		Physicians and Surgeons Professional Liability Application – Claims-Made Form

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

The following documentation must be submitted with the fully completed application:

- **Copy of your curriculum vitae.**
- **Copy of your current policy declarations page. (Claims-Made policies must reflect retroactive date.)**
- **Copy of all licenses and board certifications.**
- **Copy of all prior reporting endorsements issued to you.**
- **Currently valued 7-year claims/loss history from prior companies.**
- **Copy of your business letterhead**
- **Copy of all advertising that you use.**

NOTE: Submission of a completed application confers no obligation upon the company to bind coverage.

(If more space is needed to answer any questions, use page 11 or a separate sheet.)

I. GENERAL INFORMATION

1. A. Name of Applicant____Degree_________
First Middle Last

B. Practice Address:____
Street County

____
City State Zip Code

C. Phone: ______________________________ D. Fax: ____________________

E. E-Mail Address:________________________

F. Website Address: ____________

G. Secondary Practice Locations____

H. Social Security No. ______________________

I. Date of Birth ________________

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2. Are you a U. S. Citizen? ☐Yes ☐No If no, please indicate your status and date of entry into USA on page 11.

3. A. Are you a Foreign Medical School Graduate? ☐Yes ☐No
   B. Date of ECFMG Certification: ____________________

4. Provide the following information for all the states in which you are licensed to practice:

State	% of Practice	License No.	Effective Date	Expiration Date	Active (Yes/No)

5. Federal DEA License Number and Status____

6. List all locations and dates where you have practiced in the last ten (10) years.

Practice Name	City/State	Specialty Practiced	From	To

7. Current Practice Specialty: _______________________ Percentage of Practice: _______________
8. Subspecialty: __________________________________Percentage of Practice: _______________
9. A. Are you American Board Certified? ☐ Yes ☐ No If yes, in what specialty? ________________
   B. Check one: ☐ Allopathic ☐ Osteopathic
   C. Date of Certification: ______________________ Date of Recertification: __________________
   D. Are you Board Eligible? ☐ Yes ☐ No
      If yes, when do you plan to take the Board examinations _______________________________

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II. MEDICAL EDUCATION AND TRAINING

10. Medical Education – please complete the following:

	Name of Institution	Degree/ Specialty	Location	From	To	Completed (Yes/No)
Medical School						
Internship						
Residency						
Residency						
Fellowship						

11. Complete the following for Category I Continuing Medical Education Completed In Past Three Years:

Courses Completed	Credits Received	Dates Attended

III. PRACTICE INFORMATION

1. 12. A. Type of Practice:

☐ solo practitioner (unincorporated) ☐ solo practitioner (incorporated)*
☐ professional corporation* ☐ professional association*
☐ limited liability company* ☐ partnership*
☐ employee of ____
☐ independent contractor of ________________________________
☐ other____
* Specify name of entity:________________________________

B. Do you want coverage for the entity named in Item 12.A. above? ☐ Yes ☐ No

C. If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all physicians practicing under the entity named in Item 12.A. above.

____

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D. Do you practice with any physician(s) not named in Item 12.C. above? ☐ Yes ☐ No

If yes, provide the name of each physician and the practice relationship:

____

____

____

E. Do you employ, contract with or supervise any physician(s) or surgeon(s)? ☐ Yes ☐ No

If yes, provide the number and attach a current certificate of insurance for each. Number: ______

F. Do you have any office or expense sharing arrangement with any other physician(s) or surgeons(s) other than those named in 12.C. or 12.D. above? ☐ Yes ☐ No

If yes, provide the number and attach a current certificate of insurance for each. Number: ______

G. Do you employ, contract with or supervise any non-physician health care extenders? ☐ Yes ☐ No

If yes, enter the information below:

	No.		No.	Others (Describe)	No.
Nurse Practitioner		Laboratory Technician			
Physician Assistant		CRNA			
Surgeon Assistant		Certified Nurse Midwife			
Pharmacist		Nurses			

13. Are you employed full-time or part-time by the federal, state, or local government, or are you on active military duty? ☐ Yes ☐ No
If yes, please explain:

____

14. Provide the following information for all hospitals or surgi-centers where you are currently on staff:

Name	City	State	% of Work	Type of Privileges

15. Are you currently a hospital chief of staff or head of any hospital department? ☐ Yes ☐ No

If yes, please describe:

____

16. Do you or any entity named in 12.A. above own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgi-center, abortion clinic, walk-in clinic, or birthing center? ☐ Yes ☐ No

If yes, attach a detailed explanation and include the location name, size, and number of beds.

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17. Do you serve as a medical director of a nursing home, clinic, commercial enterprise or any other organization? ☐ Yes ☐ No

    If yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position:

    ____

    ____

18. Average weekly patient load: ______ Average weekly practice hours: ________

    Percentage of Locum Tenens work: ______%

19. Do you work in an Emergency Room, other than to maintain hospital privileges? ☐ Yes ☐ No

    If yes, provide the average number of hours you work in the Emergency Room each month: _____

20. Are you ACLS certified? ☐ Yes ☐ No Are you ATLS certified? ☐ Yes ☐ No

21. A. Do you work for any locum-tenens companies as an employee ☐ or independent contractor ☐? ☐ Yes ☐ No

    B. If yes, number of hours each month in which you work in locum-tenens positions: ___________

    C. If yes, does each company provide you with Professional Liability insurance for locum positions? ☐ Yes ☐ No

    If Yes, attach a copy of your Certificate(s) of Insurance.

22. Do you now or have you ever provided services to any state, local or federal correctional facility, jail, or prison? ☐ Yes ☐ No

    If yes, please describe: ____

23. Have there been any changes in your specialty or practice activities within the past ten (10) years? ☐ Yes ☐ No

    If yes, describe the changes: ____

24. Do you anticipate any changes in your specialty or practice in the next year? ☐ Yes ☐ No

    If yes, describe the anticipated changes: ____

25. Do you perform any procedure not routinely performed by other persons practicing your specialty or subspecialty? ☐ Yes ☐ No

    If yes, please provide complete details: ____

26. A. Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering medical services? ☐ Yes ☐ No

    B. If yes, indicate all states where the patients being treated reside: ___________________________

    C. What percentage of your practice does this extra state activity constitute? ___________

27. Do you read or interpret films, slides or specimens of patients who reside in states other than your indicated practice states? ☐ Yes ☐ No

    If yes, indicate all states in which the patients reside and indicate the percentage of your practice corresponding to each state: ____

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28. A. Do you read your own x-rays? ☐ Yes ☐ No

B. If yes, will they subsequently be read by a radiologist? ☐ Yes ☐ No

C. If yes, within how many hours? __________

29. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? ☐ Yes ☐ No

30. Do you perform surgical procedures at a same day surgery center other than your own office?

☐ Yes ☐ No

31. Do you perform surgery in your office or private suite using anesthesia other than local or topical?

☐ Yes ☐ No

If yes, complete the following information: (Use supplemental sheet if more space is needed.)

Procedure	Anesthetic or Parenteral Sedation	Emergency Equipment and/or Emergency Procedures in Place in Case of Complications

32. Are you a sports team physician for any school, college, university, semi-professional or professional team?

☐ Yes ☐ No

33. Do you practice any forms of "Alternative Medicine" including by not limited to Ayurvedic Medicine, Chinese Medicine, Homeopathic Medicine, Chiropractic Medicine, Holistic Medicine or Naturopathic Medicine? ☐ Yes ☐ No

If yes, please describe your practice: ____

34. A. Are you engaged in any "moonlighting" activities? ☐ Yes ☐ No

B. If yes, do you desire coverage for "moonlighting" activities? ☐ Yes ☐ No

C. If yes, describe the activities: ____

35. Do you treat patients in a nursing home or similar facility? ☐ Yes ☐ No

If yes, how many patients to you treat there per month, on average?______________________

36. Do you now or have you ever performed experimental or investigational procedures or prescribed or dispensed experimental drugs? ☐ Yes ☐ No

If yes, please explain on page 11 or on a separate sheet.

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37. Check All Procedures/Treatments That You Perform. Indicate In Appropriate Column, Where Performed.

Office	Hospital	Other	Procedure
			Abortion (Do you perform non-therapeutic abortions? Yes [ ] No [ ]) Which Trimester?___ No. per yr. _____
			Acupuncture
			Anesthesia – Non-Obstetrical
			Anesthesia – Obstetrical
			Angiography
			Angioplasty
			Assisting In Surgery – (Own Patients; Patients of Others) Circle those that apply.
			Bariatric Procedures
			Blepharoplasty
			Breast Implant or Reduction
			Cardiac Catheterization
			Cervical Biopsy
			Chelation Therapy (Lead Removal/Arteriosclerotic Heart Disease) Circle those that apply.
			Chemonucleolysis
			Cryosurgery (other than use on benign, malignant or pre-malignant dermatological lesions)
			Dermatological Procedures: Botox Injection
			Chemical Peels
			Chemobrasion
			Collagen Injection
			Dermabrasion
			Fat Transfer
			Hair Transplant
			Laser Hair Removal
			Laser Skin Resurfacing
			Microdermabrasion
			Silicone Injection
			Other (Describe here or on supplemental sheet)
			Dilation & Curettage
			Echocardiography
			Electroconvulsive Therapy
			Endoscopic Procedures
			Facial Plastic Surgery (Elective Cosmetic/Reconstructive) Circle those that apply.
			Fracture Reduction (Closed/Open) Circle those that apply.
			Hyperbaric Medicine
			Hysterectomy
			Intensive Care For Newborns
			Intensive Care Medicine For Adults
			Laparoscopy
			Liposuction (Tumescent/Other) Circle those that apply.
			Lymphangiography
			Myelography
			Needle Biopsy (including lung, prostate, liver and kidney)
			Obstetrics Prenatal Care
			Normal Deliveries (Provide annual number:)

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Office	Hospital	Other	Procedure
			C-Sections (Provide annual number:)
			VBAC Deliveries (Provide annual number:)
			Organ Transplantation
			Orthopedic Surgery (including spinal/without spinal) Circle those that apply.
			Osteopathic Manipulative Medicine
			Pain Management
			Penile Augmentation/Implant
			Permanent Pacemaker Insertion
			Pneumoencephalography
			Prolotherapy
			Radiation Therapy
			Radiopaque Dye Injections
			Refractive Surgery (LASIK, PRK, AK, PTK, ICR) Circle those that apply.
			Sclerotherapy
			Thoracic Surgery _________%
			Tonsillectomy/Adenoidectomy
			Transgender Surgery/Hormonal Gender Conversion
			Tubal Ligation
			Vascular Surgery _________%
			Vasectomy
			Vertebroplasty
			I do not perform any of the above procedures/treatments. Initial___________

If you answer "yes" to questions 38 through 44, please provide details on page 11.

38. Has any licensing authority or hospital ever reprimanded you or ever denied, revoked, suspended, or restricted your medical license, narcotics license or practice privileges or put you on probation?
☐ Yes ☐ No

39. Has any licensing authority or hospital conducted (or are they currently conducting) an investigation relating to the nature of your practice privileges, or to the restriction or limitation of your license or privileges? ☐ Yes ☐ No

40. Have you ever been indicted, charged, arrested (other than for motor vehicle violations) or convicted of any offense, crime, or misdemeanor in any state or any federal jurisdiction? ☐ Yes ☐ No

41. Have you ever been evaluated, diagnosed, or treated for any disease or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency? ☐ Yes ☐ No

42. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

43. Do you have a physical handicap or any chronic disease? ☐ Yes ☐ No

44. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health payors, or public health payors, including but not limited to Medicare or Medicaid? ☐ Yes ☐ No

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IV. CLAIM INFORMATION

IMPORTANT INFORMATION REGARDING QUESTIONS 45A, 45B, 45C AND 45D (INCLUDING SUB-QUESTIONS)
1. The word "claim" as used in questions 45A, 45B, 45C and 45D as follows refers to: a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional services and brought against you or any partner, associate, employee, or professional corporation or partnership; or b. Circumstances which have been brought to your attention by a patient or legal representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer yes to any parts of questions 45A and 45B, please complete the Supplementary Claims Information Form on page 13 for all such claims.

45. A. Have you ever been involved in a malpractice suit or claim, either directly or indirectly?

☐ Yes ☐ No

If yes, how many? __________ (Provide details for each on page 13.)

B. Other than the claims/suits indicated in 45.A. above, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

1. A request for records from a patient and/or attorney related to an adverse outcome?

   ☐ Yes ☐ No

2. A letter from an attorney regarding your medical treatment of a patient? ☐ Yes ☐ No
3. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability, or the need for follow-up surgery? ☐ Yes ☐ No
4. Patient or family members dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No
5. Knowledge or information relating to service or services on a Board which might result in a claim? ☐ Yes ☐ No
6. Any other circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No

C. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability company? ☐ Yes ☐ No
If yes, how many? __________ (Provide documentation of all such reports.)

If no, please explain details on page 11.

D. Has any prior professional liability company refused coverage for, or declined to accept a report of a medical incident, threat of a claim, letter of intent, adverse result notice or attorney contact?
☐ Yes ☐ No

If yes, please explain details on page 11.

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V. PROFESSIONAL LIABILITY INSURANCE HISTORY

46. Provide details of Professional Liability Insurance for the past seven (7) years, including coverage for "moonlighting" positions:

Company Name	Each Claim Limit	Aggregate Limit	Policy Dates From	To	Claims Made or Occurrence?	Retroactive Date

47. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium or issued coverage with any restrictions or exclusions related to specific practices or procedures? ☐ Yes ☐ No

If yes, provide explanation on supplemental page 11.

48. Have you ever been without professional liability coverage since beginning practice? ☐ Yes ☐ No

If yes, provide explanation on supplemental page 11.

49. Do you have professional liability insurance for work you do elsewhere? ☐ Yes ☐ No

If yes, provide explanation on supplemental page 11.

50. If prior coverage is Claims-Made, has a Reporting Endorsement ("tail" coverage) been purchased?

☐ Yes ☐ No

If yes, provide copy of the Reporting Endorsement.

If no, provide explanation on supplemental page 11.

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VI. COVERAGE REQUEST

51. Effective Date Desired: ___________________ Retroactive Date Desired: ________________________

(NOTE: THE COMPANY MAY NOT PROVIDE DESIRED DATES)

52. Policy Limits Desired: ☐$100,000/$300,000 ☐$200,000/$600,000 ☐$250,000/$750,000
☐$500,000/$1,500,000 ☐$1,000,000/$3,000,000
☐Other: ____

53. A deductible of at least $5,000 is required. Please select any optional deductibles that you desire. No aggregate limit will apply to the deductible.
☐$10,000 ☐$25,000 ☐$50,000 (approved LOC required)

SUPPLEMENTAL INFORMATION

Please use this form to provide additional information or to answer any questions.

Question No.	

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NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or “CLAIMS MADE AND REPORTED” basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an “OCCURRENCE” basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Equity Partners Insurance Services, Inc. and its respective Insurance Company[s] it is working with.

Signature of Applicant	Date

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SUPPLEMENTAL CLAIM INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each claim.

If space is insufficient to answer any question fully, please attach a separate sheet. All questions must be answered or marked not applicable (N/A).

1. Patient's Name:____

2. Date reported to insurance company:______________________________

3. Name of insurance company:_____________________________________

4. Date of incident and your treatment:_______________________________

   ____

5. Allegations:____

   ____

6. What is the present condition of the patient? _________________________

   ____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No

8. Status of claim (check applicable answer):

   ☐ Suit threatened, no action taken
   ☐ Suit filed but dropped by claimant
   ☐ Summary judgment in your favor

   Court outcome in your favor:
   ☐ Jury verdict
   ☐ Directed verdict

   Unresolved/Open Claim:
   ☐ Awaiting mediation
   ☐ Awaiting court action

   ☐ Suit settled out of court
   a. Date claim paid:____________
   b. Amount paid: $ _____________
   c. Did you want to settle this claim? ☐ Yes ☐ No

   Court outcome in favor of plaintiff:
   ☐ Jury verdict
   ☐ Directed verdict
   Amount of loss payment:
   $ ________________

   Reserve Amount:
   $______________

9. Name and address of the attorney assigned to your case:__________________

   ____

10. To your knowledge, was any settlement paid by another party involved (your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No If yes, what was the amount of the settlement? __________

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11. Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:_______

____

____

____

Signature of Applicant	Date
Name (Printed)	

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