

I. General Information (continued)

3. Office Hospital Other If other please explain: _____

% of practice _____

Practice/Hospital Name _____

Number & Street _____

Suite _____ City _____ State _____ Zip Code _____

County _____ Start Date: MM / YYYY

E. Do you admit patients to any of the above hospital locations?

Yes No

If no, please explain your protocol to admit patients to a hospital if the circumstance would arise. _____

F. Billing and Correspondence Address:

Location # (from Question D above): _____ Residence Other (Please enter below)

Number & Street _____ Suite _____

City _____ State _____ Zip Code _____

II. Educational Background

A. Medical School:

Name of School _____ Degree _____

City _____ State _____ Completed from: MM / YYYY To: MM / YYYY

Country _____

If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program?

Yes No

If no, please explain: _____

B. Residency: List all Residency training programs.

Please enter each specific specialty.

1. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? Yes No Still in training From: MM / YYYY To: MM / YYYY

2. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? Yes No Still in training From: MM / YYYY To: MM / YYYY

III. Practice Information (continued)

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.

****Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.****

F. What is your present specialty? _____

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% of total practice

What is your sub-specialty? _____

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% of total practice

G. Are you permanently retired from the practice of clinical medicine? Yes No

H. American Board Certified? Yes No

_____ Specialty Board

____/____ Date most recently certified

_____ Specialty Board

____/____ Date most recently certified

If not American Board Certified, are you board eligible? Yes No If yes, when do you plan on taking your boards?

____/____
MM YYYY

If not American Board Certified, have you ever taken a specialty board examination and failed to pass? Yes No

If yes, how many times? _____

If yes, please explain: _____

I. Indicate the estimated average weekly numbers, under each of the following categories, for which you want this insurance policy coverage.

Hours per week _____ Patients seen per week _____ None

Unscheduled walk-in patients per week _____ None

J. Please check any of the following procedures you will perform:

- Abdominoplasty - Tummy Tuck
- Abortions- Elective _____% of total practice
- Abortions- Therapeutic _____% of total practice
- Acupuncture - Therapeutic/Local Anesthetic
- Anesthesia General/Spinal/Caudal
- Angiography
- Angioplasty
- Arteriography
- Arthroscopy
- Assisting in major surgery - own patients only
- Assisting in major surgery - own & other than own patients
- Bariatric Surgery - Laparoscopic
- Bariatric Surgery - Non-Laparoscopic
- Biopsy - Endoscopic
- Blepharopigmentation - _____ % of total practice
- Blepharoplasty - Cosmetic _____ % of total practice
- Blepharoplasty - Reconstruction _____ % of total practice
- Botox _____ % of total practice
- Brachioplasty
- Breast Implants - Cosmetic _____ % of total practice
- Breast Implants - Reconstruction _____ % of total practice
- Breast Reduction - Cosmetic
- Bronchoscopy
- Bronco-esophagology
- Buttock Implants
- Calf Implants
- Cataract Surgery
- Catheterization - Left Heart
- Catheterization - Right Heart (other than CVP lines)/ Swan Ganz
- Cheek/Chin/Lip Implants
- Chelation Therapy
- Chemical Peels - Superficial / Medium
- Chemical Peels - Deep _____% of total practice
- Cleft Lip Surgery - Reconstructive
- Cleft Palate Surgery - Reconstructive
- Colonoscopy
- Cryosurgery (Cervical)
- Cryosurgery (non-external lesions)

- D & C
- Discectomy
 - Open
 - Other Than Open
- Electromagnetic Therapy
- Electroconvulsive/Shock Therapy
- Embolization
- ERCP
- Face Lifts
- Face Lifts Mini (done with laser)___% of total practice
- Gastrointestinal Endoscopy
- Gynecology - Major Surgery
- Hair Transplants - Follicular Unit Transplantations
- Hair Transplants - Other
- HVLA on the cervical spine on patients younger than 18 years of age
- Intrathecal Pumps
- Kyphoplasty
- Laparoscopic Cholecystectomy
- Laparoscopy
- Laser Surgery
- Laser Therapy (Endoscopic)
- Laser Therapy (Non-Endoscopic)
- Lipoinjection _____% of total practice
- Liposuction
 - Other Than Tumescent Technique
 - Tumescent Technique Only___% of total practice
- Lithotripsy
- Lymphangiography
- Mammograms
- Myelography
- Nerve Blocks
 - Facet
 - Lumbar Epidural Steroid
 - Myofascial
 - Occipital
 - Paraspinal/Paravertebral
 - Peripheral
 - Sciatic
 - Triggerpoint Injection
- Oxidation Therapy

- Pacemakers - Epicardial
- Pacemakers - Endocardial
- Pacemakers - Temporary
- Peritoneoscopy
- Phlebography
- Pneumoencephalography
- Polypectomy
- Prenatal /Gynecological Practice
 - Prenatal Practice - 1st & 2nd Trimester
 - Prenatal Practice - to term, no delivery
 - Prenatal Practice - to term, and delivery
 - Normal Deliveries - total per year _____
 - Cesarean Deliveries - total per year_____
- Prolotherapy
- Radial/Laser Keratotomy
- Radiation/X-Ray Therapy
- Rectal Ozone Therapy
- Rhinoplasty _____% of total practice
- Sigmoidoscopy - 60 cm or less
- Sigmoidoscopy - greater than 60 cm
- Silicone Injections___ % of total practice
- Skin Flaps/Grafts
 - Cosmetic _____% of total practice
 - Reconstruction ___% of total practice
- Spinal Cord Stimulators
- Thigh Lift
- Tubal Ligations
- Upper GI Endoscopy
- Vasectomies - own patients
- Vasectomies - own & other than your own patients
- Weight Control Medication _____ % of total practice
- Other Medical Techniques

List Procedures (do not restate your specialty)

III. Practice Information (continued)

K. Please indicate the percentage of your total practice performing the following surgical activities:

<input type="text"/> % Cardiac	<input type="text"/> % Orthopedic (including back)	<input type="text"/> % Thoracic
<input type="text"/> % Gynecology	<input type="text"/> % Orthopedic (not including back)	<input type="text"/> % Traumatic
<input type="text"/> % Hand	<input type="text"/> % Otolaryngology	<input type="text"/> % Urology
<input type="text"/> % Neurosurgery	<input type="text"/> % Plastic (cosmetic enhancement only)	<input type="text"/> % Vascular
<input type="text"/> % Obstetrics	<input type="text"/> % Plastic (reconstruction only)	<input type="text"/> % Other (Describe) _____
<input type="text"/> % Ophthalmology		

L. What percentage (based on the number of patients treated) of your practice is in Pennsylvania?

%

M. In the last 10 years,

1. Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity? Yes No

If yes, list procedures/activities, reason for discontinuing, and date discontinued.

Date: /
MM YYYY

2. Have you performed weight control surgery or prescribed weight control medication? Yes No

a. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?

<1% 1% - 10% 11%-50% >50% Never prescribed weight control medication

b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?

<1% 1% - 10% 11%-50% >50% Never performed weight control surgery

N. Do you have ownership or financial interests in a weight control clinic?

If yes, what is the name of the weight control clinic with which you are affiliated? _____

Yes No

O. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.)

Yes No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.)

hrs

2. On average how many of the above hours are you working in order to fulfill staff privilege requirements?

hrs

(If you have emergency room activities which are covered by another professional liability insurance policy, please complete Section IV, Question H.)

P. Please use the space below for any comments you feel will help us better understand any special circumstances concerning your practice.

IV. Additional Professional Information

Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the question.

(For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)

A. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates.

hrs None

B. Indicate the average hours per week devoted to treating non-federal prison inmates.

hrs None

C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes.

% None

D. Indicate the percentage of your practice devoted to working in a nursing home facility.

% None

Name: _____

City: _____ County: _____

E. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?

Yes No

If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

F. Do you practice as a medical director?

Yes No

Type and name of facility: _____

If yes, what percentage of your practice is devoted to this activity?

%

Briefly describe your responsibilities: _____

G. Do you devise or review plant/employer safety standards?

Yes No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

IV. Additional Professional Information (continued)

H. Will you be performing activities which will be covered by another professional liability policy?

Yes No

If yes, are you a(n): Employee Independent Contractor Resident/Fellow Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

I. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?

Yes No

If yes, please indicate the date(s) and explain: Date: / _____
MM YYYY

J. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy?

Yes No

If yes, please indicate the date(s) and explain: Date: / _____
MM YYYY

K. Have you ever been accused of sexual misconduct of any kind?

Yes No

If yes, please indicate the date(s) and explain: Date: / _____
MM YYYY

L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty?

Yes No

(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: _____

Date(s) of treatment(s): From: / To: / Currently in treatment
MM YYYY MM YYYY

Name of treating physician(s): _____

Address(es): _____

V. Loss Information (Important! Please fully complete.)

Please complete the **Claims Information Supplement** for each written request, incident, claim or suit (A, B or C)

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters 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.

A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?

If yes, how many? None

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to, the following:

▶ Amputation ▶ Death ▶ Loss of major organ function ▶ Loss of vision ▶ Permanent neurological injury

If yes, how many? None

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?

If yes, how many? None

VII. Coverage Information

Notes:

1. **Claims-Made coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**

2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage Desired:

- Claims-Made coverage without Prior Acts coverage
- Claims-Made coverage with Prior Acts coverage

- Occurrence coverage
- Occurrence coverage with Prior Acts coverage

B. Requested Coverage Period (12:01 am):

Annual policy term will begin and end on the same month and day.

From: MM / DD / YYYY **To:** MM / DD / YYYY

C. The retroactive date shown on your current Claims-Made policy is:

(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.)

MM / DD / YYYY

D. Desired Limits:

Per Occurrence/Per Claim Filed [] , [] , [] Annual Aggregate [] , [] , []

E. Please indicate your Medical Care Availability and Reduction of Error Fund ("MCARE") Retroactive Date if different than the retroactive date stated in Question C above. (PENNSYLVANIA INSURED ONLY)

MM / DD / YYYY

F. Are you aware of any periods of non-compliance with MCARE? (PA ONLY)

Yes No

If **yes**, please explain: _____

G. Have you ever had any application for MCARE abatement declined by MCARE? (PA ONLY)

Yes No

If **yes**, please explain: _____

H. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer: _____

- Occurrence Claims-Made

From: MM / DD / YYYY **To:** MM / DD / YYYY

2. Previous Insurer: _____

- Occurrence Claims-Made

From: MM / DD / YYYY **To:** MM / DD / YYYY

3. Previous Insurer: _____

- Occurrence Claims-Made

From: MM / DD / YYYY **To:** MM / DD / YYYY

I. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your requested retroactive date.

J. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- An extended reporting endorsement (tail coverage) has been or will be purchased.
- An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying, (Occurrence or Claims Made Policy without prior acts) will not provide Prior Acts coverage.

Initial Here

CLAIM INFORMATION FORM

Physician or Corp. Name: _____

Photocopy and complete this form for each open and/or closed claim. If more space is needed on each report, continue information on your letterhead. Please type or write legibly.

1) Name of Patient: _____ 2) Age _____ 3) Sex _____

4) Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon, etc.)

5) Other Defendants: _____

6) Allegation: _____

7) Date of Incident: ____/____/____

8) Date Claim Filed: ____/____/____

9) County where claim is filed: _____

10) Insurance Carrier Defending You: _____

- 11) Present Status: ___ Open Claim
 ___ Closed Claim Dismissed
 ___ Closed Claim Defense Verdict
 ___ Closed Claim Settlement
 ___ Closed Claim Plaintiff Verdict

Date Claim Closed: ____/____/____

Amount of Settlement: _____

12) Condition and diagnosis at time of incident:

13) Dates and description of professional services rendered:

14) Condition of patient subsequent to professional services if known:

15) Your comments regarding care rendered, allegations, patient outcome or the claim made against you:

Signature _____ Date _____