



Physicians Insurance Company

Physicians & Surgeons Professional Liability Insurance Application

YOU	<input type="checkbox"/> Copy of current most relevant medical license	<input type="checkbox"/> Copy of current declarations page
MUST	<input type="checkbox"/> Copy of letterhead or sample billing statement	<input type="checkbox"/> Curriculum vitae
ATTACH	<input type="checkbox"/> Supplemental claim form for each claim, regardless of outcome	<input type="checkbox"/> Copy of board certification

Please type or legibly print your responses in full. Please supplement this application with copies of the documents requested above and with responses to questions requiring more room than contained in this form.

1. Name (First, Middle, Last):	<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.	Birthplace:
2. Social Security Number:	3. Date of Birth:	
4. License Number/Date:	5. Narcotics DEA Number:	

6. Mailing Address:

Street:	
City/State/Zip:	County:

Office Telephone:	Fax:	E-Mail:
Business manager/contact person:		Telephone:

7. Principal office address (if different than mailing address):

Street:	Telephone:
City/State/Zip:	County:

Other Practice Locations:

Residence address (if different than mailing address):

Street:	County:
City/State/Zip:	Residence Telephone:

8. Requested limits of insurance:

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9. Requested effective date (12:01 a.m.): _____ Requested retroactive date (12:01 a.m.): _____
 Retroactive date is the date to which coverage is to be extended for acts prior to the effective date.

10. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage for? Yes No
 If yes, please list name of employer and insurance company:

11. Medical Specialty:	Subspecialty (if any):
12. Specialty Board Certification(s):	Date of certification(s):
If not board certified, are you board eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	

13. All states where you are licensed:

State	License Number	Active/Inactive

14. All hospitals and surgi-centers at which you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each:

Name	City	State	Type of privileges	% of admissions

15. All medical societies, medical associations, or other related professional societies, to which you belong:

16. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation Date

If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates? Yes No

If yes, date certified: _____ If no, please explain:

17. All internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Mo./Yr. Completed
Served internship at:		
Served residency at:		
Served fellowship at:		

18. All practice locations within the ten years prior to this application, the current or most recent first:

19. Please indicate below your best estimate of the number of the following procedures you expect to perform, or in which you will participate, in the next year, beginning with the date of your requested coverage:

Abortions - first trimester:

- _____ Hospital
- _____ Clinic
- _____ Office

Abortions - after first trimester:

- _____ Hospital
- _____ Clinic
- _____ Office

_____ Acupuncture

_____ Adenoidectomies

_____ "Alternative Medicine" or "complementary medicine" procedures (as viewed by most physicians)

_____ Please describe: _____

Anesthesia - obstetrical:

- _____ General
- _____ Spinal
- _____ Epidural

Anesthesia - non-obstetrical:

- _____ General
- _____ Spinal
- _____ Epidural

_____ Anesthesia (other) - Please describe: _____

_____ Angiographies

_____ Angioplasty

_____ Arteriographies

_____ Assisting in major surgery - own patients

_____ Assisting in major surgery - other than own patients

_____ Breast implants

_____ Breast reductions

Catheterizations:

_____ Cardiac

_____ Arterial

_____ Other - Please describe: _____

_____ Chelation therapy

_____ Chemabrasion

_____ Chemical Peels

_____ Chemotherapy

_____ Colonoscopies

_____ Cosmetic implantation or injection of silicone or other materials - Please describe:

_____ Cryosurgery - Please describe: _____

_____ D & C's

Deliveries:

_____ Vaginal

_____ Cesarean

_____ Vaginal after Cesarean

_____ Discograms

_____ Electromyography

_____ Endoscopy (other than proctoscopy or sigmoidoscopy) - Please describe: _____

_____ Eyeliner pigmentation

_____ Fracture reductions - closed

_____ Fracture reductions - open

_____ Hair transplants, or other hair growing or replacement techniques

Hemorrhoidectomies:
 Internal
 External
 Herniorrhaphies
 Laparoscopy:
 Diagnostic - Please describe: _____
 Surgical - Please describe: _____
 Laser Surgery - Please indicate type of surgery: _____
 Liposuction
 Lumbar punctures
 Manipulation therapy
 Manipulation Under Anesthesia
 Myelography
 Needle aspirations
 Needle biopsies
 Neonatology
 Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts - Please indicate type of surgery: _____
 Pacemaker insertion
 Pain management - Please indicate type: _____
 Pre-natal care
 Radial keratotomy
 Radiation - diagnostic
 Radiation - therapeutic
 Sclerotherapy (choose one) <1mm >1mm
 Shock therapy
 Spinal Surgery
 Tattoo removal
 Thoracentesis
 Tonsillectomies
 Total joint replacements
 Tubal ligations
 Vasectomies
 Venography
 Weight control by means other than diet or exercise - Please describe: _____
 Any other procedure you reasonably believe will be of interest to a medical professional liability insurer - Please describe: _____
 I DO NONE OF THESE PROCEDURES

20. Please indicate the **percentage of your surgical practice, if any, that involves the following types of major surgery:**

<input type="checkbox"/> Abdominal	<input type="checkbox"/> Ophthalmological
<input type="checkbox"/> Bariatric	<input type="checkbox"/> Orthopedic - including spinal surgery
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Orthopedic - without spinal surgery
<input type="checkbox"/> Colon/rectal	<input type="checkbox"/> Plastic - cosmetic
<input type="checkbox"/> General	<input type="checkbox"/> Plastic - reconstructive
<input type="checkbox"/> Gynecologic	<input type="checkbox"/> Thoracic
<input type="checkbox"/> Hand	<input type="checkbox"/> Traumatic
<input type="checkbox"/> Head and Neck	<input type="checkbox"/> Urologic
<input type="checkbox"/> Neurosurgical	<input type="checkbox"/> Vascular
<input type="checkbox"/> Obstetrical	

21. Please describe, and provide dates for, any major changes in your practice in the last seven years, such as changes of speciality, or significant procedures initiated or no longer performed:

In responding to questions 22 through 38, please explain any "yes" response, or provide any required explanation or details on supplementary pages and attach to this application.

22. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. A. Has any state ever refused you're a license to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Has any state ever restricted, suspended or revoked your license to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Have you ever voluntarily surrendered a license to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Has any state agency ever placed you on probation or restricted your practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Have you ever been investigated by any governmental agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. Has any hospital ever denied, restricted, reduced, or suspended your privileges or invoked probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30. Have you ever been refused board certification?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31. Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had renewal refused?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To your knowledge is any such action under consideration by any current medical professional liability insurer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33. Are you an employee of, or do you do contract work for, any government agency? If so, provide name _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34. Are you a sports team physician for any college, university or professional team?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
35. Do you participate in any pharmaceutical testing programs? If yes, is it (are they) FDA approved?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
36. Please indicate the number of people you employ by the following categories:		
_____ Lab or X-ray technicians	_____ Nurse practitioners	
_____ Medical Assistants	_____ Physicians or surgeons	
_____ Nurses	_____ Physician assistants	
_____ Nurse anesthetists	_____ Surgical assistants	
_____ Nurse midwives	_____ Other (please specify):	

37. Do you treat or review treatment for jail or prison inmates? (If coverage is to be provided by another carrier, please provide evidence of that other coverage.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
38. Do you admit patients for other physicians?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
39. Do you engage in any "moonlighting" activity, apart from your practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
40. Do you work in an emergency room? If yes, how many hours on average per week? _____ For what institution? _____ If coverage is to be provided by another carrier, please provide evidence of other coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
41. Do you use a collection agency? If yes, does the collection agency have authority to file collection suit at its discretion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
42. Do you work with a blood bank?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
43. If you are NOT a radiologist: Do you take and/or interpret your own X-rays or other imaging procedures? _____ If yes, estimated number per year _____ Does a radiologist over-read your X-rays? If a non-radiologist is over-reading your X-rays, who? _____ What specialty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
44. Do you perform surgery in your office? If yes, please list the specific procedures: _____ Is general anesthesia administered for these office procedures? If yes, by whom? _____ With what training? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
45. Do you perform invasive pain management procedures? If yes, please list the procedures you perform and indicate if each is done in a hospital or office:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
46. Average number of patients per week:	# of patients	_____
47. Average weekly number of hours practiced per week:	hours per week	_____
48. If you are practicing part time, please provide the date on which you began practicing in that capacity:		
49. Do you provide services at a nursing home?: If yes, how many patients per month? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
50. Do you utilize a Hospitalist for admission:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
51. Do you practice as a Hospitalist:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
52. Do you practice as an: Please check all that apply.		
a). Individual (solo practice)? Please provide the name and Federal ID of the solo professional corporation or service corporation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b). Employee? Name of Employer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c). Independent contractor? Name of hiring party to contract:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d). Partner/shareholder? Name of corporation/partnership: Federal ID of the solo professional corporation or service corporation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
53. If you practice as a partner in a partnership or shareholder in a multi-shareholder professional corporation, is corporation coverage desired?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If coverage is desired, a corporate/organization application may be required. **Note: This coverage is not available unless all partners, shareholders and employed physicians/surgeons are insured by the company.**

54. Beginning with your most recent, or current, insurer please list all professional liability insurers for the past ten years. Please explain any gaps in the continuity of your professional liability coverage.

Name of Insurer	Coverage Type (Occurrence or Claims-made)	Policy Number	Policy Period

55. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer?

Yes No

(Please provide a copy of the Declarations page of your current coverage and any reporting period extension "tail").

56. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged?

Yes No

If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage?

Yes No

57. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim?

Yes No

If yes, has this incident (these incidents) been reported to a prior insurer?

Yes No

58. Have you had a request for medical records of a patient?

Yes No

If yes, have you reported the request to your current carrier?

Yes No

Regarding questions 56 - 58, please provide complete details for each incident on a separate page and attach to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition or current status must be included.

FRAUD WARNING

FLORIDA - Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

TEXAS - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICANT'S REPRESENTATIONS AND AUTHORIZATION

I understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of the carrier intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned.

I understand that should an incident, injury, or death occur, subsequent to signing and dating this application, I will notify Physicians Insurance Company or their authorized broker, in writing of such event.

The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I authorize the release of any underwriting and/or claim information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents.

I authorize Physicians Insurance Company to release certificates of insurance and claim information to any third party payor, HMO, PPO, hospital or Managed Care Organization.



Signature of Applicant

Date



SUPPLEMENTAL CLAIM INFORMATION FORM

Please provide the information below for each additional claim or suit to report.

If you do not have any claims/incidents open or paid, please check the box at left and sign the bottom

1. Physician's name (please print): _____

2. Patient's name: _____ Age: _____ Sex: _____

3. Date of first consultation: _____

4. Physical condition and diagnosis at the above date: _____

5. Nature of treatment given and dates of same: _____

6. Date of incident or occurrence from which claim resulted: _____

7. Date of claim: _____

8. Allegations made against you: _____

9. Was this claim reported to your insurance carrier? Yes No

If yes, list name of carrier and policy number:

10. Present status or disposition of claim including **amount of settlement or judgment**:

11. Subsequent condition or health of patient:

12. Names of other doctors, and hospitals, if any, involved in the claim or suit:

13. To whom may we refer for further information about the claim?

Signature of Applicant

Date



RETROACTIVE COVERAGE FORM

(This form must be completed, signed and dated; attach a separate sheet where necessary)

1. Name of Applicant: _____
First
Middle
Last

2. I am applying for: Retroactive coverage on my professional liability policy - Effective: _____
(Retroactive Date)

3. Limits of liability requested: _____

4. Did you practice as part of a partnership or corporation during the prior acts period? Yes No
 If yes, name(s) of corporation/partnership _____

5. Have you reported any incidents (potential claims) to a prior carrier during the prior acts period? Yes No
 If yes, date of incident: _____ Name of carrier: _____
 If yes, please describe: _____

6. Was the nature of your practice different during any of the prior acts period than it is now? Yes No
 If yes, please describe: _____

7. Did you practice in another state during the prior acts period? Yes No
 Please list states: _____

8. Did you function as a Medical Director for any facility? Yes No
 If yes, name of the facility _____ and the length of time you have been there.
 Medical Director from _____ to _____
 Do you admit patients to the above facility? _____

9. Have you been involved in any instances where the outcome has resulted in death, permanent damage/disability, or unfavorable outcome? Yes No
 If yes, have you reported these instances to your current or prior carrier? Yes No

I understand that, if granted prior acts coverage by the carrier, such coverage will apply only to liability arising out of occurrence which happened prior to the effective date and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

- 1. any claim which has been reported to another insurance carrier prior to the effective date.**
- 2. any claim known to the insured at the effective date which has not been reported to a prior carrier.**
- 3. any claim which may arise out of an incident which has been reported to another insurance carrier prior to the effective date.**
- 4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.**

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge, and that I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I further authorize the release of any underwriting or claim information from all prior and current insurers, professional societies or association, or hospitals to the carrier.

FRAUD WARNING

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.



Signature of Applicant

Date

No coverage will be bound until after the Company has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment in advance of review of the application is not an expression of the Company's intent to provide coverage. If coverage is refused by the Company, any advance payment will be returned.



This form must be completed
ONLY if you are requesting
1st year/no prior acts coverage

WAIVER OF PRIOR ACTS COVERAGE Physicians Insurance Company

I acknowledge the need to purchase tail coverage (reporting endorsement) from my previous carrier where I was insured under a claims-made policy. I realize that my failure to purchase such coverage from my previous carrier will result in an uninsured exposure for any claims which should arise in the future as a result of professional services rendered while insured by my previous carrier's policy. I understand that the policy which I am purchasing from Physicians Insurance Company will not provide prior acts coverage.

Signature

Printed Name

Date