

MEDICAL PROFESSIONAL LIABILITY INSURANCE

APPLICATION INSTRUCTIONS

- A. Please complete all questions.*
- Accuracy and legibility are important.
 - If a question does not pertain to your practice, answer "N/A".
 - If you need to provide extra information, please do so on a separate sheet of your letterhead.
- B. Sign and date the application on page 5 and also on page 6.
- C. Be sure all required information, such as claims supplement or a copy of the Declarations Page and any Endorsements from your current policy, is attached.
- D. To expedite the Underwriting process and provide you with a faster decision on coverage, please attach a copy of your:
- Curriculum Vitae
 - Current State License(s)
 - Letterhead
- E. If you fax the information, you must also mail the original and all attachments.

SEND COMPLETED APPLICATIONS TO:

Submitting Broker: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____

Surplus Lines License #: _____ State: _____

** If you are changing your practice in any way, please fill out the application for the new practice - rather than the practice in which you are presently involved. This includes any change in location, procedures or type of practice. An explanation of the change is required in section III, Question D.*

III

SECTION III: TRAINING, LICENSE INFORMATION & PRACTICE HISTORY (CONT)

C. List all states in which you are licensed to practice. List additional licenses separately.

| | State | License # | % of patient visits in each state |
|----|-------|-----------|-----------------------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

D. Has there been any change in your practice in the past five years? Yes No
 If YES, please describe: _____

E. List all locations where you have practiced in the last 10 years. Attach additional page if necessary.

| | Street | City | County/State | From-To |
|----|--------|------|--------------|---------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

IV

SECTION IV: PRIOR CARRIER INFORMATION

List all malpractice carriers for the last 10 years:

| | Name of Insurer | Dates Covered (From-To) | Limit of Liability | Number of Pending Claims | Number of Closed Claims | Total |
|----|-----------------|-------------------------|--------------------|--------------------------|-------------------------|-------|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

V

SECTION V: CURRENT PRACTICE INFORMATION

A. General Information

1. Type of Practice

a. **Individual Practice**

Sole Proprietor

Employee

Name of Employer: _____

Independent Contractor

Contracted To:

Individual Professional Corporation, if any:

b. **Group Practice** (attach page with names of all partners, shareholders and employees)

Partnership

Legal Name of Partnership: _____

Multi-Shareholder Corporation

Name of Professional Corporation: _____

c. **Professional Association/Office Sharing** Fictitious Name (DBA), if any: _____



SECTION V: CURRENT PRACTICE INFORMATION (CONT)

2. Employees

- a. Do you employ any physicians or surgeons? Yes No
 If YES, please provide name, specialty and information on each employee's current malpractice coverage.
- b. Do you employ, contract with or supervise any non-physician Health Care Providers? Yes No
 If YES, please complete the following:

| | Name(s) | | Name(s) |
|----------------------------|---------|-----------------------|---------|
| Acupuncturist | | Nurse Anesthetist | |
| Cardiac Perfusionist | | A. Hospital Based | |
| Cert. Physicians Assistant | | B. Non-Hospital Based | |
| Chiropractor | | Optometrist | |
| Nurse Midwife | | Psychologist | |
| Nurse Practitioner | | RN First Assistant | |
| Other (please describe) | | | |

Note: There is no coverage for any employed physician/surgeon or non-physician health care provider unless a separate application is made, approved and the appropriate premium is paid.

3. Please list the names and addresses of all hospitals where you have or are applying for staff privileges:

4. Average number of individual patients that you see per week: _____ 5. Average number of patient visits per week: _____

6. Average number of hours that you work each week: _____

7. If you practice less than 20 hours per week, what is the reason for your part-time practice? _____

8. Number of continuing medical education credits in the past 12 months? _____

9. Number of credits in excess of state license requirement? _____

B. Scope of Practice – Check All That Apply

- Angiography Arteriography Cardiac catheterization Percutaneous coronary angioplasty
- Anti-aging therapy Prenatal care beyond the first trimester
- Bronchoscopy Second trimester abortions
- Care of bariatric surgery patients or bariatric surgery Sex change surgery/phalloplasty/penile implants
- Chelation therapy (other than heavy metal poisoning)
- First trimester abortions – number per year _____
- Jail/correctional facility patients in my practice
- No Surgery Minor Surgery Major Surgery

If minor surgery, list procedures _____

General cosmetic surgery

Limited cosmetic surgery – list procedures _____

Weight treatment, reduction or control: percentage of practice _____

Liposuction – body areas _____

I have my own surgical suite: Yes No If yes, do other practitioners use the facility for their own patients? Yes No

V

SECTION V: CURRENT PRACTICE INFORMATION (CONT)

C. Specialty Practice Profile

If your specialty is listed below, please complete the appropriate section.

General Surgery

- 1. Peripheral Vascular Surgery Yes No
- 2. Neck Node Dissections Yes No

Obstetrics

- 1. Do you use standardized documentation forms that meet or exceed ACOG Guidelines? Yes No
- 2. Do you provide home deliveries or supervise lay midwives? Yes No
- 3. Do you perform deliveries in any hospitals that do not have policies and procedures regarding umbilical cord blood acid-base assessment and placental evaluation that meet ACOG guidelines? Yes No
- 4. What is the total number of VBAC deliveries per year?

Orthopedics

- Spinal Column Surgery Yes No

Psychiatry

- ECT? Yes No

Radiology

- 1. Number of Mammograms per year
- 2. Do you have any capitated contracts for mammograms? Yes No
- 3. Do you provide Telemedicine services? Yes No

If YES, please describe on attachment to application and include all states to which you provide services.

Urology

- Prosthetic implants? Yes No

VI

SECTION VI: UNDERWRITING INFORMATION

If the answer to any of the following questions is YES, please attach a detailed explanation (including dates) and provide any pertinent documentation:

- A. 1. Have you ever been denied hospital privileges? Yes No
- 2. Has any hospital as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision? .. Yes No
- 3. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? Yes No
- 4. Has any hospital after granting you any privilege: (a) suspended or revoked that privilege; (b) modified or restricted that privilege; or (c) placed your exercise of that privilege under supervision, observation, or any other type of review? Yes No
- B. Have you ever
 - 1. Been convicted of a crime other than a traffic violation? Yes No
 - 2. Been convicted of a crime or a traffic violation involving drugs or alcohol? Yes No
 - 3. Suffered from or been treated for substance abuse, disability, mental illness or serious physical illness/injury? Yes No
 - 4. Had a complaint filed against you with a medical association, foundation, state or federal government authority (i.e., Medicare, licensing board, etc.)? Yes No
 - 5. Had any professional license or permit investigated, suspended, revoked, restricted or placed under probation? Yes No
 - 6. Received a decree of censure from the licensing board (of any state) or been under a boards probation or stipulation? Yes No
 - 7. Entered into any voluntary stipulation, order or similar action with a licensing board (of any state)? Yes No
 - 8. Been denied any professional license or certification by a specialty board? Yes No
- C. Have you ever had professional liability insurance declined, canceled, issued on special terms or been non-renewed? Yes No
- D. Have any claims or suits ever been made or brought against you? Yes No
If YES, total number of incidents, claims and suits in which you have been involved: _____
Please complete one Supplemental Claim Information form for each claim or suit.
- E. Do you have knowledge of any incident or activity (including a request for patient records) that might give rise to a claim or suit in the future? Yes No
If YES, have all such matters been reported to your current or prior malpractice insurance company? Yes No

Remarks:

I understand that this is an application for insurance, not an insurance binder.

I hereby certify that I have read the above application and that all statements in this application are true, material and complete. I understand that: (1) If the policy is issued, this is done in reliance upon these representations; and (2) any policy obtained by fraud, material misrepresentation or omission is void.

I agree that a facsimile copy of my signature may be relied upon as if it were the original.

Signature of Applicant

Date of Signature

Print or Type Name

Please Note: You are required to notify your agent or SSA Special Programs, P.O. Box 10067, Phoenix, AZ 85064 immediately of any change in your practice. Failure to do so may jeopardize coverage.

If you have any questions about any part of this application, please call your agent or SSA Special Programs at (602) 977-3511. Office Hours: Monday through Friday, 8:30 a.m. – 5:00 p.m., MST.

| | |
|---|---|
| COLORADO FRAUD WARNING – | “It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, or denial of insurance. Misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies.” |
| FLORIDA 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.” |
| KENTUCKY, OHIO, OKLAHOMA AND MINNESOTA FRAUD WARNING – | “Any person 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 commits a fraudulent insurance act, which is a crime.” |
| NEW JERSEY FRAUD WARNING – | “Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.” |
| NEW YORK FRAUD WARNING – | “Any person 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 commits a fraudulent insurance act, which is a crime, and shall be also subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.” |
| PENNSYLVANIA FRAUD WARNING – | “Any person 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 commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.” |

APPLICANT'S AUTHORIZATION

I authorize the release of all relevant information to SSA Special Programs from the following:

- Any medical college or other institution where I have received training;
- Any person(s) with whom I received training, such as a preceptorship, which I am using as a basis for specialty training and requesting coverage;
- Any hospital at which I have applied for privileges, whether those privileges were granted or not;
- Past and present medical associations, societies, specialty boards and the regulatory body granting me a license to practice medicine in any state;
- Any insurance company to which I have applied for professional liability insurance coverage, whether such coverage was granted or not;
- Any employer for whom I performed medical services, whether as an employee or an independent contractor;
- Any Credit Reporting Agency, Equifax, Dunn & Bradstreet or similar organization.

I understand that information requested by SSA Special Programs may include, but not necessarily be limited to:

- Any incident, claim or suit in which I may be or may have been involved.
- Denial, suspension, revocation, or disciplinary recommendation or action connected with my providing medical services.
- Censure, probation or any disciplinary action taken by any medical licensing authority or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities.

I understand that the information will be used in addition to my application in making insurability decisions.

I agree that the persons providing the information, their agents, directors and employees shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I also authorize SSA Special Programs to release any such information, as well as any and all other information which they may have, to any committee of a professional association or society, or any subcommittee or section thereof, formed for the purpose of providing services to SSA Special Programs pursuant to an agreement entered into between them, including consultation and advice with respect to underwriting review, claims review, loss prevention, physician counseling and related services.

I consent to SSA Special Programs obtaining reviews from other physicians/surgeons if necessary or appropriate to evaluate my application.

I understand that this is an application for insurance, not an insurance binder.

I hereby certify that I have read the above application and that all statements made in this application are true, material and complete. I understand that: (1) if the policy is issued, this is done in reliance upon these representations; and (2) any policy obtained by fraud, material misrepresentation or omission is void.

**I AGREE THAT A FACSIMILE COPY OF MY SIGNATURE MAY BE RELIED UPON
AS IF IT WERE THE ORIGINAL.**

Signature of Applicant

Date of Signature

Print or Type Name

SUPPLEMENTAL CLAIM INFORMATION

1. Full Name of Applicant: _____

2. Full Name of Claimant: _____ Age _____

3. Indicate whether: Claim Suit Incident

4. Date of Incident: _____ 5. Date Claim was Reported: _____

6. Additional Defendants: _____

7. If Closed:

Total Loss Paid Including Deductible: \$ _____ Defense Costs: \$ _____

Indicate whether: Court Judgement or Out of Court Settlement

Date Closed: _____

8. If Pending:

| | Amount \$ | | Amount \$ |
|------------------------------|--|---------------------------------|-----------|
| Claimant's Settlement Demand | | Defendants Offer for Settlement | |
| Insurers Loss Reserve | | Deductible Amount | |
| Is Claim in Suit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Amount asked in Summons | |

9. Insurance Carrier: _____

10. Description: (Please provide enough information to allow evaluation. Use reverse side or attachment if additional space is required.)

| | |
|--|--|
| a. Alleged acts, error or omission upon which Claimant bases claim | |
| b. Description of case and events: | |
| c. Description of the type and extent of injury or damage allegedly sustained: | |

Signature of Applicant

Date of Signature

Print or Type Name

P.O. Box 10067 • PHOENIX, AZ 85064