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.

	Employed	Contracted	Carry their own Med Mal policy?	
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? Yes No
If yes, describe:

B. Catheterization, other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel? Yes No
If yes, describe:

C. Arteriography, lymphangiography, myelography or phenmoencephalography? Yes No

D. Interventional radiology-percutaneous transluminal angioplasty or embolization? Yes No

E. Radiation therapy, including implants? Yes No
If yes, describe:

F. Chemobrasion or dermabrasion? Yes No

G. Hair transplantation or suturing of hairpieces? Yes No

H. Mhos micrographic surgery? Yes No
If yes, describe:

I. Acupuncture? Yes No
If yes, describe:

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? Yes No

If yes, which procedures?

BB. Experimental research, surgical research, or experimental therapy in human patients? Yes No

If yes, describe:

CC. Cosmetic/plastic surgery? Yes No

If yes, please complete the following:

Do you perform breast augmentation? Yes No

Do you perform breast reductions? Yes No

Do you perform liposuction? Yes No

If yes, what is the maximum amount of cc's removed? ________________

Do you perform fat recycling? Yes No

If yes, in what parts of the body? ____

Do you perform vaginoplasty or labiaplasty? Yes No

Do you use silicone implants? Yes No

If yes, in which parts of the body? ____

Do you perform Botox injections? Yes No

If yes, in which parts of the body? ____

DD. Penile lengthening or enhancement procedures? Yes No

EE. Do you perform pain management procedures? Yes No

If yes, please indicate the procedures you perform?

<u>CATEGORY A:</u>

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

<u>CATEGORY B:</u>

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? Yes No
If yes, describe:

*PLEASE ATTACH A LIS T OF ALL SURGICAL PROCEDURES YOU PERFORM

31. Do you perform surgery in your office? Yes No
If yes, list:

32. Do you perform surgery in other non-hospital facilities? Yes No
If yes, what type of facility and list the surgical procedures:

33. In the course of surgery does a Board Certified Anesthesiologist provide the anesthesia? Yes No
If no, provide details:

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:

INSURANCE COMPANY	LIMITS OF LIABILITY	POLICY PERIOD	PREMIUM	RETRO DATE
______________________________	________________	______________	____________	_____________
______________________________	________________	______________	____________	_____________
______________________________	________________	______________	____________	_____________
______________________________	________________	______________	____________	_____________
______________________________	________________	______________	____________	_____________

*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:

____

Title: **Current Date:**

____ ________________________

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:

____

Title: Current Date:

____ ________________________