

Physicians Claims-Made Application



Medical Professional Liability

EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A. If additional space is required, please use page 6.

NAME OF APPLICANT (LAST, FIRST, MIDDLE): _____ DEGREE: _____
SOCIAL SECURITY #: _____ BIRTH DATE: _____ AGE: _____ GENDER: M F
PHONE: _____ FAX: _____ EMAIL: _____
Your email address will never be sold. It will be used to send you important notices.
NAME OF PRACTICE: _____
CONTACT: _____
HOME ADDRESS (STREET OR BOX): _____
HOME ADDRESS (CITY, STATE, ZIP): _____ COUNTY: _____
MAILING ADDRESS (STREET OR BOX): _____ SUITE: _____
MAILING ADDRESS (CITY, STATE, ZIP): _____ COUNTY: _____
PRACTICE ADDRESS (IF DIFFERENT): _____
NUMBER OF YEARS AT THIS ADDRESS: _____
BILLING ADDRESS (IF DIFFERENT): _____

1. Requested effective date: (month/date/year): / / 12:01 am

2. Requested limits: Per Occurrence / Aggregate:

- \$2,000,000/\$4,000,000
- \$1,000,000/\$3,000,000
- \$500,000/1,000,000
- \$250,000/\$750,000
- \$100,000/\$300,000
- \$200,000/\$600,000 (In Kansas, this is the only limit available)

Do you desire a deductible? Yes No

If yes, please indicate the desired amount: \$ _____

3. In which states are you licensed to practice medicine and what percentage of your practice occurs in those states:

STATE: _____ LICENSE #: _____ %: _____

STATE: _____ LICENSE #: _____ %: _____

STATE: _____ LICENSE #: _____ %: _____

If an employee, give employer's name:

4. Will you be participating in a state-operated patient's compensation fund?

Yes No

STATE: _____

5. If yes, are you a resident of the comp fund state? Yes No

A. History

1. Claims-made coverage history

a. Have you ever been insured under a claims-made policy?

- Yes *Complete questions A1b and A1c.*
- No *Skip to question A2*

b. Was extended reporting coverage (tail coverage) purchased?

- Yes *Please furnish a copy of the reporting endorsement.*
- No *Please explain on page 6.*

c. Are you requesting Prior Acts Coverage?

- Yes
- No

If "yes," provide retroactive date below and attach a copy of the current professional liability insurance policy, including Declarations and Endorsements. We cannot evaluate your application without these documents.

RETROACTIVE DATE (month/day/year): _____

You are not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Prior Acts Coverage period. **Note: Prior Acts Coverage is optional and subject to underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by Professional Solutions Insurance Company that your request for Prior Acts Coverage has been approved.**

Physicians Claims-Made Application

2. List malpractice coverage for past 10 years:

Use page 6, or an additional sheet of paper, if more space is required:

NAME OF CARRIER: _____

POLICY LIMITS: _____

DATES COVERED, FROM _____ TO _____

PLEASE CHECK ONE INDICATE NUMBER OF CLAIMS

OCCURRENCE _____ PENDING

CLAIMS-MADE _____ CLOSED

NAME OF CARRIER: _____

POLICY LIMITS: _____

DATES COVERED, FROM _____ TO _____

PLEASE CHECK ONE INDICATE NUMBER OF CLAIMS

OCCURRENCE _____ PENDING

CLAIMS-MADE _____ CLOSED

3. Please answer the following questions regarding previous coverage:

a. Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in Section B of this application?

- Yes
 No

For instance, did your practice formerly include obstetrical care or emergency room services that you are no longer providing?

If "yes," please describe the changes in your practice, including all applicable dates, on page 6.

NOTE: Adequate Prior Acts Coverage is contingent upon your description of your former practice.

b. Did any of your policies contain coverage restrictions?

- Yes
 No

If "yes," please describe on page 6.

c. Are you aware of any claims or suits, or any conduct, circumstances, occurrences or incidents likely to give rise to a claim that have not been reported to your prior insurer(s)?

- Yes
 No

d. Have you received any correspondence threatening a claim or suit against you, a pre-litigation notice of intent to commence suit, or have you been named as a respondent in discovery at any time in the past five years?

- Yes
 No

If you answer "yes" to question A3d or A3e, complete a separate Claim Information Sheet and provide a written narrative for each such claim or incident. For your protection, we urge you to report all applicable claims or incidents to your previous insurer(s).

4. Current and past locations where you have practiced.

(Last 10 years): *Use page 6 if more space is required.*

CITY: _____ STATE: _____

HOSPITAL: _____ FROM _____ TO _____

CITY: _____ STATE: _____

HOSPITAL: _____ FROM _____ TO _____

CITY: _____ STATE: _____

HOSPITAL: _____ FROM _____ TO _____

5. Are you a member of a State Medical Society or other medical association or have you applied for membership?

- Yes
 No

NAME OF ASSOCIATION:

Physicians Claims-Made Application

6. Current hospital staff appointments or privileges:

Use page 6 if more space is required.

HOSPITAL: _____	DEPARTMENT: _____
CITY: _____	STATE: _____
APPOINTMENT: _____	PRIVILEGES: _____

HOSPITAL: _____	DEPARTMENT: _____
CITY: _____	STATE: _____
APPOINTMENT: _____	PRIVILEGES: _____

HOSPITAL: _____	DEPARTMENT: _____
CITY: _____	STATE: _____
APPOINTMENT: _____	PRIVILEGES: _____

If you do not currently hold hospital privileges, please indicate in the space provided on page 6, or on an additional sheet of paper, what protocols you have in place if your patient required hospital admission.

7. Present specialties:

SPECIALTY: _____ % OF PRACTICE: _____

SPECIALTY: _____ % OF PRACTICE: _____

8. List medical training and education:

Please provide additional training information on page 6, or use an additional sheet of paper.

MEDICAL SCHOOL/TRAINING: _____

DATE COMPLETED: _____ COUNTRY: _____

CITY: _____ STATE: _____

INTERNSHIP LOCATION: _____

DATE COMPLETED: _____

SPECIALTY: _____

RESIDENCY LOCATION: _____

DATE COMPLETED: _____

SPECIALTY: _____

FELLOWSHIP LOCATION: _____

DATE COMPLETED: _____

SPECIALTY: _____

9. If granted from a foreign medical school, are you ECFMG certified?

Yes

No

10. Are you currently Board certified?

Yes

No

SPECIALTY: _____

Are you currently Board eligible?

Yes

No

SPECIALTY: _____

11. If you are now an intern or resident, when is training to be completed?

DATE (month/date/year): _____

12. Have you completed any AMA or State Medical Society Continuing Education Credit program for Risk Management/Prevention in the past 12 months?

Yes

No

If "yes," please attach a copy of your Certificate of Completion.

13. Please give a complete explanation of all "yes" answers for the following questions. Use page 6, or an additional sheet of paper, if more space is required.

a. Has any group or hospital suspended, restricted or refused your staff privileges, or have you voluntarily or involuntarily surrendered or limited your privileges anytime?

Yes

No

b. Have you ever voluntarily or involuntarily surrendered or had a state license to practice medicine or a narcotics license refused, restricted, suspended or revoked?

Yes

No

c. Has membership in any professional association or society ever been revoked or refused?

Yes

No

d. Do you have any health problems or any type of disability, or have you been treated for any chronic illness or physical defect which might affect your practice of medicine?

Yes

No

Physicians Claims—Made Application

e. Have you been asked to participate in or have you volunteered to participate in an impaired physicians program?

Yes

No

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

f. Have you ever been convicted of a felony?

Yes

No

g. Have you ever had any professional liability insurance refused, cancelled or non-renewed?

Yes

No

Missouri residents skip this question.

h. Are you now, or have you ever practiced without professional liability insurance?

Yes

No

i. Have any claims or suits for alleged sexual misconduct ever been brought against you?

Yes

No

j. Have any claims or suits ever been filed against you as a result of professional services?

Yes

No

If "yes," give details, amount paid, dates, etc. on a separate Claim Information Sheet.

k. Were the claims identified in questions A12i and A12j reported to a previous insurer(s)?

Yes

No

If "yes," name the insurer(s) on the Claim Information Sheet.

l. Will you carry additional professional liability insurance with another company for activities outside those for which you are requesting coverage from us?

Yes

No

If "yes," show name of company, limits, expiration date and services covered.

m. Do you provide medical services over the Internet or telephone to patients outside your state?

Yes

No

If "yes," please provide details on page 6, or use an additional sheet of paper if more space is required.

n. Do you work in any free-standing emergency centers?

Yes

No

o. Do you render patients unconscious for treatment in your office or other non-hospital facility?

Yes

No

p. Have you discontinued any procedures in the last five years?

Yes

No

If "yes," please describe what procedures, when discontinued and approximately the number performed annually.

q. Are you currently under contract to provide services on behalf of an HMO or other managed care organization?

Yes

No

r. Are you currently providing, or have you provided, in the past five years, healthcare services for patients in any governmental institute, prison, county or city jail, or nursing home?

Yes

No

B. Practice Information

1. Limited practice

a. How many hours per week do you practice? _____

Hours per year? _____

Please include hours spent on administrative duties, office practice, on-call duties, hospital rounds and surgical schedule.

b. Date you began practicing on a limited basis (month/day/year):

Physicians Claims-Made Application

2. If you are a faculty member of an accredited medical education institution, please give name of institution and percent of total practice time devoted to non-clinical teaching: _____

3. Check the appropriate box indicating the extent of surgery you perform as of the effective date of this coverage:

- No surgery except incision of boils, cysts, other superficial abscesses or suturing of minor lacerations
- Minor surgery
- Assisting in surgery on own patients
- Assisting in surgery on other's patients
- Major surgery

4. Indicate whether you perform the following procedures and the number of these procedures you expect to perform per year. If none, check here:

PROCEDURE	NUMBER PERFORMED ANNUALLY
<input type="checkbox"/> Acupuncture – anesthesia	_____
<input type="checkbox"/> Angiography	_____
<input type="checkbox"/> Angioplasty	_____
<input type="checkbox"/> Appendectomy	_____
<input type="checkbox"/> Arthroscopic surgery	_____
<input type="checkbox"/> Breast injection or implants	_____
<input type="checkbox"/> Caesarean section	_____
<input type="checkbox"/> Cardiac surgery	_____
<input type="checkbox"/> Catheterization – cardiac	_____
<input type="checkbox"/> Circumcision – adult	_____
<input type="checkbox"/> Closed reduction of fractures	_____
<input type="checkbox"/> Colonoscopy	_____
<input type="checkbox"/> Corrective eye surgery	_____
<input type="checkbox"/> Cosmetic plastic surgery – elective	_____
<input type="checkbox"/> Cosmetic plastic surgery – traumatic	_____
<input type="checkbox"/> Dilation & Curettage	_____
<input type="checkbox"/> Diagnostic arthroscopy	_____
<input type="checkbox"/> Gastric by-pass surgery	_____
<input type="checkbox"/> Gastric stapling	_____
<input type="checkbox"/> General anesthesia	_____
<input type="checkbox"/> Hair growing or transplant	_____
<input type="checkbox"/> Hemorrhoid banding	_____

PROCEDURE	NUMBER PERFORMED ANNUALLY
<input type="checkbox"/> Hemorrhoidectomy	_____
<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Independent Medical Examinations	_____
<input type="checkbox"/> Interventional radiology	_____
<input type="checkbox"/> Laparoscopy	_____
<input type="checkbox"/> Laser therapy or surgery	_____
<input type="checkbox"/> Obstetrical deliveries	_____
<input type="checkbox"/> Open reduction of fractures	_____
<input type="checkbox"/> Orthopedic surgery	_____
Involving the spine	_____
Not involving the spine	_____
<input type="checkbox"/> Peripheral vascular surgery	_____
<input type="checkbox"/> Prenatal care	_____
<input type="checkbox"/> Radiopaque dye injections	_____
<input type="checkbox"/> Shock therapy (ECT)	_____
<input type="checkbox"/> Spinal anesthesia	_____
<input type="checkbox"/> Suction-assisted lipectomy/liposuction	_____
<input type="checkbox"/> Tonsillectomies & Adenoidectomies	_____
<input type="checkbox"/> Thoracic surgery	_____
<input type="checkbox"/> Tubal ligation	_____
<input type="checkbox"/> Vascular surgery	_____
<input type="checkbox"/> Weight control – other than diet	_____

Do you practice as any of the following, and if so do you maintain a license?

SPECIALTIES	LICENSED	% OF PRACTICE
<input type="checkbox"/> Acupuncture /Oriental Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Holistic Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Homeopathic Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Naturopathic Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Other procedures not listed: _____

Do you refer patients to a hospitalist? Yes No

If "yes," please describe on page 6 your patient preparation, admittance and follow-up protocol.

Do you perform any procedures that are experimental, not usual or customary to the specialty or disapproved by the AMA or FDA?

Yes No If "yes," explain on page 6, or use an additional sheet of paper.

Physicians Claims-Made Application



Professional Entity

Medical Professional Liability

It is the intent of the company to insure all providers in a corporation, partnership or professional association. Please type or print. **EVERY ITEM MUST BE COMPLETED.** If not applicable, write N/A. If additional space is required, please use page 2. A separate application is required for each entity that is requesting separate limits.

ENTITY NAME: _____

FEDERAL TAX ID #: _____ CONTACT: _____

PRACTICE ADDRESS (STREET or PO BOX): _____

PRACTICE ADDRESS (CITY, STATE, ZIP): _____ COUNTY: _____

NUMBER OF YEARS AT THIS ADDRESS: _____

MAILING ADDRESS (IF DIFFERENT): _____

MAILING ADDRESS (IF DIFFERENT): _____

PHONE: _____ FAX: _____ E-MAIL: _____

Your email address will never be sold. It will be used to send you important notices.

BILLING CONTACT (IF DIFFERENT): _____

BILLING ADDRESS (IF DIFFERENT): _____

1. Type of coverage desired:

- Shared limits
- Separate limits

The entity is not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Prior Acts Coverage period.

2. Requested effective date: (month/date/year): / / 12:01 am

Note: Prior Acts Coverage is optional and subject to underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by Professional Solutions Insurance Company that your request for Prior Acts Coverage has been approved.

3. Requested limits: Per Occurrence / Aggregate:

- \$2,000,000/\$4,000,000
- \$1,000,000/\$3,000,000
- \$500,000/1,000,000
- \$250,000/\$750,000
- \$100,000/\$300,000
- \$200,000/\$600,000 (In Kansas, this is the only limit available)

Select your deductible:

- \$ 0
- \$

5. Claims History

a. Have any claims or suits ever been filed against the entity a result of professional services?

- Yes
- No

b. Are you aware of any conduct, circumstances, occurrences or incidents against the entity that are likely to give rise to a claim?

- Yes
- No

4. Is the entity requesting Prior Acts Coverage?

- Yes
- No

If "yes," attach a copy of the current declarations page and any restrictive endorsements. We cannot evaluate your application without these documents.

RETROACTIVE DATE (month/day/year): / /

Professional Entity

c. Has the entity received any correspondence threatening a claim or suit against you, a pre-litigation notice of intent to commence suit, or have you been named as a respondent in discovery at any time in the past five years?

- Yes
- No

d. If you answered "yes" to question 5a, 5b or 5c, have the claims, conduct, circumstances, occurrences or incidents been reported to a previous insurer?

- Yes
- No

If you answered "yes" to questions 5a, 5b or 5c, complete a separate Claim Information Sheet and provide a written narrative for each such claim or incident. For your protection, we urge you to report all applicable claims or incidents to your previous insurer(s).

6. List all members, shareholders or partners of the organization.

Use an additional sheet of paper if more space is required.

NAME: _____	SPECIALTY: _____
EXPIRATION DATE: _____	LIMITS: _____
CURRENT INSURER: _____	

NAME: _____	SPECIALTY: _____
EXPIRATION DATE: _____	LIMITS: _____
CURRENT INSURER: _____	

NAME: _____	SPECIALTY: _____
EXPIRATION DATE: _____	LIMITS: _____
CURRENT INSURER: _____	

7. Does the entity employ any of the following Ancillary Medical Personnel?

If "yes," please indicate the number in each category.

OCCUPATION	# EMPLOYED
<input type="checkbox"/> Advanced Practice Nurse Practitioner	_____
<input type="checkbox"/> Certified Registered Nurse Anesthetist	_____
<input type="checkbox"/> Scrub Nurse	_____
<input type="checkbox"/> Paramedic	_____
<input type="checkbox"/> PhD Psychologist	_____
<input type="checkbox"/> Physician Assistant	_____
<input type="checkbox"/> Operating Room Technician	_____
<input type="checkbox"/> Surgical Assistant	_____
<input type="checkbox"/> Heart/ Lung Profusion Technician	_____

Do the employees in Question 7 require:

- Individual separate limits (if available).** Please complete an Ancillary Medical Personnel application for each individual when requesting separate limits.
- Shared limit.** Employed Ancillary Medical Personnel approved by Underwriting automatically share in the entity's limit while working within the scope of their licensure and while under the supervision of the doctor.
- Shared separate limit (if available).** Employed Ancillary Medical Personnel approved by Underwriting share collectively in a separate limit.

8. Please list the number of ancillary providers that are employed and supervised by named insured physicians:

OCCUPATION	# EMPLOYED
<input type="checkbox"/> Registered Nurse	_____
<input type="checkbox"/> Licensed Practical Nurse	_____
<input type="checkbox"/> Radiation Therapy Technician	_____
<input type="checkbox"/> Medical Assistant	_____
<input type="checkbox"/> Physical Therapist	_____
<input type="checkbox"/> Other ancillary providers:	_____

9. What is your form of incorporation?

- Solo corporation
- Partnership
- Multi-shareholder corporation
- Limited liability corporation

10. Nature of business?

- General office practice
- Surgery center
- Lab
- Urgent care center
- Clinic or ambulatory care center
- Other (please explain)

Please use this space to provide additional required information.

Question number: _____	Explanation: _____

If you require additional space for explanation, attach additional pages as needed.

Physicians Claims—Made Application



PLEASE DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM THIS COMPANY.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

THE ABOVE STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE, THE TRUTH, AND I HAVE NOT KNOWINGLY WITHHELD ANY INFORMATION IN COMPLETING THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE.

I hereby acknowledge that the foregoing information constitutes my application for insurance with Professional Solutions Insurance Company (Professional Solutions), and that the information contained in the application will be relied upon by Professional Solutions in deciding whether or not to issue such insurance.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by Professional Solutions and I am notified by the company of said acceptance.

Furthermore, I understand that, if requested, Prior Acts Coverage will not apply to liability arising out of any claims, suits, circumstances, conduct or incidents described in questions A12i and A12j of this application, unless such coverage is specifically granted in writing by Professional Solutions Insurance Company. In addition, I understand that this Prior Acts Coverage does not apply to any claims or incidents that I have already reported to any previous insurers.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by the company.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to Professional Solutions Insurance Company, and I expressly release and discharge the company from any and all liability that 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 source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by Professional Solutions to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

Date signed: _____

Signature of applicant: _____

Print name: _____

Title: _____

THIS APPLICATION FORM DULY COMPLETED, TOGETHER WITH ANY SUPPLEMENTARY INFORMATION, MUST BE SIGNED IN INK BY THE APPLICANT. SIGNATURE OF THE FORM DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE.

Signature of agent: _____

Name of agency (type or print): _____

Telephone number of agency: _____

Address of agency: _____

How did you hear about Professional Solutions Insurance Company?

- Insurance Agent
- Advertisement
Which publication? _____
- Professional Solutions display booth
Which convention? _____
- Colleague
- Website
- Direct mail
- Other? Please explain: _____

Check List – Please include a copy of:

- Most recent declarations page from previous carrier
- Current/up-to-date CV
- All active licenses you hold
- Currently valued loss runs for past 10 years
- Practice letterhead

Physicians Claims Information

EVERY ITEM MUST BE COMPLETED. If not applicable, write N/A.

NAME OF APPLICANT (LAST, FIRST, MIDDLE): _____

NOTE: Failure to provide complete information as requested will result in delays in processing your application. Additional documentation (office/hospital records) may be requested by us at a later date.

PATIENT/CLAIMANT NAME: _____ AGE: _____

DATE OF ALLEGED MALPRACTICE: _____

NATURE OF ALLEGED MALPRACTICE: _____

1. List location of incident:

CITY/STATE: _____

2. List name(s) of healthcare provider(s) involved:

NAME: _____

NAME: _____

NAME: _____

3. Was suit ever filed?

Yes. *If "yes," state when:* Month: _____ Year: _____

No

4. Name of insurance company defending you:

COMPANY NAME: _____

5. Indicate disposition or current status of claim or suit:

Open

RESERVE AMOUNT: _____

AMOUNT PAID TO DATE: _____

Closed *Please check one*

Settlement

Verdict

If payment was made, indicate total settlement amount and date paid:

AMOUNT PAID: \$ _____ DATE: _____

AMOUNT PAID ON YOUR BEHALF: \$ _____

6. Narrative description of the MEDICAL facts. (Must include, but not be limited to, the type of treatment and/or surgery rendered, result of treatment and current status of patient's injury, your involvement, i.e., consultant, primary provider, assistant in surgery, etc.) Attach additional sheets as necessary.