

## Application for Professional Liability Insurance

This is an application for insurance and is not a binder. No coverage exists until authorized in writing by the Company.

### 1. Personal and Demographic Information

**Requested effective date:**

<b>Name:</b>				Office Phone: (    )	
<b>Office Address:</b>				Office Fax: (    )	
				Email:	
<b>City/State/Zip Code:</b>			<b>County:</b>		Web Site:
<b>Residence Address:</b>		<b>Billing Address (Complete if different from Office Address)</b>			Last four digits of Social Security #:
					Date of Birth:
					Female <input type="checkbox"/> Male <input type="checkbox"/>
<b>Preferred Mailing Address:</b> Please check one		<input type="checkbox"/> Office	<input type="checkbox"/> Residence	<input type="checkbox"/> Other	If "other," state here:
		If not chosen, default is office address			

### 2. Professional Education

Please indicate the name of the medical or dental school and/or hospital and the city and state where located.	Degree and/or Specialty	Completed?		Date Completed (or expected)
		Yes	No	
<b>Medical or Dental School:</b>				
<b>Internship:</b>				
<b>Residency:</b>				
<b>Residency:</b>				
<b>Fellowship:</b>				

### 3. Certification/Specialty

<b>Are you Board Certified</b> (By a member-board of the American Board of Medical Specialties or Osteopathic Specialties)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Are you Board Eligible</b> (and <u>currently</u> in the exam process)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>In what specialties are you Board Certified?</b>			<b>Have you ever failed a specialty or sub-specialty exam? Number:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**General and/or Subspecialty Certificate (or other training, e.g., laser or laparoscopic procedures) in:**

**Describe the specialty you will be practicing while insured by MDAvantage:**

**List the primary focus of your practice:**

#### 4. Licensure

Please indicate in which states you are presently licensed to practice and indicate what percentage of your total practice is spent in each. For surgeons or obstetricians, base your percentages on surgeries or deliveries.

State	License Number	Date of License	% of Total Practice

**D.E.A. Registration Number:**

If you answer "Yes" to any of the first three questions, please attach a complete explanation.	Yes	No
1. Has your medical or dental license in any state ever been suspended, revoked or limited?		
2. Are you currently under investigation by any state or federal licensing board or agency?		
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited?		
4. In the past two years, have you been diagnosed or treated for any substance abuse?		
5. In the past two years, have you been diagnosed or treated for disability, mental illness, serious physical injury, or illness that has or might affect your ability to practice medicine or surgery?		
6. If you answered yes to either question 4 and/or 5 above, then are you being monitored by a Professional Assistance Program approved by the State Board of Medical Examiners?		

#### 5. Practice Locations

Please state the name and location(s) including street address, city, and state where you work/practice. Describe if your duties differ from your practice specialty: Attach additional sheets if needed.

1.
2.
3.
4.
5.
6.

If you are approved for coverage, do you want MDA Advantage to send you a Certificate of Insurance for each hospital listed above?	Yes	No
Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges or your application or reapplication for medical staff privileges? If yes, attach complete explanation.		
Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? If yes, attach complete explanation.		

<b>Name of Practice Manager:</b>	<b>Practice Manager's Email Address:</b>
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#### 6. Other Exposures

Do you wholly or partially own or directly or indirectly operate, or serve as an executive or administrative officer, medical director or department head for any hospital, nursing home, non-hospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization? If "yes," indicate its name and describe your relationship(s) below.	Yes	No

## 6. Other Exposures (Continued)

## 7. Type of Coverage

Policy Selection		Limits of Insurance
Please indicate your choice of policy type:		Please check the limits of insurance desired: (each medical incident/aggregate)
Claims-made	Claims-made coverage does not include extended reporting ("tail") coverage.	
Permanent Protection	Permanent Protection is claims-made coverage that includes extended reporting ("tail") coverage.	

- \$1M/\$3M       \$2M/\$4M  
 \$3M/\$5M       \$5M/\$7M

Optional Policy Provision – Waiver of Right to Consent to Settle	Deductibles
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If insured under a Group Policy, this section (Waiver of Right to Consent to Settle) does not apply. Groups must submit a written request for this quote separately.

- Please check here if you would like to request a quote to waive your right to Consent to Settle of any claim or suit and receive a premium reduction. If you choose this option, MDAdvantage has the right to settle any claim or suit against you without requiring your consent.  
 I do not choose to waive my right to consent to settle of any claim or suit.

If insured under a Group Policy, this section (Deductible) does not apply. Groups must submit a written request for this quote separately.

**Deductibles apply to indemnity only.** If this option is chosen, you will need to collateralize the deductible with an unconditional and irrevocable evergreen letter of credit prior to the inception of the policy. Please check the deductible option below to receive additional information:

- \$5,000 per claim /\$15,000 annual aggregate deductible  
 \$25,000 per claim /\$75,000 annual aggregate deductible  
 \$100,000 per claim /\$300,000 annual aggregate deductible  
 \$250,000 per claim /\$750,000 annual aggregate deductible  
 \$500,000 per claim /\$1,500,000 annual aggregate deductible  
 \$1M per claim /\$3M annual aggregate deductible  
 I do not choose a deductible option.

## Solo Practice

If you wish to add your **Solo Professional Corporation** as an additional insured on your policy, sharing your limits of insurance (no additional premium), please check the box to the right. **We will add the name you indicate on page 4.** **Note:** If coverage is needed for any other type of corporation or partnership other than a Solo Corporation, please complete an **Application for Corporation/Partnership Insurance**. Coverage will not take effect unless an application has been approved by MDAdvantage.

Add Solo Corporation?

Yes No

## 8. Professional Liability Insurance History

	Current Year	1 <sup>st</sup> Year Prior	2 <sup>nd</sup> Year Prior	3 <sup>rd</sup> Year Prior	4 <sup>th</sup> Year Prior	
Insurance Company						
Limits of Insurance						
Type of Policy (Claims-made / Permanent Protection or Occurrence))						
Policy Period						
Retroactive Date						
If your previous policy was <b>claims-made</b> , did you obtain extended reporting period (“tail”) coverage? If “yes,” please enclose a copy.					Yes	No
Have you ever practiced without professional liability insurance? If “yes,” please attach a complete explanation including dates.						
Has your professional liability insurance ever been cancelled or nonrenewed (other than at your request); has your policy premium ever been surcharged or has your application for professional liability insurance ever been declined? If “yes,” please attach a complete explanation.						
<b>Note: If you practice as a general surgeon, obstetrician/gynecologist or orthopedic surgeon, you must also complete the specialty application on page 10.</b>						

## 9. Current Practice

Practice Organization	Name of Employer/Legal Entity	Members of Your Group
Check which applies:	Please indicate the name of your employer:	Please indicate the number of:
Solo unincorporated		Physicians, Dentists or Podiatrists in your group
Solo professional corporation		
Partner in a partnership		Those insured by or applying to MDAdvantage:  (Note: MDAdvantage must insure at least 50% if you also wish to insure your corporation and paramedical employees with MDAdvantage).
Shareholder & employee in a professional corporation		
Employee or contractor for a professional corp., hospital, clinic, etc.		

Practice Profile	Average Number Per Week	Principal Medical or Surgical Practice
		Please describe the practice for which this insurance is needed.
Practice hours (total hours – not just patient contact)		
Patient visits, excluding obstetrical deliveries (in office, hospital, etc.)		
Surgeries (major – in hospital)		
Surgeries (major – in surgical centers)		
Obstetrical deliveries		
Does your practice utilize an electronic medical record system?		Yes No
Does your practice utilize an electronic prescription writer?		Yes No
<b>First Date of Practice:</b> Please indicate your first date of practice (For physicians or dentists entering practice for the first time after completing a residency or fellowship program or service in a government-funded health care program, such as the U.S. Public Health Service or the U.S. Military, as repayment of a medical education funding obligation). <b>Date:</b>		





## 12. Claim History

**Note: Your application will not be approved unless you provide complete claim information.**

In the past ten years, has any claim or suit been made against you arising from your practice of medicine or surgery?  
If yes, please indicate the **number** of claims or suits:

Yes No

Besides any claim or suit made against you, have you reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any of your previous insurers?

Are you aware of any medical incidents, adverse outcomes or other circumstances that you expect to give rise to a claim in the future?

**Claim No. \_\_\_ of \_\_\_ Name of Patient:**

Name of Insurance Carrier:

1. Date of medical/ surgical incident		8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	Yes	No
2. Date claim reported to your insurer:		9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):	No	
4. Current Status		11. Describe the alleged injury or problem that led to the claim made against you.		
Open	Closed		Date Closed	
5. Amount paid on your behalf				
6. Amount paid on behalf of all defendants				
7. Amount of reserve, if an open claim (if known)				

**Claim No. \_\_\_ of \_\_\_ Name of Patient:**

Name of Insurance Carrier:

1. Date of medical/ surgical incident		8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	Yes	No
2. Date you reported the claim to your insurer:		9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):	No	
4. Current Status		11. Describe the alleged injury or problem that led to the claim made against you.		
Open	Closed		Date Closed	
5. Amount paid on your behalf				
6. Amount paid on behalf of all defendants				
7. Amount of reserve, if known (if claim open)				

## 12. Claim History (Continued)

Claim No. \_\_\_ of \_\_\_ Name of Patient:

Name of Insurance Carrier:

1. Date of medical/ surgical incident			8. Is this an incident that you reported to your insurer even though a claim has not yet been made?		Yes	No
2. Date you reported the claim to your insurer:			9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?			
3. Has a suit been filed?		Yes	No	10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):		
4. Current Status		11. Describe the alleged injury or problem that led to the claim made against you.				
Open	Closed					
5. Amount paid on your behalf						
6. Amount paid on behalf of all defendants						
7. Amount of reserve, if known (if claim open)						

**Note: You may be requested to provide information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.**

**Please use multiple copies of this form if you have had more than three claims.**

## Procedures

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.	Yes	No	How Many?
1. If you are not an Obstetrician, do you treat patients beyond the first trimester of pregnancy			
2. Prenatal or postnatal care			
3. Any endoscopic procedure			
4. Any laparoscopic surgeries? If yes, please explain procedures and training below.			
5. Any invasive procedure (incision, excision, puncture, tap, etc.) of any organ, including the skin.			
6. Any procedure performed while the patient is under any type of anesthesia ( <input type="checkbox"/> local, <input type="checkbox"/> general, <input type="checkbox"/> regional, <input type="checkbox"/> acupuncture) (Please check type of anesthesia used.)			
7. Any procedure involving withdrawal by needle of bodily fluids (other than blood products) such as amniocentesis, lumbar puncture, abdominal tap, etc.)			
8. Biopsy of any type (excisional or needle)			
9. Catheterization (other than urethral)			
10. Weight reduction procedures, treatments or medications			
11. Cervical/vaginal smears			
12. Hair transplants and/or restorations			
13. Any procedure involving injection and/or diagnosis using any radiopaque contrast material			
14. Any imaging procedure that you perform and/or results that you interpret (x-ray, mammogram, etc.)			



## Procedures (continued)

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.	Yes	No	How Many?
15. Do you perform intervention procedures?			
16. Laser therapy or surgery			
17. Polyp removal (from any mucous membrane)			
18. Dialysis therapy (hemodialysis or peritoneal dialysis)			
19. Liposuction			
20. Diabetes management			
21. Do you practice invasive cardiology?			
22. <input type="checkbox"/> Electrocardiography, <input type="checkbox"/> echocardiography, <input type="checkbox"/> cardiac stress tests or <input type="checkbox"/> implantation of any pacemaker			
23. Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			
24. If your specialty is Surgical Assistant, do you also conduct office hours?			
25. Assist at any major surgical procedure as first assistant: (making incisions, excising or handling organs, suturing, etc.)			
26. Assist at any major surgical procedure other than as first assistant			
27. Teach, supervise or proctor medical students, residents or fellows (indicate number of hours per week)			
28. Do you perform any cosmetic surgery such as ( <input type="checkbox"/> botox, <input type="checkbox"/> laser hair removal, <input type="checkbox"/> laser spider vein removal, <input type="checkbox"/> other (comment))			

Please use this space to provide details about any item above to which you provided a "yes" answer. Attach additional sheets as needed. Include sufficient detail so as to avoid delay in processing your application.

## Specialty Application:

### General Surgery Orthopedic Surgery Pathology Radiology Obstetrics & Gynecology

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.

General Surgery	Yes	No	How Many?
Breast surgery (excision of tumors, etc.)			
Bariatric surgery / gastric bypass surgery / lap band surgery			
Cosmetic procedure (liposuction, abdominoplasty, rhinoplasty, breast reduction or augmentation, etc.)			
Any surgical procedure performed in a non-hospital setting			
Any non-hospital procedure using anesthesia (other than local)			
Any laparoscopic procedure			
Any laser procedure			
Vascular or peripheral vascular surgery			
Transplant surgery (lung, kidney, liver, heart, etc.)			
Any orthopedic procedure			
Any obstetrical or gynecologic procedures, including, but not only, termination of pregnancies, etc.			
Any surgical procedure or treatment method that you have trained for after finishing your residency or fellowship			

**Specialty Application: (Continued)**

**General Surgery Orthopedic Surgery Pathology Radiology Obstetrics & Gynecology**

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.

<b>Orthopedic Surgery</b>	<b>Yes</b>	<b>No</b>	<b>How Many?</b>
Spine surgery			
Microsurgical procedures			
Hip replacement surgery			
Any surgical procedure outside the scope of your training in orthopedics			

**Pathology and Radiology**

Pathology Physician:

What percent of work is performed while actually working in New Jersey? \_\_\_\_\_ %

While working in New Jersey, in what state(s) are you providing interpretations?

Radiologist Physician:

What percent of work is performed while actually working in New Jersey? \_\_\_\_\_ %

While working in New Jersey, in what state(s) are you providing interpretations?

What percent of your practice is designated to mammography interpretations? \_\_\_\_\_ %

Do you use computer aided detection for mammography interpretations? 

<b>Yes</b>	<b>No</b>
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**Please use the page 11 to provide details about any question to which you answered "yes." Attach additional sheets as needed.**

**Obstetrics & Gynecology**

	<b>Yes</b>	<b>No</b>
Do you make patient records available to any replacement physician seeing your patients? If no, please comment.		
Are your deliveries performed at hospitals with at least a Level II NICU? If no, please comment on the emergency arrangements that you require?		
Do you refer high-risk pregnancies to a perinatologist? If no, please comment.		
Are your deliveries performed at hospitals that have both 24-hour in-house anesthesia services and 24-hour in-house surgical assistants? If no, please comment.		
Are all ultrasounds performed by a certified ultrasonographer? If no, please comment.		
Are all ultrasounds co-interpreted by a Radiologist? If no, please comment.		
Are all mammographies and other imaging reviewed by a radiologist? If no, please comment.		



## Certification, Authorization and Signature

I certify that the information in this application is true and correct and I authorize the release and exchange of any information regarding my medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which I am or have been a member and MDAvantage Insurance Company of New Jersey.

I further agree to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

Notice: Any person who knowingly or intentionally includes false or misleading information on any application for insurance commits insurance fraud and may be subject to civil or criminal penalties.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Assignment of Any Return Premium

This section should be completed if the premium for this insurance is paid by someone other than the Applicant.

If the premium for this insurance has been paid and the policy is later cancelled or otherwise changed, any refund of premium that results from such cancellation or change should be assigned to:

**Name of the Payor:** \_\_\_\_\_  
(employer or other person or entity to whom any refund check should be made payable)

The Payor agrees to pay any premium for the professional liability insurance policy applied for and any renewal or replacement of it. The Applicant for this insurance assigns any and all rights to receive any refund of premium in excess of that earned by MDAvantage Insurance Company of New Jersey for this insurance to the Payor named above. The Applicant appoints Payor or Payor's successors or assigns as Applicant's Attorney-in-Fact with full authority to cancel or amend the insurance policy applied for and to execute or receive any document, instrument, payment or notice of any kind relating to the insurance policy, except with respect to giving or withholding consent to settle claim or suit as may be provided in the insurance policy applied for.

No other interest in the insurance applied for may be assigned by any party without the written consent of MDAvantage Insurance Company of New Jersey.

This assignment will remain in effect unless both Payor and Applicant agree in writing to its termination.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_