="checkbox"/> TUBAL LIGATIONS |
| <input type="checkbox"/> BLEPHAROPLASTY - BROW LIFTS | <input type="checkbox"/> SCIATIC | <input type="checkbox"/> VASECTOMIES |
| COSMETIC _____% OF PRACTICE | <input type="checkbox"/> FACET | <input type="checkbox"/> ON OWN PATIENTS |
| RECONSTRUCTION _____% OF PRACTICE | <input type="checkbox"/> PARAVERTEBRAL | <input type="checkbox"/> ON OTHER THAN OWN PATIENTS |
| <input type="checkbox"/> BREAST IMPLANTS | <input type="checkbox"/> PERIPHERAL | <input type="checkbox"/> WEIGHT CONTROL THERAPY/SURGERY _____% PRACTICE |
| COSMETIC _____% OF PRACTICE | <input type="checkbox"/> MYOFASCIAL | <input type="checkbox"/> MEDICATION-WEIGHT CONTROL |
| RECONSTRUCTION _____% OF PRACTICE | <input type="checkbox"/> OCCIPITAL | <input type="checkbox"/> GASTRIC BUBBLE |
| <input type="checkbox"/> BRONCHOSCOPY | <input type="checkbox"/> TRIGGERPOINT INJECTION | <input type="checkbox"/> GASTRIC STAPLING |
| <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> PHLEBOGRAPHY | <input type="checkbox"/> OTHER WEIGHT CONTROL PROCEDURES |
| <input type="checkbox"/> CRYOSURGERY (OTHER THAN EXTERNAL LESIONS) | <input type="checkbox"/> PNUOMOENCEPHALOGRAPHY | <input type="checkbox"/> PRENATAL PRACTICE |
| <input type="checkbox"/> ERCP | <input type="checkbox"/> RADIAL/LASER KERATOTOMY | <input type="checkbox"/> SEE PATIENTS DURING THE FIRST & SECOND TRIMESTER |
| <input type="checkbox"/> D & C | <input type="checkbox"/> RADIATION/X-RAY THERAPY | <input type="checkbox"/> SEE PATIENTS TO TERM BUT DO NOT PERFORM DELIVERY |
| <input type="checkbox"/> PHENOL FACIAL PEELS | <input type="checkbox"/> RADIOPAQUE DYE | <input type="checkbox"/> SEE PATIENTS TO TERM AND PERFORM DELIVERY |
| <input type="checkbox"/> DIAGNOSTIC EMBOLIZATION | <input type="checkbox"/> NON-IONIC ONLY | <input type="checkbox"/> NORMAL OBSTETRICAL DELIVERIES |
| <input type="checkbox"/> GENERAL/SPINAL/CAUDAL ANESTHESIA | <input type="checkbox"/> SHOCK THERAPY | HOW MANY PER YEAR? _____ |
| <input type="checkbox"/> PULSE OXIMETRY | <input type="checkbox"/> SIGMOIDOSCOPY | <input type="checkbox"/> CESAREAN SECTIONS |
| <input type="checkbox"/> END TIDAL CO ₂ ANALYZER | <input type="checkbox"/> LESS THAN 60 CM | HOW MANY PER YEAR? _____ |
| <input type="checkbox"/> HAIR TRANSPLANTS | <input type="checkbox"/> GREATER THAN 60 CM | <input type="checkbox"/> OTHER MEDICAL TECHNIQUES |
| <input type="checkbox"/> SCALP EXCISION/TRANSPLANTATIONS | <input type="checkbox"/> COLONOSCOPY | LIST PROCEDURES _____ |
| <input type="checkbox"/> PLUG TECHNIQUE/MINIGRAPH | <input type="checkbox"/> POLYPECTOMY | _____ |
| | <input type="checkbox"/> GASTROINTESTINAL ENDOSCOPY | _____ |

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

- | | | |
|--------------------------------------------|-------------------|----------------------------------------|
| _____% PLASTIC (RECONSTRUCTION ONLY) | _____% THORACIC | _____% ORTHOPEDIC (INCLUDING BACK) |
| _____% PLASTIC (COSMETIC ENHANCEMENT ONLY) | _____% CARDIAC | _____% ORTHOPEDIC (NOT INCLUDING BACK) |
| _____% HAND | _____% VASCULAR | _____% OTHER (DESCRIBE) _____ |
| _____% TRAUMATIC | _____% OBSTETRICS | |

F. IN THE LAST TEN (10) YEARS,

- Have you discontinued major surgical procedures? Yes No
If **Yes**, list procedures **and date** discontinued _____
- Have you ever been a representative of a Pedicle Screw Manufacturer? Yes No
If **Yes**, please attach an explanation.
- 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: _____ **Indiana Only:** _____% Major Surgery _____% Minor Surgery
If you have emergency room activities which are covered by another professional liability insurance policy, complete question I.

I. WILL YOU BE PERFORMING ACTIVITIES WHICH WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY?

Yes No

If **Yes**, complete the following:

Practice name and location: _____

Employee Independent Contractor Resident/Fellow Faculty 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

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? _____%
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 I)
3. Do you treat or review treatment of Federal prison inmates? Yes No
4. Do you treat non-federal prison inmates? Yes No
If yes, what percentage of your practice is devoted to treating non-federal inmates? _____%
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
7. Do you devise or review plant/employer safety standards? Yes No
(1) What products are manufactured by the company? _____
(2) Company name _____ Location _____
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 indicate the date(s): _____
9. Have you had any professional liability insurance refused, canceled or non-renewed? Yes No
10. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.) Yes No

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	Duration	Treating Physician (Name & Address)
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B. PRACTICE ORGANIZATION:

Please check the boxes that best describes your practice affiliation(s): ("X" applicable boxes under **B1** and **B2**).

B1. Employment status:

- Employee
- Shareholder/Partner
- Independent Contractor
- Solo Unincorporated/Sole Proprietor
- Other: _____

B2. Entity Type:

- Multi-Shareholder Corporation, Partnership, Limited Liability Company
- Solo Incorporated – No employed or contracted physicians
- Hospital
- Government
- Industrial
- Other - please explain: _____

C. NAME OF YOUR PARTNERSHIP, PROFESSIONAL CORPORATION OR ASSOCIATION:

D. 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 number**, if known: _____
The Medical Protective Company **Group Number**, if known: _____

E. IF THE BUSINESS PURPOSE OF THE ENTITY IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN: _____

VIII. COVERAGE INFORMATION

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS. LIST CURRENT INSURER FIRST.

1. OCCURRENCE
 CLAIMS-MADE / / TO / /
INSURER

2. OCCURRENCE
 CLAIMS-MADE / / TO / /
INSURER

3. OCCURRENCE
 CLAIMS-MADE / / TO / /
INSURER

B. COVERAGE DESIRED

1. Occurrence

CLAIMS-MADE

2. Claims-Made Coverage with Prior Acts Coverage.

(A copy of current declaration page showing current retroactive date must be attached).

Claims-Made Coverage without Prior Acts Coverage.

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 in the future as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am purchasing from The Medical Protective Company, 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

From: / / 12:01 a.m.
MONTH DAY YEAR

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. To: / / 12:01 a.m.
MONTH DAY YEAR

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS / / 12:01 a.m.

This date cannot be greater than the retroactive date shown on your current policy. MONTH DAY YEAR

E. IF YOU PRACTICE IN THE FUND STATES OF INDIANA, KANSAS, LOUISIANA, NEBRASKA, NEW MEXICO, PENNSYLVANIA OR WISCONSIN, PLEASE INDICATE YOUR CURRENT FUND RETROACTIVE DATE IF DIFFERENT THAN THE RETROACTIVE DATE STATED ABOVE: / / 12:01 a.m.
MONTH DAY YEAR

Are you aware of any gaps in your Fund coverage? Yes No

If yes, please provide the exact dates and a written explanation: _____

F. LIMITS DESIRED _____ / _____ per occurrence/annual aggregate

IX. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer 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 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

