

HEALTHCARE RISK SPECIALISTS

Physician Professional Liability Insurance Application

I. GENERAL INFORMATION

A. _____
LAST NAME FIRST NAME MIDDLE NAME DEGREE

DATE OF BIRTH (M/D/Y) _____ SOCIAL SECURITY NUMBER _____

B. PRACTICE NAME CONTACT PERSON

C. OFFICE LOCATIONS (List Principal Location First)

1. _____
NUMBER & STREET CITY/STATE ZIP CODE COUNTY % OF PRACTICE

2. _____
NUMBER & STREET CITY/STATE ZIP CODE COUNTY % OF PRACTICE

D. HOSPITALS WHERE YOU PRACTICE. LIST PRINCIPAL LOCATIONS FIRST.

1. _____
HOSPITAL CITY/STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

2. _____
HOSPITAL CITY/STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

3. _____
HOSPITAL CITY/STATE COUNTY TYPE OF PRIVILEGES % OF PRACTICE

E. HOME ADDRESS

SUITE NUMBER & STREET CITY/STATE ZIP CODE COUNTY

F. PREFERRED MAILING ADDRESS: OFFICE # _____ HOME OTHER (BELOW)
(FROM B ABOVE)

OTHER ADDRESS: _____
STREET ADDRESS CITY/ STATE ZIP

() ()
BUSINESS PHONE BUSINESS FAX E-MAIL ADDRESS

II. EDUCATIONAL BACKGROUND

A. MEDICAL SCHOOL

NAME OF SCHOOL CITY/STATE COUNTRY DEGREE YEAR COMPLETED

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL
GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM?

Yes No

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS.

If you are currently in a residency or fellowship program, please enter your anticipated residency/fellowship ending date here: _____

Your policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.

1. _____
NAME OF HOSPITAL STATE/COUNTRY FROM (MO/YR) TO (MO/YR) TYPE COMPLETED

2. _____
NAME OF HOSPITAL STATE/COUNTRY FROM (MO/YR) TO (MO/YR) TYPE COMPLETED

ADDITIONAL TRAINING (FELLOWSHIP, ETC.)

3. _____
NAME OF HOSPITAL STATE/COUNTRY FROM (MO/YR) TO (MO/YR) TYPE COMPLETED

C. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? Yes No

D. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS? Yes No

If "yes," how many category 1 credit hours? _____

E. HAVE YOU COMPLETED A RISK-MANAGEMENT EDUCATION COURSE WITHIN THE PAST TWELVE (12) MONTHS? Yes No

F. IF YOU ANSWERED YES, DID THE COURSE PROVIDE ALL OF THE FOLLOWING:

A minimum of three category 1 continuing medical education (CME) hours;
Provide the CME hours through an approved national / regional medical education sponsor; and
Strictly adhere to a risk management (loss prevention) curriculum? Yes No

Please attach your completion (attendance) certificate from the CME program.

III. PRACTICE INFORMATION

A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? Yes No

(If this is covered by another professional liability insurance policy, complete question IV. I.)

IF YES, WHICH STATE(S) _____

B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE

1. STATE _____ LICENSE# _____ 3. STATE _____ LICENSE# _____

2. STATE _____ LICENSE# _____ 4. STATE _____ LICENSE# _____

5. PENDING LICENSE? YES NO PENDING STATE _____ TEMPORARY LICENSE# _____

C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST.

CITY	STATE	SPECIALTY	FROM MONTH/YEAR TO MONTH/YEAR
CITY	STATE	SPECIALTY	FROM MONTH/YEAR TO MONTH/YEAR

D. TO WHICH STATE/LOCAL MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG?

IV. RATING INFORMATION

A. WHAT IS YOUR PRESENT SPECIALTY? _____ **SUB-SPECIALTY?** _____

What **percentage of your practice** is devoted to your specialty? _____ Sub-specialty? _____

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

B. AMERICAN BOARD CERTIFIED? Yes No _____ **SPECIALTY BOARD** _____ **DATE CERTIFIED**

IF NO, ARE YOU BOARD ELIGIBLE? Yes No

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS? _____

C. INDICATE THE AVERAGE WEEKLY NUMBERS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE COVERAGE. (If you practice in multiple states, please identify the following information for each state.)

PATIENTS SEEN PER WEEK _____ HOURS PER WEEK _____ WALK-IN PATIENTS PER WEEK _____

D. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- | | | |
|--|---|---|
| <input type="checkbox"/> ABORTIONS | <input type="checkbox"/> GENERAL/SPINAL/CAUDAL ANESTHESIA | <input type="checkbox"/> COLONOSCOPY |
| <input type="checkbox"/> ACUPUNCTURE | <input type="checkbox"/> PULSE OXIMETRY | <input type="checkbox"/> POLYPECTOMY |
| <input type="checkbox"/> THERAPEUTIC/LOCAL ANESTHETIC | <input type="checkbox"/> END TIDAL CO ² ANALYZER | <input type="checkbox"/> GASTROINTESTINAL |
| <input type="checkbox"/> GENERAL ANESTHETIC | <input type="checkbox"/> HAIR TRANSPLANTS | <input type="checkbox"/> BIOPSY (ENDOSCOPIC) |
| <input type="checkbox"/> ANGIOGRAPHY | <input type="checkbox"/> SCALP EXCISION/TRANSPLANTATIONS | <input type="checkbox"/> PERITONEOSCOPY |
| <input type="checkbox"/> ANGIOPLASTY | <input type="checkbox"/> PLUG TECHNIQUE/MINIGRAPH | <input type="checkbox"/> LASER THERAPY (ENDOSCOPIC) |
| <input type="checkbox"/> ARTHROSCOPY | <input type="checkbox"/> LAPAROSCOPIC CHOLECYSTECTOMY | <input type="checkbox"/> PACEMAKERS UNDER GEN ANEST |
| <input type="checkbox"/> ARTERIOGRAPHY | <input type="checkbox"/> LAPAROSCOPY | <input type="checkbox"/> SILICONE INJECTIONS |
| <input type="checkbox"/> ASSISTING IN MAJOR SURGERY | <input type="checkbox"/> LASER SURGERY | <input type="checkbox"/> SKIN FLAPS/GRAFTS |
| <input type="checkbox"/> OWN PATIENTS ONLY | <input type="checkbox"/> LIPOSUCTION | COSMETIC _____% OF PRACTICE |
| <input type="checkbox"/> OWN & OTHER THAN OWN PATIENTS | <input type="checkbox"/> LYMPHANGIOGRAPHY | RECONSTRUCTION _____% OF PRAC |
| <input type="checkbox"/> BLEPHAROPIGMENTATION | <input type="checkbox"/> SWAN-GANZ CATHETERIZATION | <input type="checkbox"/> RIGHT HEART CATHETERIZATION (nonCVP) |
| <input type="checkbox"/> BLEPHAROPLASTY - BROW LIFTS | <input type="checkbox"/> LITHOTRIPSY | <input type="checkbox"/> LEFT HEART CATHETERIZATION |
| COSMETIC _____% OF PRACTICE | <input type="checkbox"/> MAJOR GYNECOLOGICAL SURGERY | <input type="checkbox"/> TUBAL LIGATIONS |
| RECONSTRUCTION _____% OF PRACTICE | <input type="checkbox"/> MYELOGRAPHY | <input type="checkbox"/> VASECTOMIES |
| <input type="checkbox"/> BREAST IMPLANTS COSMETIC _____% OF PRACTICE | <input type="checkbox"/> PHLEBOGRAPHY | <input type="checkbox"/> ON OWN PATIENTS |
| RECONSTRUCTION _____% OF PRACTICE | <input type="checkbox"/> PNUOMOENCEPHALOGRAPHY | <input type="checkbox"/> ON OTHER THAN OWN PATIENTS |
| <input type="checkbox"/> BRONCHO-ESOPHAGOLOGY | <input type="checkbox"/> NEEDLE BIOPSY | <input type="checkbox"/> WEIGHT CONTROL |
| <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> NERVEBLOCKS - TYPE _____ | SURGERY/THERAPY _____% OF PRACT. |
| <input type="checkbox"/> CRYOSURGERY (OTHER THAN EXTERNAL LESIONS) | <input type="checkbox"/> RADIAL/LASER KERATOTOMY | <input type="checkbox"/> GASTRIC BUBBLE |
| <input type="checkbox"/> ERCP | <input type="checkbox"/> RADIATION/X-RAY THERAPY | <input type="checkbox"/> GASTRIC STAPLING |
| <input type="checkbox"/> D & C | <input type="checkbox"/> RADIOPAQUE DYE | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> DISCOGRAMS | <input type="checkbox"/> NON-IONIC ONLY | <input type="checkbox"/> OTHER MEDICAL TECHNIQUES |
| <input type="checkbox"/> PHENOL FACIAL PEELS | <input type="checkbox"/> SHOCK THERAPY | LIST PROCEDURES _____ |
| <input type="checkbox"/> DIAGNOSTIC EMBOLIZATION | <input type="checkbox"/> SIGMOIDOSCOPY | |
| | <input type="checkbox"/> LESS THAN 60 CM | |
| | <input type="checkbox"/> GREATER THAN 60 CM | |

E. INDICATE THE PERCENTAGE OF YOUR SURGICAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

____% PLASTIC (RECONSTRUCTION ONLY)	____% ORTHOPEDIC (NOT INCLUDING BACK)	____% PRENATAL PRACTICE
____% PLASTIC (COSMETIC ENHANCEMENT ONLY)	____% ORTHOPEDIC (INCLUDING BACK)	<input type="checkbox"/> SEE PATIENTS DURING THE FIRST AND SECOND TRIMESTER
____% HAND	____% ENDOCRINOLOGY	<input type="checkbox"/> SEE PATIENTS TO TERM BUT DO NOT PERFORM DELIVERY
____% TRAUMATIC	____% NEOPLASTIC	<input type="checkbox"/> SEE PATIENTS TO TERM AND PERFORM DELIVERY
____% THORACIC/CARDIAC/VASCULAR M	____% NEPHROLOGY	____% NORMAL OBSTETRICAL DELIVERIES, # PER YEAR _____
____% OTHER (DESCRIBE)		____% CESAREAN SECTIONS, # PER YEAR _____

F. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures? Yes No
If **Yes**, list procedures **and date** discontinued _____
2. Have you ever been a representative of a Pedicle Screw Manufacturer? Yes No
If **Yes**, please attach an explanation.
3. Have you prescribed fenfluramine or dexfenfluramine for weight control? Yes No
4. If **yes**, what percentage of your practice (% of patient care) **was** devoted to prescribing anorectic drugs?
 <1% 1%-10% 11%-50% >50%
5. Do you currently prescribe anorectic drugs? Yes No
6. If **yes**, what percentage of your practice (% of patient care) **is** devoted to prescribing anorectic drugs?
 <1% 1%-10% 11%-50% >50%
7. Are you or have you been affiliated with during the last five years a weight control clinic that prescribed anorectic drugs as part of its treatment program? Yes No
8. If **yes**, what percentage of your practice (% of patient care) is rendered on or on behalf of a weight control clinic?
 <1% 1%-10% 11%-50% >50%
9. Do you have ownership interests in a weight control clinic? Yes No
10. If **yes**, what is the name of the weight control clinic with which you are affiliated: _____

G. IF YOU USE SILICONE GEL/SALINE BREAST IMPLANTS, DO YOU USE THE MANUFACTURER'S INFORMED CONSENT FORMS IN ADDITION TO YOUR NORMAL INFORMED CONSENT PROCEDURE?

Yes No

H. DO YOU SERVE IN A HOSPITAL EMERGENCY ROOM FOR WHICH YOU REQUIRE COVERAGE?

Yes No

If **Yes**, number of hours per month: _____
If you have emergency room activities which are covered by another professional liability insurance policy, complete question I.

I. WILL YOU BE PERFORMING ACTIVITIES THAT WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY?

Yes No

If **Yes**, complete the following:
Practice name and location: _____

Employee Independent Contractor Resident/Fellow Faculty Name of Carrier _____

J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP US BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE.

V. ADDITIONAL PROFESSIONAL INFORMATION

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

- 1. Do you perform surgery on professional athletes? Yes No
 If yes, what percentage of your practice is devoted to performing surgery on professional athletes? _____%
- 2. 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.
 (If you are covered by other insurance for this activity, please complete Section IV, I.)
- 3. Do you treat or review treatment of federal prison inmates? Yes No
- 4. Do you treat non-federal prison inmates? Yes No
 If yes, what percentage of your practice is devoted to treating non-federal inmates? _____%
- 5. Do you use a collection agency that has the authority to file collection suits without your knowledge? Yes No
- 6. Do you practice as a Medical Director at a blood bank? Yes No
- 7. Do you devise or review plant/employer safety standards? Yes No
 (1) What products are manufactured by the company? _____
 (2) Company name _____, Location _____
- 8. 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 Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Yes No
- 9. Have you had any professional liability insurance refused, canceled or non-renewed? Yes No
- 10. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (e.g. alcoholism, convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, abuse, addiction to alcohol, narcotics or other controlled substances, etc.) Yes No

If **Yes**, state condition, date(s) and identify your treating physician 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.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type	Duration	Treating Physician (Name & Address)

B. PRACTICE ORGANIZATION:

Please check the boxes that best describe your practice affiliation(s): ("X" applicable boxes under 1 and 2).

1. Employment status:

- Employee
- Shareholder/Partner
- Independent Contractor
- Solo Unincorporated/Sole Proprietor
- Other: _____

2. Entity Type:

- Multi-Shareholder Corporation, Partnership, Limited Liability Company
- Solo Incorporated – No employed or contracted physicians
- Hospital
- Government
- Industrial
- Other - please explain: _____

C. NAME OF YOUR PARTNERSHIP, PROFESSIONAL CORPORATION OR ASSOCIATION:

D. IF THE BUSINESS PURPOSE OF THE ENTITY IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN:

E. DO YOU DESIRE COVERAGE FOR THIS ENTITY?

Yes No

F. DO YOU WISH TO SHARE YOUR INDIVIDUAL POLICY LIMITS WITH YOUR SOLO CORPORATION?

Yes No

Note: To qualify for shared limit solo corporation coverage, you must have no physician employees or independent contractors.

Tax I.D.#: _____

Initial Here if Yes

If "Yes," and not a Solo Corporation as described above and you desire a separate entity policy, please complete a separate entity application.

VI. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

- A.** Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? Yes No
 If "Yes," how many? _____
 If "Yes," have these been reported to your insurer? Yes No
- B.** Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? Yes No
 If "Yes," how many? _____
 If "Yes," have these been reported to your insurer? Yes No

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

VII. CLAIM/SUIT INFORMATION FORM (Please make copies if additional forms are needed.)

If making additional copies, please enter applicant's name here _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT

1. Patient/Claimant Information – Name: _____ Age: _____ Sex: Male Female
2. Date of treatment and/or surgery, which led to the allegations against you: _____
3. Date claim/incident notice received (MM/YY) _____
4. Date claim reported to prior insurer (MM/YY) _____
5. Name of other doctor(s), hospital(s) or health-care provider(s), if any, involved in the claim or audit _____
6. Disposition or current status of claim or suit: Open Closed
Date of Closing/Settlement or award (MM/YY): _____
7. Indicate case value established by carrier, if known (in \$): _____
8. Defending Insurance carrier name: _____
9. Claim file number, if known: _____
10. Was this matter closed with your consent? Yes No
 Was a suit filed? Yes No
 Was payment made? Yes No
 If no, was claim or suit withdrawn? Yes No
 If Yes, indicate total amount of settlement or award (in \$): _____
 Amount paid on your behalf (in \$): _____
11. Nature of allegations in the claim or suit:
 Condition treated: _____
 Treatment provided: _____
 Alleged Negligence: _____
 Alleged injury: _____
12. Please provide a narrative description of the medical facts: (must include, but not limited to, the type of treatment and/or surgery; your involvement) _____

VIII. COVERAGE INFORMATION

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS OVER THE LAST TEN (10) YEARS. LIST CURRENT INSURER FIRST

1. _____ OCCURRENCE
INSURER CLAIMS-MADE _____ From _____ To _____

2. _____ OCCURRENCE
INSURER CLAIMS-MADE _____ From _____ To _____

**B. COVERAGE DESIRED
CLAIMS MADE:**

- Claims-Made Coverage with Prior Acts Coverage.**
(A copy of current declaration page showing current retroactive date must be attached).
 - Claims-Made Coverage without Prior Acts Coverage.**
- ___ An extended reporting endorsement (tail coverage) has been purchased (**copy of tail is attached**).
- ___ An extended reporting endorsement **has not** and **will not** be purchased.

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

Initial here:

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 an "extension contract" or "tail coverage."

C. REQUESTED COVERAGE EFFECTIVE DATE 12:01 A.M. From: ___/___/___ 12:01 a.m.
This date cannot be earlier than the expiration date of your current policy. Month Day Year

Annual policy terms will begin and end on the same month and day. To: ___/___/___ 12:01 a.m.
Month Day Year

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY: ___/___/___ 12:01 a.m.
This date cannot be greater than the retroactive date shown on your current policy. Month Day Year

E. IF YOU PRACTICE IN A FUND STATE, PLEASE INDICATE YOUR CURRENT FUND RETROACTIVE DATE IF DIFFERENT THAN THE RETROACTIVE DATE STATED ABOVE: ___/___/___ 12:01 a.m.
Month Day Year

Are you aware of any gaps in your coverage? Yes No
If yes, please provide the exact dates and a written explanation:

F. LIMITS DESIRED _____ / _____ per occurrence/annual aggregate

IX. STATE STATUTORY REQUIREMENT

NOTE: All applicants must read and initial the following:

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

XI. PLEASE READ AND SIGN.

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company.

I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm, or professional association.

I UNDERSTAND AND AGREE THAT THE COMPLETION OF THIS APPLICATION TOGETHER WITH ANY PREMIUM OR FINANCING DOES NOT BIND THE COMPANY TO ISSUE, NOR ME TO PURCHASE, A CONTRACT OF INSURANCE, PROVIDED HOWEVER, IF I AM ISSUED INSURANCE BY THE COMPANY AND I PURCHASE SUCH CONTRACT OF INSURANCE, I UNDERSTAND AND AGREE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION BY ME IN THIS APPLICATION MAY ACT TO VOID SUCH CONTRACT OF INSURANCE AND MAY GIVE THE COMPANY A RIGHT TO RESCIND SUCH CONTRACT.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, and other entities listed in this application to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

REMINDER: If you answered "yes," to questions in the Loss Information Section, you must complete a Claim Information Form for **EACH** claim or suit.

Please **MAIL** or **FAX** completed application to: HealthCare Risk Specialists
1038 Farmington Avenue
West Hartford, CT 06085
(860) 521-8555

Signature

Date

Name

Title