



# PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

1. Full Name of Applicant:

2. Principal Office Address:

County:

3. Home Address:

4. Social Security #:

DEA #:

5. List the States and license numbers where you practice:

6. Date of Birth:

Place of Birth:

7. Are you a U.S. citizen?

Yes

No

If no, indicate your status and date of entry into the United States:

8. What is your medical or surgical specialty?

What percentage of your practice is dedicated to this specialty?

%

9. What is your sub-specialty?

What percentage of your practice is dedicated to this specialty?

%

10. Do you limit your practice to the above specialties? Yes      No

If no, what other specialties do you practice? Provide details:

11. Are you American Board certified? Yes      No

Medical Specialty: Date Certified:

Medical Specialty: Date Certified:

12. Type of Practice (check all that apply):

Individual                       Employee                       Member of Multi-person Corp or Association

Individual Corporation                       Partnership                       Other: \_\_\_\_\_

13. What is your total annual revenue?

\$100,000 or less     \$100,001 - \$250,000     \$250,001 - \$499,999     \$500,000 or more

14. Please provide the names of all facilities that you practice at and your interest in each facility.

Name of Clinic or Facility and Location	Interest (Owner, Partner or Employee)
_____	_____
_____	_____
_____	_____
_____	_____

\*Attach a separate attachment if necessary.

15. Are you seeking coverage for your work at all of the above facilities? Yes      No

If no, list those facilities for which you do not require coverage and explain why coverage isn't needed:

16. Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.

	<u>Employed</u>	<u>Contracted</u>	<u>Carry their own Med Mal policy?</u>	
Physicians			Yes	No
Physicians Assistants			Yes	No
Nurse Practitioners			Yes	No
Surgical Technicians			Yes	No
CRNA's			Yes	No
Chiropractors			Yes	No
RN's			Yes	No
LPN's, Nurse Aides			Yes	No
Other:			Yes	No
Other:			Yes	No

\*Attach copies of declarations pages on above professional that carry their own malpractice policies.

17. Are all of the above individuals licensed in accordance with applicable state and federal regulations? Yes      No

If no, attach an explanation.

18. List the hospitals at which you are currently a staff member:

19. Briefly describe the type and extent of your hospital privileges:

20. Are you the Chief or Head of a hospital department? Yes      No

If yes, which department(s):

21. Are you the medical director of a nursing home or assisted living facility? Yes      No

If yes, provide the name of the facility:

22. Are you the medical director of any other facilities? Yes  No

If yes, provide the names of each facility:

23. From what medical school did you graduate?

City, State and Country of medical school:

Degree:

Year of Graduation:

If foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?

Yes  No

If yes, state the year:

24. Internship?

Yes  No

If yes, complete the following:

Location: \_\_\_\_\_

Dates From \_\_\_\_\_ To \_\_\_\_\_

Type: \_\_\_\_\_

Completed? Yes  No

25. Residency?

Yes  No

If yes, complete the following:

Location: \_\_\_\_\_

Dates From \_\_\_\_\_ To \_\_\_\_\_

Type: \_\_\_\_\_

Completed? Yes  No

Location: \_\_\_\_\_

Dates From \_\_\_\_\_ To \_\_\_\_\_

Type: \_\_\_\_\_

Completed? Yes  No

26. Where have you practiced your profession since completion of training:

In \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

In \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

In \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

27. Additional medical training?

Yes  No

If yes, provide details including type, location and date of training:

28. Have you participated in any continuing medical education program(s) within the past 5 years?	Yes	No
If yes, provide details:		
29. Indicate memberships in professional societies:		
30. Do you perform one or more of the following?		
A. Endoscopic procedures other than sigmoidoscopy or proctoscopy? If yes, describe:	Yes	No
B. Catheterization, other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel? If yes, describe:	Yes	No
C. Arteriography, lymphangiography, myelography or phenmoencephalography?	Yes	No
D. Interventional radiology-percutaneous transluminal angioplasty or embolization?	Yes	No
E. Radiation therapy, including implants? If yes, describe:	Yes	No
F. Chemobrasion or dermabrasion?	Yes	No
G. Hair transplantation or suturing of hairpieces?	Yes	No
H. Mhos micrographic surgery? If yes, describe:	Yes	No
I. Acupuncture? If yes, describe:	Yes	No
J. Prenatal care and normal deliveries?	Yes	No
If yes, do you perform home deliveries?	Yes	No
If yes, do you only perform prenatal care?	Yes	No

If yes, do you supervise nurse midwives?	Yes	No
When do you refer: _____ weeks' gestation?		
K. Dilation and curettage?	Yes	No
L. Needle biopsies?	Yes	No
If yes, describe:		
M. Electroshock therapy or hypnosis?	Yes	No
If yes, describe:		
N. Radial keratotomy, excimer laser PRK, LASIK or any other surgical vision correction procedure?	Yes	No
O. Surgery, other than incision of boils and superficial abscesses or suturing skin and superficial fascia?	Yes	No
If yes, attach a list of all surgical procedures.		
P. Non-spontaneous, induced abortions?	Yes	No
If yes, what is the maximum trimester? _____		
Q. Vasectomies or reversal of vasectomies?	Yes	No
R. Hysterectomies?	Yes	No
If yes, do you perform laparoscopic hysterectomies?	Yes	No
S. Cholecystectomies?	Yes	No
If yes, do you perform laparoscopic cholecystectomies?	Yes	No
If yes, how many performed as of this date? _____		
T. Tonsillectomies and/or adenoidectomies?	Yes	No
U. Caesarian sections?	Yes	No
V. Spinal surgery?	Yes	No
If also chemonucleolysis , check here: _____		
and/or percutaneous lumbar discectomy, check here: _____		
W. Administration of general, spinal or caudal block anesthesia?	Yes	No
X. Open reduction of fractures?	Yes	No
Y. Organ transplantation?	Yes	No
If yes, describe:		

Z. Sex change operations?	Yes	No
AA. Weight reduction surgery including gastric bypass or other stomach banding procedures? If yes, which procedures?	Yes	No
BB. Experimental research, surgical research, or experimental therapy in human patients? If yes, describe:	Yes	No
CC. Cosmetic/plastic surgery? If yes, please complete the following: Do you perform breast augmentation?	Yes	No
Do you perform breast reductions?	Yes	No
Do you perform liposuction? If yes, what is the maximum amount of cc's removed? _____	Yes	No
Do you perform fat recycling? If yes, in what parts of the body? _____	Yes	No
Do you perform vaginoplasty or labiaplasty?	Yes	No
Do you use silicone implants? If yes, in which parts of the body? _____	Yes	No
Do you perform Botox injections? If yes, in which parts of the body? _____	Yes	No
DD. Penile lengthening or enhancement procedures?	Yes	No
EE. Do you perform pain management procedures? If yes, please indicate the procedures you perform?	Yes	No
<b><u>CATEGORY A:</u></b>		
Acupuncture	Yes	No
Botox Injections	Yes	No
Medication Only	Yes	No
Massage/Osteopathic Manipulation – No Anesthesia	Yes	No
Medical Marijuana – Prescription Only – No Dispensing	Yes	No
<b><u>CATEGORY B:</u></b>		
Facet Joint Blocks	Yes	No
Lesioning	Yes	No
Percutaneous Discectomy	Yes	No

Percutaneous Endoscopic Nerve Root Decompression	Yes	No
Peripheral Nerve Block	Yes	No
Radio Frequency Nerve Ablation	Yes	No
Rapid Opiate Detoxification	Yes	No
Selective Nerve Root Block	Yes	No
Sympathetic Blocks	Yes	No
Trigger Point Injections	Yes	No
Schedule I or Schedule II Prescription Medications	Yes	No

**CATEGORY C:**

Dorsal Column Stimulator Implants/Reprogramming	Yes	No
Epidural or Spinal Catheters	Yes	No
Intradiscal Electrothermal Therapy	Yes	No
Peripheral Nerve Stimulation	Yes	No
Spinal Infusion Implants/Pumps; Removal, Refilling/Reprogramming	Yes	No
Spinal Manipulation under General Anesthesia	Yes	No
Vertebroplasty	Yes	No
Discectomy	Yes	No
FF. Any other surgical procedures not shown above? If yes, describe:	Yes	No

\*PLEASE ATTACH A LIST OF ALL SURGICAL PROCEDURES YOU PERFORM

- |   |     |    |
|---|-----|----|
| 31. Do you perform surgery in your office?<br>If yes, list:   | Yes | No |
| 32. Do you perform surgery in other non-hospital facilities?<br>If yes, what type of facility and list the surgical procedures: | Yes | No |
| 33. In the course of surgery does a Board Certified Anesthesiologist provide the anesthesia?<br>If no, provide details:         | Yes | No |



- |   |     |    |
|---|-----|----|
| 34. Do you do any hospital emergency room work?   | Yes | No |
| If yes, is the emergency room care:   | Yes | No |
| Only for your own patients?   | Yes | No |
| Required for staff privileges?  | Yes | No |
| How many hours per month: _____   |     |    |
| Does the hospital cover you for malpractice while you work in the emergency room?   | Yes | No |
| Are you requesting coverage for your emergency room work?   | Yes | No |
| 35. Do you assist in surgery:   | Yes | No |
| On your own patients?   | Yes | No |
| On patients of others?  | Yes | No |
| 36. If your practice includes plastic surgery, specify the percentage of your practice devoted to:  |     |    |
| Traumatic Surgery _____ %                  Cosmetic/Elective Surgery _____ %  |     |    |
| 37. If your practice includes weight reduction/control (other than by diet and exercise), specify the percentage of patients that re exclusively weight control: _____ %  |     |    |
| Do you prescribe any weight control drugs?  | Yes | No |
| If yes, list drugs prescribed:  |     |    |
| Do you dispense supplements for weight control?   | Yes | No |
| If yes, list supplements dispensed:   |     |    |
| Do you use injections for weight control?   | Yes | No |
| If yes, list drugs injected:  |     |    |
| 38. Have you or any of your employees: (If yes, attach details.)  |     |    |
| A. Ever been the subject of investigation or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Attach a copy of Complaint and Consent Order document if applicable.                                      | Yes | No |
| B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?   | Yes | No |
| C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction? | Yes | No |

- D. Ever had any state profession license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No
- E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? Yes No
- F. Ever failed any medical licensing or specialty organization examination? Yes No
- G. Do you have any chronic illnesses or defects? Yes No  
If yes, describe:
39. Do you supervise any individuals other than your own employees? Yes No  
If yes, provide a detailed explanation of your responsibilities, relationship and whether or not these individuals have their own medical malpractice coverage:
40. Are you under contract to any individual, firm or corporation other than your own? Yes No  
**If yes, attach an explanation including details of responsibilities. If this contract contains a hold harmless agreement, attach a copy of the contract language.**
41. Are you in the employ of, or under contract to any governmental entity? Yes No  
If yes, provide details and outline your duties:
42. Do you offer professional advice to the public such as through a website, radio or TV broadcasts, newsletters, etc.? Yes No  
If yes, provide details:
43. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? Yes No  
If yes, provide details and attach copies of all advertising brochures:
44. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? Yes No  
If yes, provide details:
45. Average Weekly Patient Load: \_\_\_\_\_ Total Patients Annually: \_\_\_\_\_  
Total surgeries performed annually: \_\_\_\_\_

46. Average number of hours worked per week: \_\_\_\_\_

47. Do you anticipate any changes in your practice? Yes      No  
If yes, describe:

48. List the prior medical malpractice insurance carried for each of the past 5 years beginning with the most current:

<u>INSURANCE COMPANY</u>	<u>LIMITS OF LIABILITY</u>	<u>POLICY PERIOD</u>	<u>PREMIUM</u>	<u>RETRO DATE</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

\*Attach a copy of the declarations page of your most recent policy.

49. Do you own, operate or provide professional services for, or at, any health care facility or business enterprise not already clearly described in this application? Yes      No  
If yes, describe:

50. Has any claim or suit for alleged malpractice been brought against you? Yes      No  
If yes, how many total claims or incidents: \_\_\_\_\_

Please complete the Supplemental Claim Information Form attached to this application for each and every claim. **Also, please attach 10 years of currently valued company loss runs.**

51. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? Yes      No  
If yes, complete the Supplemental Claim Information Form attached to this application for each and every claim.

52. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? Yes      No  
If yes, provide details including name of claimant, date of occurrence, date of first contact allegation and current status of incident:

The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations mad in this application. The Applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Electronic Signature of Applicant or Authorized Representative:

Title:

Current Date:

If you prefer not to return an application with an electronic signature, please print and sign below.

Signature of Applicant or Authorized Representative:

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Title: \_\_\_\_\_ Current Date: \_\_\_\_\_

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Please attach the following documents to this application:

- C.V. or resume
- Five years of currently valued company loss runs
- Copies of any disciplinary actions, stipulation orders or probation documents
- Copies of declarations pages for all employees or contractors that carry their own med mal
- Copy of applicant's most current declarations page

# **SUPPLEMENTAL CLAIM INFORMATION FORM**

(Complete one form for each claim, potential claim or incident)

1. Name of Applicant or Named Insured:
  
2. Name of other parties or defendants named in suit:
  
3. Date of alleged error or incident:
  
4. Date claim was made:
  
5. Name of claimant:
  
6. Name of insurance company handling your claim:
  
7. Present status of claim or final disposition:        \_\_\_ Closed    \_\_\_ Open
  
8. Defense costs paid to date inclusive of any deductible:
  
9. If closed, total loss paid, inclusive of any deductible:
  
10. If claim is open or pending what are the insurer's reserves?  
  
    Defense: \_\_\_\_\_                      Loss: \_\_\_\_\_
  
11. Description of case and events including allegations and assessment of liability:

12. Claimant's last settlement demand:

13. Description of any changes that were implemented in order to reduce potential for future losses of this same type or nature:

The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application. The Applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Electronic Signature of Applicant or Authorized Representative:

Title:

Current Date:

*If you prefer not to return the application with an electronic signature, please print and sign below.*

Signature of Applicant or Authorized Representative:

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Title: \_\_\_\_\_ Current Date: \_\_\_\_\_

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