Agency/Broker: ____________________

Application for Coverage - Physicians/Surgeons

This application is for claims made coverage. Please read the policy carefully

I. Personal Information:

Full Name: MD ____ DO ____

____
First Middle Last

Date of Birth: ________________________

II. Address - Office Address:

____
Street City County State Zip Code

Office Phone: ___________________ Office Fax: __________________ Office Email: ___________________

Website: ______________________________________

III. Corporation Information:

____ FEIN Number ________________
Name of Corporation (if applicable)

Type of Corporation: Individual/Solo Corporation Partner/Shareholder/Employee

Is there any other name under which you practice (i.e. DBA)? ____

Is your corporation requesting coverage: Yes No If yes, Shared or Separate Limits ___________________

Do you or your corporation have a website: ____

IV. Limits of Liability:

$100,000/$300,000

$200,000/$600,000

$250,000/$750,000

$500,000/$1,500,000

$1,000,000/$3,000,000

Requested Effective Date: _____________________ Requested Retroactive Date: _____________________

V. Medical Licensure

State: ______________________
License No. _________________
Expiration Date: ____________

State: ____________________
License No. _______________
Expiration Date: ___________

DEA License Number: _____________________

Have you ever had your license revoked, limited, refused, suspended or denied? Yes No
If yes, give details:

VI. Certification

Are you American Board Certified: Yes No Eligible until when: ____________________

Name of Specialty Board(s): ___________________________ Year: _______ Recertified ______________

VII. Education/Training

Must submit CV

Are you entering private practice for the first time following your residency, training, military services or an academic position: Yes No

VIII. Current Practice and Practice History

Current Practice:

Primary Specialty: ___________________________ Percentage of Practice: __________

Secondary Specialty: _________________________ Percentage of Practice: __________

Average number of hours worked per week: _______________
Average number of patients seen per week: ________________

Percentage of practice outside of an office location; please provide details:

Have there been significant changes in your practice in the past five years (i.e. changes in specialty, addition or deletion of procedures) Yes No
If yes, please explain:

Practice Locations – Please provide ten (10) years of practice history from most rent, attach additional page if necessary:

Current Practice Locations:

Location 1: ____ From: ____________ To: ____________
Location 2: ____ From: ____________ To: ____________
Location 3: ____ From: ____________ To: ____________
Location 4: ____ From: ____________ To: ____________
Location 5: ____ From: ____________ To: ____________

Historic Practice Locations:

Location 1: ____ From: ____________ To: ____________
Location 2: ____ From: ____________ To: ____________
Location 3: ____ From: ____________ To: ____________
Location 4: ____ From: ____________ To: ____________
Location 5: ____ From: ____________ To: ____________

Have you ever had medical professional liability insurance declined, canceled, surcharged, non-renewed, or issued with a deductible or other reduction in coverage? Yes No

If yes, please describe:

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VIII. Current and Practice History (cont'd)

Do you treat celebrities or professional athletes? Yes No

If yes, please describe

Do you practice at a prison, correctional facility or on inmates? Yes No
If yes, what is the total percentage of your practice and where are you practicing?

Do you see patients in a Nursing Home: Yes No
If yes, what is the percentage of your practice and where are the Nursing Homes located?

Do you practice as a Hospitalist? Yes No
If yes, what is the percentage and at what hospitals are you practicing as a hospitalist?

Do you have another practice for which you carry separate coverage or coverage is provided for you? Yes No
If yes, please attach a copy of a declarations page or certificate of insurance

Did you practice with other physicians in an employer-employee relationship, implied or formal partnership, professional association or Medical Corporation during the period for which you are requesting prior acts coverage? Yes No

If yes, please list the full name of the entity(ies) physician(s) with whom you practiced and the period of each such association

Name of Entity	Name of Physician	Dates: From - To

IX. Medical Staff

Do you employ/contract/supervise any of the following personnel? Indicate the number of the following non-physician/healthcare providers utilized by you or your group.

____ Employ ____ Contract ____ Supervise ____ N/A

CRNA____	Residents____	Other Physicians____	Psychologist____
CNM____	Podiatrist____	Social Worker____	Respiratory Therapist____
Interns____	Fellows____	Speech Therapist____	Laboratory Technician____
Optician____	Pharmacist____	Physicians Assistant____	Occupational Therapist____
Optometrist____	Nurse Practitioner____	Physical Therapist____	X-Ray Technician____
Audilogist/Udiologist____			

Other (please explain) ____

Are you requesting the above to be covered by Physicians Casualty? Yes No
If yes, should the ancillary be covered on a shared or separate limit of liability: ______________________________

Are any of the above ancillary staff independent contractors? Yes No
If yes, please provide declarations page or certificate of insurance

Does any of the ancillary staff have his/her own coverage? Yes No

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X. Additional Professional Information

Please provide a complete explanation for each question answered "Yes":

A. Has membership of any Professional Association or Society ever been refused, revoked or limited in any way? Yes No

B. Have you ever had a complaint filed, been censured or had a private reprimand with a County or State Medical Society? Yes No

C. Have you ever been treated for alcoholism, narcotic addiction or mental impairment Yes No

If yes, please provide details of rehabilitation program including dates of treatment

D. Have you ever been indicted, charged or convicted of felony other than a minor traffic violation? Yes No

E. Do you work as an emergency room physician, other than for maintaining hospital privileges? Yes No

If yes, do you have separate coverage for this exposure Yes No

F. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director or attending physician at any of the following:

Hospital	Sanitarium	Nursing Home	Surgi-Center
Clinic	Laboratory	Blood Bank	Prepaid Health Plan
HMO	Other Medical Facility		

If you checked any of the above, please list the names of the facility and your affiliation with them.

Name	Affiliation	Who Provides Coverage for this	Limits

Do you practice medicine at the above institutions? Yes No
If yes, are you looking for coverage for this exposure? Yes No

G. Do you ever enter into arbitration or similar agreements with your patients? Yes No
If yes, please attach a copy of the agreement(s)

EXPLANATION OF QUESTION(S) ANSWERED 'YES'

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XI. Hospital Privileges Currently Held

Hospital Name | Location | Privileges

Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily? Yes No
If yes, please give details

Have your hospital privileges been expanded in the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or your Specialty Board? Yes No
If yes, please explain

XII. Medical Procedures

Please check the appropriate box, indicating the extent of surgery you perform:

No surgery except incisions of boils, cysts, or other superficial abscesses or suturing or minor lacerations
Minor surgery includes most procedures performed under local anesthesia
Assist in Major Surgery on your own patients # Annually __________
Assist in Major Surgery on patients other than your own # Annually __________ "
""""""Major Surgery includes all procedures done under general, spinal or caudal anesthesia, and specifically includes tonsillectomy, appendectomy, D&C, cesarean section, abortion and open reduction of fracture

Check the procedures which you perform for which you are requesting coverage. Check any procedure you have performed in the last three (3) years

___ Abortion (indicate trimesters)
___ 1st ___ 2nd ___ 3rd
___ Acupuncture or Acupressure
___ Adenoidectomy
___ Anesthesia - General
___ Angiography, Angioplasty, Arteriography
___ Appendectomy
___ Banding Hemorrhoids
___ Bronchoscopy
___ Cardiac Catheterization
Left Heart Right Heart
___ Cesarean Section # per year
___ Chelation Therapy
___ Chemabrasion/Demabrasion
___ Cosmetic Plastic Surgery or Procedures (elective) Please list

___ Cryosurgery
___ D&C
___ Endoscopic Procedures-Please list

___ ERCP
___ Experimental Surgery-Please list

___ Other

___ Fertility/Infertility Treatment
___ Gastric By-Pass/Stapling or Bariatrics
___ Hair Growing or Transplants
___ Hemorrhoidectomy
___ Hernias
___ Hysterectomy
___ Injection or Implants in Breasts
___ Insertion of intrauterine Contraceptive Devices
___ LAP BAND Procedures # per year
___ Laparoscopy-Please list

___ Laser used in Therapy or Surgery
Type of Laser used _______________
Please list type of therapy or surgery

___ Liposuction, SAL
___ Needle Biopsy ___ Breast ___ Kidney ___ Lung ___Prostrate
__ Other ____________________
___ Obstetrical Deliveries at other than a licensed Acute Care Hospital

___ Pre-Natal Care (indicate trimesters)
___ 1st ___ 2nd ___ 3rd

___ Pain Management (other than oral analgesics)

___ Other

___ Radial Keratotomy, LASIK or PRK
___ Radiation Therapy, X-Ray
___ Reconstructive Plastic Surgery
___ Shock Therapy (ECT)
___ Spinal Anesthesia
___ Swan Ganz
___ Telemedicine-list specialty and where
____
___ Thoracic Surgery
___ Tonsillectomy
___ Tubal Ligation
___ Vascular Surgery
___ VBACS _______ # per year
___ Weight Control Medicine-Please list

___ Weight Control Surgery-Please list

___ Administering or Injecting Silicone Fluid
___ Use of Laetrile Therapy
___ Use or Administration of Human Chronic Gonadotropin (HGG) in the treatment of Obesity or Weight Control
___ Use of Blood or Blood By-Products that have not been tested for HIV
___ Sex Change Operations
___ Other

XIII. Current Insurance

Please provide current insurance information

Carrier: ____
Effective Date ____________________________
Expiration Date ___________________________
Retroactive Date __________________________
Limit of Liability _________________________
Type of Coverage _________________________
Premium _________________________________

XIV. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? Yes____ No____

If yes, please complete a claim supplemental for each claim and provide prior carriers loss history

Total Number of Claims: _________ Open/Reserved: _________ Closed: _________

Any change in your practice as a result of claims?

Warranty

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by Physicians Casualty as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by Physicians Casualty. In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever soure.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

Acknowledged and Agreed:

____ Date: ______________________________
Applicant Signature

Signing this application does not bind Physicians Casualty to complete the insurance. All information requested in this application is considered material and important. If Physicians Casualty agrees to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

SUPPLEMENT TO APPLICATION
CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient ____ Age __________ ___Male ___Female

2. Date of Incident ________________________ Location of Incident _____________________________
   Insurance Carrier _______________________ Date Reported to Insurer _________________________

   ___Suit ___Demand for Money ___Incident Only
   ___Notice of Intent to Sue ___Request for Records ___Other ___________________________________

3. Summary of condition/diagnosis at time of incident

4. Description of treatment rendered, including dates

5. Allegation

6. Other physicians or entities involved

7. Status/Disposition of Claim:

   Closed without indemnity payment
   Settled
   Judgment/Verdict
   For the defense
   For the plaintiff

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendants	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

   ___Open-please provide current status and defense strategy: ____

8. Has there been a change in practice as a result of this claim(s)? ____ Yes ____ No
   If yes, what has been the change?

I understand this information is part of my Application for Physician/Surgeon Medical Professional Liability Insurance.

Please print your name: ____

Signature: ____ Date: __________________________

Fraud Warnings:

__General Fraud Statement__ (not applicable in Arizona, Colorado, Georgia, Hawaii, Kansas, Kentucky, Nebraska, North Carolina, Ohio, Oklahoma, Oregon, Texas, Utah, Vermont and West Virginia

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia insurance benefits may also be denied.

__Notice to Arizona and Oregon Applicants:__ All statements and descriptions in any application for an insurance policy or in negotiations therefore, by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy unless: 1 Fraudulent; 2. Material either to the acceptance of the risk, or to the hazard assumed by the insured; 3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

__Notice to Colorado Applicants:__ This Notice is a Part of Your Application for Professional Liability Insurance: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

__Notice to Georgia, Nebraska, North Carolina and West Virginia Applicants__: By statute, warranties are deemed representations.

__Notice to Hawaii Applicants__: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

__Notice to Kansas Applicants__: By statute, warranties are deemed representations. The definition of fraud is found in and complies with K.S.A. 40-2, 118.

__Notice to Kentucky Applicants__: By statute, warranties are deemed representations. Misrepresentations, omissions, and incorrect statements shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent, or (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer, or (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contact in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required by the application for the policy.

__Notice to Ohio Applicants__: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

__Notice to Oklahoma Applicants__: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

__Notice to Texas Applicants__: Pursuant to Chapter 705 of the Texas Insurance Code, the company may void the policy only in the event of material misrepresentations in the application, and it must be shown at trial that such misrepresentations were material.

__Notice to Utah Applicants__: For your protection, Utah law requires the following to be included in this application: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a a false or fraudulent claim for disability compensation or medical benefit, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify Physicians Casualty of such changes and Physicians Casualty may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

____ **Date:**__________________________

Signature

____ **Title:** __________________________

Printed Name

This application is not valid without your complete signature, date, printed name, and the title above