



# Medical Professional Liability Renewal Application



2600 Professionals Dr, Box 150 - Okemos, MI 48805-0150  
800/292-1036 - 517/349-6500 - Fax - 517/347-6319

Policy Number: \_\_\_\_\_

Expiring Date: \_\_\_\_\_

Agency Lic#: \_\_\_\_\_ Agency: \_\_\_\_\_

**IMPORTANT:** Please complete this form and return it **with a copy of your updated curriculum vitae** in the envelope provided. Your prompt and accurate reply will avoid any unnecessary delay of your policy's renewal. Please type or print legibly, ensuring that the form is completed in its entirety. Also, please verify that the pre-filled information below is correct. If it is not, please mark through the incorrect information and make the necessary corrections. Thank you for your cooperation.

## 1. Personal Information

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender Male  Female  Place of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Practice Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_ Client ID: \_\_\_\_\_

Medical License Number(s):      State                      License Number                      % of Practice  
\_\_\_\_\_

## 2. Office Information

Principal Office Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Practice County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Professional office located within the city limits of: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Contact Name and Title: \_\_\_\_\_

Preferred mailing address:  Office     Home     Other, specify: \_\_\_\_\_

Preferred billing address:  Office     Home     Other, specify: \_\_\_\_\_

## 3. Practice Information

A. Do you perform any surgical procedures utilizing nurse anesthetists for the administration of conscious sedation, general or regional anesthesia who are not directed by or responsible to an anesthesiologist?..... Yes  No   
If yes, indicate percentage of total surgery involved: \_\_\_\_\_ %, OR average number of cases per month: \_\_\_\_\_

B. Do you perform deliveries? ..... Yes  No   
If yes, indicate:

i. average number of deliveries per month: \_\_\_\_\_

ii. percentage of high risk deliveries: \_\_\_\_\_ %

iii. average number of VBAC deliveries per year: \_\_\_\_\_

iv. Do you have privileges to perform C-sections at each hospital where you provide obstetrical care? ..... Yes  No

v. Do you utilize the approved ACOG prenatal form or an acceptable substitute?..... Yes  No

- C. How many patients do you see on average per week? \_\_\_\_\_
- D. How many hours do you practice per week? \_\_\_\_\_ (Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision and on-call hours involving patient contact, whether direct or by telephone.)
- E. If you are presently in a residency or fellowship program or completed such a program within the past twelve months, please provide the month/year of completion: \_\_\_\_\_
- F. Is your practice less than full time? ..... Yes  No

If yes, please check any of the following applicable reason(s):

- Semi-retirement       Disability       Pregnancy or dependent care       Employer-provided insurance
- Teaching role insured elsewhere       Practice in bordering state insured elsewhere

i. List the name and address of each location and employer(s), if applicable, for which our coverage is needed. Additional space is available on page 7 or you may attach separate sheet.

Location 1 \_\_\_\_\_  
 Location 2 \_\_\_\_\_  
 Location 3 \_\_\_\_\_

ii. Indicate total number of hours per week and per month devoted to the following activities at each location described above:

PRACTICE ACTIVITIES	LOCATION 1		LOCATION 2		LOCATION 3	
	Hrs/wk	Hrs/mo	Hrs/wk	Hrs/mo	Hrs/wk	Hrs/mo
Total number of hours the practice is open						
Your actual patient care, including hospital rounds						
Your time on-call for urgent care/emergency room						
Your time spent at a lab, or other medical facility						
Your administrative tasks/duties related to your practice						
Your consult time with other health care providers						
Your surgeries and assisting in surgeries						
Your house calls and/or nursing home visits						
Your other patient care related activities						

iii. Specialty practiced at the above location(s): \_\_\_\_\_

iv. List the name and address of all other locations of employment for which coverage with the Company is not needed. Additional space is available on page 7 or you may attach separate sheet.

v. Please indicate:

- a. Number of hours worked per week at the above location: \_\_\_\_\_
- b. Specialty practiced at the above location: \_\_\_\_\_
- c. Insurance carrier providing coverage at the above location: \_\_\_\_\_

G. Have you ever failed a medical licensing examination? ..... Yes  No

If yes, specify the section(s) and indicate the number of times for each section \_\_\_\_\_

H. Are you board certified?..... Yes  No

i. If yes, please indicate which board and specialty/subspecialty:

- American Board of \_\_\_\_\_
- American Osteopathic Board of \_\_\_\_\_

ii. If not boarded, when do you plan to take your Boards? \_\_\_\_\_

iii. Are you required to recertify? ..... Yes  No

If yes, please provide date of recertification: \_\_\_\_\_

iv. Have you ever failed a Board certification examination? ..... Yes  No

If yes, how many times? \_\_\_\_\_

I. Please indicate below, your current certification(s):

- ACLS Certified  BCLS Certified  ATLS Certified  PALS Certified  CPR Certified  Not Certified

J. List the names of others in your office who are currently certified and specify ACLS, BCLS, ATLS, PALS or CPR:

Full name of Employee	Type of Certification
_____	_____
_____	_____

K. Do you provide services to any nursing home or similar facility? ..... Yes  No   
If yes, how many hours per week do these services constitute? \_\_\_\_\_

L. Do you serve as a Medical Director? ..... Yes  No

i. If yes, please list the name of the facility(s): \_\_\_\_\_

ii. Is professional liability insurance provided by the facility for your duties as Medical Director? ..... Yes  No

M. Do you provide services to any local, state or federal correctional facility, jail or prison? ..... Yes  No

i. If yes, how many hours per week do these services constitute? \_\_\_\_\_

ii. Please list the name of the facility(s): \_\_\_\_\_

N. Are you a sports team physician for any high school, college, university, semi-professional or professional team? ..... Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

O. Do you, or any partnership or corporation of which you are a member or shareholder, own or operate a surgi-center, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? If yes, please describe on page 7. .... Yes  No

P. Do you perform medical or surgical procedures at a surgi-center, office-based surgical suite or similar facility? ..... Yes  No

Q. Do you have a website for your practice? ..... Yes  No   
If yes, please indicate the website address:

**4. Out of State Exposure**

A. Do you perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine) Yes  No

i. If yes, please indicate all states in which the patients being treated reside:

What percentage of your total practice does this activity constitute? \_\_\_\_\_%

B. Do you read, interpret or diagnose films, slides or specimens taken from patients who reside in states other than your indicated state of practice? Yes  No

If yes, please list all states in which the patients reside:



**6. Group Membership**

- A. Please give us the name and Federal Tax ID Number of any newly formed or not previously reported solo or professional group practice entity (e.g., P.A.,P.C.,L.L.C., L.L.P., Inc., etc.) related to your practice  
\_\_\_\_\_
- B. Do you desire coverage for this practice entity? ..... Yes  No
- C. If you have a group affiliation, give the name and Federal Tax ID Number of the group and check the box (or boxes) that correctly identify your affiliation. If other, please explain on page 7 or a separate sheet.  
Name of Group: \_\_\_\_\_  
I am a:  sole owner     partner     shareholder     employee     independent contractor     other \_\_\_\_\_
- D. Have you or your group practice employed any new physicians or other medical professionals that you have not previously reported? ..... Yes  No   
If yes, please describe and provide proof of current liability coverage. \_\_\_\_\_
- E. Please give us the name and Federal Tax ID Number of any practice entity which has dissolved since the date of your last renewal and the effective date of the dissolution:  
\_\_\_\_\_
- F. At this time how many physicians are affiliated with your group organization? \_\_\_\_\_  
Does the Company insure all of them? ..... Yes  No   
If no, how many are not insured by the Company? \_\_\_\_\_  
Please list: \_\_\_\_\_  
**NOTE:** You must provide proof of current professional liability coverage for all physicians insured elsewhere.
- G. Please tell us if any practice entity of which we were previously aware has had a name change: \_\_\_\_\_
- H. Do you rent, lease or share office space with any physician or surgeon not listed above?..... Yes  No
- I. Are you practicing under a d/b/a name (doing business as) name? ..... Yes  No   
If yes, please list all d/b/a names including the effective date of each: \_\_\_\_\_

**7. Personal History** - If you answer yes to any of the following questions, provide complete details on page 7 or a separate sheet.

- A. Have any of the following ever been denied, investigated, suspended, restricted, placed on probation, revoked or voluntarily surrendered for any reason:
  - i. State Medical License? ..... Yes  No
  - ii. Hospital Privileges? ..... Yes  No
  - iii. License to prescribe or dispense medicine? ..... Yes  No
- B. Have your Medicare/Medicaid billing procedures ever been investigated? ..... Yes  No
- C. Have you ever:
  - i. Undergone psychiatric treatment? ..... Yes  No
  - ii. Been evaluated for, diagnosed with, treated or recommended for treatment of alcohol, narcotics or any other substance abuse, sexual addiction (including but not limited to misconduct, harassment or boundary violations) or mental illness? ..... Yes  No
  - iii. Been diagnosed with any chronic illness or physical defect? ..... Yes  No
  - iv. Been convicted or pled guilty to, or entered into a plea agreement for, a violation of any law or ordinance other than minor traffic offenses but including "driving under the influence"? ..... Yes  No
  - v. Had a patient or a patient representative complain or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners or other medical review committee? ..... Yes  No
  - vi. Appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing board, state Board of Medical Examiners, licensing Board or other medical review committee? ..... Yes  No
- D. Has any claim or suit for alleged malpractice been made against you and reported to another insurance carrier or hospital self-insured trust since you became insured by the Company? ..... Yes  No
- E. Has any claim or suit for alleged malpractice made against you and reported to another insurance carrier or hospital self-insured trust resulted in payment by you or on your behalf since you became insured by the Company? ..... Yes  No

**8. Professional Employees**

A. List all current allied health professionals employed by you or your organization, for the following categories: Cytotechnologist, EMT – Paramedic, Nurse Midwife, Nurse Practitioner, Occupational Therapist, Perfusionist, Pharmacist, Physical Therapist, Physician Assistant w/o surgery, Psychologist, Respiratory Therapist, Social Worker, Surgical Assistant/ PA with surgery, Technician, Nurse Anesthetist, or Optometrist.

Employee Name	DOB	SSN	Specialty	Date
				Begin/Terminate

If you desire coverage from the Company for any paramedicals not currently insured by us, please contact your agent or the Marketing Department for applications. NOTE: You must provide proof of current liability coverage for each paramedical insured elsewhere.

- B. Do any of the persons listed above see patients on the initial visit who are not seen by you or any member of your group at the same visit? ..... Yes  No
- C. Do you or any member of your group supervise or are responsible (e.g., a collaborative agreement with a nurse practitioner) for patient care rendered to your patients by anyone other than yourself? ..... Yes  No 
  - i. Are any of these persons involved in patient care/contact at facilities where you are not physically present? These include but are not limited to nursing homes, correctional facilities, extended care facilities and satellite offices. .... Yes  No
  - ii. Is a supervisory or collaborative agreement on file with the State Board of Medicine and/or Nursing for each paramedical? ..... Yes  No
  - iii. Is the agreement on file in your office? ..... Yes  No
  - iv. Do you review the medical records generated by paramedicals for your patients?  
If yes, indicate: \_\_\_\_\_% or #\_\_\_\_\_ charts reviewed every day / week / month / quarter. (circle one)
- D. Do you or any member of your group currently supervise any paramedical who is not in your employ? .. Yes  No

**I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:**

- A. A change in specialty or medical procedures performed;
- B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
- C. Investigation, restriction, suspension or surrender of any state medical license, DEA license or hospital privileges;
- D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing;
- E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

**Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.**

**GENERAL FRAUD WARNING – Any person who, with intent to defraud or knowing that he 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.**

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and that I have not willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof:

Date: \_\_\_\_\_ Signature of Insured Physician: \_\_\_\_\_

**Additional Comments**

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Please attach additional sheets as necessary.

