COVERYS RRG

Physicians and Surgeons
Professional Liability Application

Coverys RRG, Inc.

NOTICE: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state State insurance insolvency guaranty funds are not available for your risk retention group.

PART I - PRODUCER INFORMATION

Agency Name		Submitted By	
Agency License Number	State	Telephone	Most Recent Coverys RRG Policy Number

PART II - APPLICANT INFORMATION

First Name	Middle Initial	Last Name ❑ Male ❑ Female	Social Security Number	Date of Birth

Email Address	Website
Contact Person/Insured Representative	**National Provider Identifier**

Office Address One
Address One — Percentage of practice: _____
Address Two — County
City — State — Zip
Phone — Fax

Residence Address
Address One
Address Two
City — State — Zip
Phone — Fax

Office Address Two
Address One — Percentage of practice: _____
Address Two — County
City — State — Zip

Mailing Address
(if different than Office Address One)
Address One
Address Two
City — State — Zip

Office Address Three
Address One — Percentage of practice: _____
Address Two — County
City — State — Zip

Billing Address
(if different than Office Address One)
Address One
Address Two
City — State — Zip

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed	Additional Malpractice Insurance
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No

Is there any part of your practice that is covered by any other professional liability? ❑ Yes ❑ No

If yes, please provide details and copy of declaration page of policy: _____

Name and location of all healthcare facilities where you have medical staff or courtesy privileges:

Facility Name	City	State	JCAHO Approved?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

PART IV - COVERAGE INFORMATION

Type of Coverage (choose one)

❑ Occurrence ❑ Claims Made Retroactive date desired*_____

❑ Moonlighting Only (When selected, please complete and submit CRRG APP 017, Moonlighter Credit Addendum.)

Coverage Effective Date

From _____ To _____

Do you wish to purchase Prior Acts Coverage? ❑ Yes ❑ No (If yes, please complete and submit CRRG APP 015, Prior Acts Application.)

*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Requested limits and/or policy types may not be available in all states.

Professional Liability

Each Claim $ _____ Annual Aggregate $ _____

You may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from $5,000 to $1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy the deductible must be fully collateralized. Would you like more information on deductibles? ❑ Yes ❑ No

PART V - EDUCATION

Country	State/Province	School of Graduation	Type of Degree:
			Graduated: *(month)* *(year)*

Name of location where internship was served:

City: State: Country: Graduated: *(month)* *(year)*

Name of location where residency was served:

City: State: Country: Graduated: *(month)* *(year)*

Name of location where fellowship was served:

City: State: Country: Graduated: *(month)* *(year)*

If foreign medical school graduate, are you certified by the educational council for foreign medical graduates? ❑ Yes ❑ No

Have you participated in any continuing medical education within the last five years? If yes, please attach a description or a copy of a certificate of completion. ❑ Yes ❑ No

Are you certified by an approved specialty board? ❑ Yes ❑ No

If so, list specialty and attach a copy of the certificate(s): _____ Date Certified: _____ *(month)* / _____ *(year)*

Which professional organizations are you a member of? ❑ AMA ❑ State medical ❑ County medical (list counties): _____

❑ Other _____

PART VI - CURRENT PRACTICE

Type of practice: ❑ Individual ❑ Postgraduate year one (intern) ❑ Resident ❑ Fellow ❑ Partnership ❑ Professional Corporation ❑ Solo Corporation ❑ Locum Tenens

Residents and Fellows *(complete this section)*

Indicate specialty this year

Date program ends *(month)* *(year)*

Separate Limit of Liability for Partnership or Corporation ❑ Yes ❑ No

Not available on solo corporations (except in PA). Current practice must be partnership or corporation.

If yes, please complete and submit **CRRG APP 008, Partnership & Corporation Professional Liability Application**.

Partnership or Corporation *(complete this section)*

Name of Partnership or Corporation

Name of partner(s) or other members

If you are employed by others, or perform services on behalf of others as an independent contractor, list the names of those other persons or entities.	Employment Status
	❑ Employee ❑ Independent Contractor
	❑ Employee ❑ Independent Contractor
	❑ Employee ❑ Independent Contractor

Are you covered by the Federal Tort Claims Act? (If yes, please complete and submit CRRG APP 024, FTCA Restricted Coverage.) ❑ Yes ❑ No

Do you practice 20 hours or less a week or 80 hours or less a month in direct patient care? ❑ Yes ❑ No

(If yes, please complete and submit CRRG APP 020, Limited Practice Credit.)

Do you hold a full time teaching appointment with regular clinical supervision responsibilities? ❑ Yes ❑ No

(If yes, please complete and submit CRRG APP 021, Academic Credit.)

Do you use Locum Tenens? ❑ Yes ❑ No

If yes, indicate the number of days per year: _____ days

PART VII - PRACTICE ACTIVITIES

Surgeons, please provide breakdown of surgical activities:

% (Surgery)

_____Abdominal
_____Bariatric
_____Cardiac
_____Colon/Rectal
_____General
_____Gynecology
_____Hand
_____Head/Neck
_____Laparoscopic Surgery
_____Neurosurgery
_____OB/GYN
_____Ophthalmology
_____Orthopedic (incl. spinal surgery)
_____Orthopedic (no spinal surgery)
_____Otorhinolaryngology
_____Plastic
_____Plastic Otorhinolaryngology
_____Podiatric
_____Thoracic
_____Traumatic
_____Urological
_____Vascular

Please state your medical specialty: _____

Indicate below the percentage of time devoted to the following medical activities.

%	%	%
_____Aerospace	_____Hematology/Oncology	_____Otorhinolaryngology
_____Allergy/Immunology	_____Hospitalist	_____Pain Management
_____Anesthesiology	_____Hypnosis	_____Pathology
_____Broncho-esophagology	_____Infectious Disease	_____Pediatrics
_____Cardiovascular	_____Intensive Care (including patients of others)	_____Pharmacology - clinical
_____Dermatology		_____Physiatry/Physical Medicine & Rehab
_____Diabetes	_____Intensivist (hospital based only)	_____Podiatry
_____Emergency Medicine	_____Internal Medicine	_____Psychiatry
_____Endocrinology	_____Neoplastic Disease	_____Psychoanalysis
_____Family Practice (excludes all OB)	_____Nephrology	_____Psychosomatic Medicine
	_____Neurology	_____Public Health
_____Family Practice (includes OB)	_____Nuclear Medicine	_____Pulmonary Diseases
	_____Nutrition	_____Radiology
_____Forensic	_____Obstetrics	_____Radiation Oncologist
_____Gastroenterology	_____OB/GYN	_____Rheumatology
_____General Preventive	_____Occupational Medicine	_____Urgent Care
_____Geriatric Medicine	_____Ophthalmology	_____Urology
_____Gynecology	_____Orthopedics (office practice only)	
_____Other, specify: _____		

Please list type of Laparoscopic procedures performed: _____

Do you perform robotic surgery? ❑ Yes ❑ No

Have your practice specialties/procedures, etc., changed in the past five years? ❑ Yes ❑ No

Specialty/Procedure	Describe Change	Date of Change

Select one of the following as applicable:

❑ No Surgery - Includes incision of boils and superficial abscess, or suturing of skin or superficial fascia, or Mohs surgery.

❑ Minor Surgery - Includes obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered *major surgery*. If assisting on own patients, indicate average time per month: _____

❑ Major Surgery - Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures, the removal of any gland or organ, and plastic surgery.

❑ Assisting in Major Surgery - On the patients of others. If assisting, indicate the percentage of total practice spent assisting: _____ %
(Do not include if you occasionally assist on an emergency basis.)

All Specialties: Identify the medical techniques/procedures that you perform by indicating the number per month.

_____ Angiography
_____ Arteriography
_____ Catherization: cardiac OR
_____ Insertion of permanent pacemakers
_____ Catherization: arterial, diagnostic, swan ganz, or umbilical OR
_____ Insertion of temporary pacemakers
_____ Circumcisions
_____ Colonoscopy
_____ Cryosurgery - other than use on benign or pre-malignant dermatological lesions
_____ ERCP (Endoscopic retrograde cholangiopancreatography)
_____ Hair transplants
_____ Lasers - ablative
_____ Laser lithotripsy
_____ Liposuction/suction lipectomy
_____ Lymphangiography
_____ Mohs micrographic surgery
_____ Myelography
_____ Needle biopsy - other than liver, breast, kidney, or bone marrow biopsy. Indicate type: _____
_____ Phlebography
_____ Pneumatic or mechanical esophageal dialation (not with bougie or olive)
_____ Polypectomy
_____ Purcutaneous lithotripsy
_____ Radiation therapy
_____ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae
_____ Rigid bronchoscopy
_____ Other: _____
_____ None of the Above

Have you ever performed any of these techniques/procedures in the past five years? ❑ Yes ❑ No

If yes, please explain: _____

Obstetricians, Family & General Practitioners

Give the number of the following you perform per year

Deliveries: Babies delivered by normal vaginal delivery only: _____ Babies delivered by C-Section: _____

Babies delivered vaginally after a C-Section: _____ C-Section Assists: _____

Are you assisting with C-Sections on patients of others? ❑ Yes ❑ No Are you a laborist only? ❑ Yes ❑ No

Otorhinolaryngologists

Do you perform plastic surgery? ❑ Yes ❑ No Do you perform cosmetic plastic surgery? ❑ Yes ❑ No

If yes, do you do reconstructive or any other plastic surgery procedure in an area of the anatomy other than the ear, nose, throat area? ❑ Yes ❑ No

If yes, please specify or attach an explanation: _____

_____

All Specialties

Do you perform surgical procedures in your office? ❑ Yes ❑ No

Do you own, operate or use surgi-center facilities? ❑ Yes ❑ No

Do you normally staff an emergency room? ❑ Yes ❑ No

If yes, are you board certified in emergency medicine? ❑ Yes ❑ No

Give number of hours in emergency medicine per month: _____ hours

Do you or any of your employees perform Botox or Collagen injections? ❑ Yes ❑ No
(If yes, please complete and submit CRRG APP 042, Botox/Cosmetic Procedures Addendum.)

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ❑ Yes ❑ No

(If yes, please complete and submit CRRG APP 040, Clinical Trials Addendum.)

Do you provide services at a correctional facility? ❑ Yes ❑ No

(If yes, list where: _____)

Do you participate in any telemedicine activities? (If yes, please complete and submit CRRG APP 043, Telemedicine Addendum.) ❑ Yes ❑ No

Do you participate on any committees that conduct quality assurance, peer, or utilization review? ❑ Yes ❑ No

(If yes, please complete the chart below.)

Name	City	State	Type of Review
			❑ Quality Assurance ❑ Peer Review ❑ Utilization Review
			❑ Quality Assurance ❑ Peer Review ❑ Utilization Review
			❑ Quality Assurance ❑ Peer Review ❑ Utilization Review

PART VIII- EMPLOYEES/ADDITIONAL INSUREDS

Please list the following for any physicians, surgeons or certified nurse midwives you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete CRRG APP 041, Independent Contractor Addendum.

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Independent Contractor	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Coverys RRG Insured	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

(continued next page)

Applying for Coverys RRG Coverage	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Specialty				
Surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery
Assisting with Surgery	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients	❑ Own patients ❑ Others' patients
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Graduation Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Residency Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Fellowship Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*

Job Title/Specialty	Number of Employees

Does any one physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? ❑ Yes ❑ No

If yes, please submit either a letter outlining practice guidelines or a copy of practice guidelines.

Do you want employee coverage under separate limits? ❑ Yes ❑ No

Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete **CRRG APP 026, Employee Limit of Liability Application**.

PART IX - HISTORY

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	*From* *To*	*From* *To*	*From* *To*	*From* *To*
Insurer				
Policy #				
Coverage				
Premium				
Tail Purchased	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Retroactive Date				
Limit				
Facility				
State				
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.

Have you ever been denied a medical license? ❑ Yes ❑ No

Has your medical license ever been restricted, suspended, voluntarily surrendered or revoked in any state? ❑ Yes ❑ No

Has your DEA certification ever been restricted, suspended, voluntarily surrendered or has probation been invoked? ❑ Yes ❑ No

Has any hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges, or probation? ❑ Yes ❑ No

Have you ever been involved in or are you aware of any future involvement in any local, state or federal investigation or proceeding by a regulatory agency or peer review board? ❑ Yes ❑ No

Have you ever had a complaint or claim brought against you for sexual misconduct? ❑ Yes ❑ No

Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree? ❑ Yes ❑ No

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? (If yes, please list company, date and reason for this action below.) ❑ Yes ❑ No

Company	Date	Reason

Have you ever been indicted and/or convicted of a crime other than minor traffic violations? ❑ Yes ❑ No

Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)? ❑ Yes ❑ No

Do you know of any pending claims, incidents or activities, including any request for patient records, that might give rise to any claim in the future? ❑ Yes ❑ No

If you answered yes to any of the above questions, you must provide a detailed written narrative.

Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such? ❑ Yes ❑ No

If yes, please accompany this application with a letter outlining dates of treatment, results of treatments, and current status.

This letter should be from your treating physician or institution.

PART X - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

Professional Contractual Liability

Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance*. There is a charge based on a percentage of your professional liability premium. ❑ Yes ❑ No

For New Jersey Applicants Only - Consent to Settle

The right to consent to settle is automatically provided to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. You may choose to waive this right for a 5% premium credit to your policy. Would you like to waive this right? ❑ Yes ❑ No

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- ❑ Copy of current Declaration Page.
- ❑ Curriculum vitae (C.V.) for applicant and each employed or contracted physician.
- ❑ Loss runs from all carriers for prior 15 years, or since the start of the practice, whichever is greater.
- ❑ A narrative of all past claims - *a Claim Information Form may be used when necessary.*
- ❑ Signed Notice to New Applicants (CRRG APP 028) for claims made policies.
- ❑ Signed Anti-Fraud Statement (New Jersey).
- ❑ Copies of each physician's license to practice and board certification.
- ❑ Copy of previously purchased tail policies, if applicable.

READ CAREFULLY BEFORE SIGNING

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

REPRESENTATIONS AS TO ACCURACY OF APPLICATION, THE AUTHORITY OF PERSON SIGNING, AND APPLICANT'S OBLIGATION TO SUPPLEMENT INFORMATION

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

AUTHORIZATION TO OBTAIN INFORMATION

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Signature of Applicant	**Title**
Printed Name	**Date**