

Claims – Made
Professional Liability Insurance Application
For
Physicians and Surgeons

Return the application to:

Americana Program Underwriters
Attention: PhysiciansProUSA
355 North 21st Street
Camp Hill, PA 17011

For Questions about the completion of the application you may contact us:

Facsimile (717) 920-0731

Email: fritz.seifert@amwins.com

Voice Call (Toll Free) 877-552-3772 Extension # 403

or

(717) 214-7576

NOTICE

This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services or the use of your professional office premises, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

INSTRUCTIONS

Please print responses in ink, and answer all questions in full. If a question does not apply to your practice, state "none" or "NA" (Not Applicable). Please include a copy of your letterhead and all of your advertisements with this application. Please indicate any additional responses on the Remarks Section on page 11.

This application consists of A) an application for insurance, including a Remarks Section page and Claim Information Form, B) a Proxy form, and C) a Subscriber Agreement and Power of Attorney. The completed application, together with any supplementary information, must be signed in ink and dated by the applicant in all spaces indicated. **Failure to provide complete information will delay the processing of the application.**

GENERAL INFORMATION

1. Social Security # - -

2. Corporate I.D. # (if applicable)

3. First Name Middle Name Last Name Suffix Title
Jr./Sr./III

4. Male Female

5. Date of Birth / /
Month Day Year

6. Formal Name of Partnership, Corporation, or Employer

ADDRESSES

7. Practice Addresses

Please list all office locations where you currently practice. List primary practice office first. Use the Remarks Section on page 11 to list additional locations at which you render professional services.

A. Street Bldg./Suite
City State Zip -
County Number of years at this location % of practice

B. Street Bldg./Suite
City State Zip -
County Number of years at this location % of practice

C. Street Bldg./Suite
 City State Zip -
 County Number of years at this location % of practice

8. Home Address

Street Apt.
 City State Zip -

9. Telephone/E-mail Address

Primary Practice Office Fax Home
 () - () - () -

E-mail Address

Web Site Address

10. Billing Address Other Than Primary Practice

If you require that your premium billing be sent to an address other than your primary practice address, please indicate.

Street/P.O. Box Bldg./Suite
 City State Zip -

EDUCATION

11. Medical School

Name

City/State/Country Degree Dates

12. Additional Education

If you have completed more than two residencies, one fellowship, or other training program, please provide details in the Remarks Section, page 11.

A. Internship

Hospital City/State

Date
 From To
 Mo./Day/Yr. Mo./Day/Yr.

B. Residency

Hospital City/State

Date Type

From To

Mo./Day/Yr. Mo./Day/Yr.

C. Residency

Hospital City/State

Date Type

From To

Mo./Day/Yr. Mo./Day/Yr.

D. Fellowship

Location City/State

Date Type

From To

Mo./Day/Yr. Mo./Day/Yr.

E. Other Training

Location City/State

Date Type

From To

Mo./Day/Yr. Mo./Day/Yr.

SPECIALTY

13. If you are a graduate of a non-U.S. medical school, are you certified by the Educational Council for Foreign Medical School Graduates?

Yes No

14. Primary Specialty

Name of specialty

% of practice Are you board certified? Yes No If yes, date

Mo./Day/Yr.

Name of board

If not board certified, what is the expiration date of eligibility?

Mo./Day/Yr.

If expired, why?

15. Secondary Specialty

Name of specialty

% of practice Are you board certified? Yes No If yes, date

Mo./Day/Yr.

Name of board

If not board certified, what is the expiration date of eligibility?
Mo./Day/Yr.

If expired, why?

**LICENSES,
AFFILIATIONS**

16. Licenses
Specify states where you are or have been licensed.

State	Year	License #	Permanent	Temporary	Status*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

*If any of your licenses are or have been inactive, suspended, restricted, or revoked, please explain in the Remarks Section, page 11.

17. Affiliations/Associations/Society Membership

A. Are you a member of any national (not specialty) medical societies? Yes No
If yes, list:

B. Are you a member of any national medical specialty societies? Yes No
If yes, list:

C. Are you a member of any state medical society? Yes No

D. Are you a member of any county medical society? Yes No

**PRACTICE
HISTORY**

18. Are you entering practice for the first time since completing an internship, residency program, fellowship, or military service?
 Yes No

19. Indicate your number of practice hours per week (include office hours, administrative activities, direct patient care, surgery, consultation, etc.). Please indicate only the practice hours to be insured by The Doctors' Company.

20. Estimate the number of patients you see on an average day of clinical practice.

PRIOR PRACTICE LOCATIONS

21. A. Indicate number of weeks per year you practice (include office hours, administrative activities, direct patient care, surgery, consultation, etc.).

B. If less than 26 weeks, are the weeks all consecutive? Yes No

C. Maximum number of consecutive weeks out of practice.

22. Where have you practiced your profession for the past 10 years *other than your current practice locations*? Please explain any gaps in your practice. Use the Remarks Section, page 11, to list additional locations.

Entity Name

Address

City

State

From

(Mo./Yr.)

To

(Mo./Yr.)

Entity Name

Address

City

State

From

(Mo./Yr.)

To

(Mo./Yr.)

Entity Name

Address

City

State

From

(Mo./Yr.)

To

(Mo./Yr.)

Entity Name

Address

City

State

From

(Mo./Yr.)

To

(Mo./Yr.)

Entity Name

Address

City

State

From

(Mo./Yr.)

To

(Mo./Yr.)

TEACHING/ MEDICAL DIRECTORSHIP RESPONSIBILITIES

23. Do you have any teaching or medical director responsibilities? Yes No
If yes, complete the following questions. Use Remarks Section if needed.

A. Name of facility and location:

B. What is your title?

C. Describe your responsibilities:

D. Does the entity provide you with coverage for:

Your administrative responsibilities? Yes No

Your direct patient care? Yes No

E. If teaching, what percentage of your weekly time is devoted to clinical teaching? %

STAFF PRIVILEGES

24. List all facilities, including nonhospital facilities, where you have staff privileges. List principal location first. Use the Remarks Section, page 11, to list additional facilities.

Facility	City	State	Department	% of practice
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

EMPLOYED PERSONNEL

25. If you or your entity employs or contracts for the services of any health care personnel in the following categories indicated by *, a separate application form must be submitted for each.

A. Physician's Assistants*

Number Employed Number Contracted Insurer, If Any

B. Nurse Practitioners*

Number Employed Number Contracted Insurer, If Any

C. Certified Registered Nurse Anesthetists*

Number Employed Number Contracted Insurer, If Any

D. Certified Nurse Midwife*

Number Employed Number Contracted Insurer, If Any

E. List other paramedical personnel, including nurses, technicians, technologists, physical therapists, etc.

Number Employed Number Contracted Insurer, If Any

CHANGES IN PRACTICE

26. Have your practice specialties/procedures, etc., changed in the past five years? Yes No
If yes, please explain how the specialty/procedures, etc., have changed and give the dates of changes.

PROCEDURES

27. If you are not an anesthesiologist, do you perform:

Intravenous Analgesia? Yes No

If yes, what type?

Anesthesia - General? Yes No

Spinal? Yes No

Intravenous? Yes No

28. Do you practice in any office surgical facility in which IV analgesia or general anesthetics are administered?

Yes No If yes, list facilities:

A. If yes to question #28, is the office certified by AAAASF or AAAHC? Yes No
If yes, please submit a copy of current certification; if no, please complete supplemental surgery suite questionnaire.

29. Do you perform elective cosmetic surgery? Yes No

If yes, do you perform the following?

Blepharoplasty? Yes No

Cosmetic Surgery of the Breast? Yes No

Chemical Peel? Yes No

If yes, what type?

Dermabrasion/Chemabrasion? Yes No

Suction-assisted Lipectomy? Yes No

If yes, please provide proof of training, copy of consent form, and proof of hospital privileges for this procedure.

Endoscopic-assisted Forehead Lifts? Yes No

If yes, please provide proof of training (12 hours of AMA category ICME credit) and hands-on experience.

30. Do you practice neonatology (treatment of critically ill or premature neonates)? Yes No

If yes, % of practice:

31. Do you practice obstetrics? (obstetrics includes prenatal care) Yes No

Do you perform deliveries other than in a hospital? Yes No

If yes, specify facility:

Do you perform obstetrical home deliveries? Yes No

32. Do you perform abortions? Yes No
If yes,

First Trimester? Yes No

Second Trimester? Yes No

Third Trimester? Yes No

List facilities where you perform abortions:

Number of abortions per month: Do you receive referrals? Yes No

If yes, from whom?

33. If you are a pathologist, do you routinely perform frozen sections and gross surgical pathology examinations and then send material to an unrelated group of pathologists for microscopic examination and final signout?
 Yes No

34. Do you perform radial keratotomy? Yes No

Sex-reassignment Surgery? Yes No

Weight-control Surgery? Yes No

35. If you are a cardiologist, do you perform invasive procedures? Yes No
If yes, specify the procedure(s):

36. If you are a dermatologist, do you make your own histopathologic diagnoses of pigmented lesions?
 Yes No

If you answer yes to any of the following questions, please give full details in the Remarks Section, page 11. Include dates and copies of related documents.

MISCELLANEOUS 37. Are you now being—or have you ever been—treated for alcoholism, narcotics addiction, or mental illness?
 Yes No

(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.)

38. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?
 Yes No

(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.)

39. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you?
 Yes No
40. Have you ever been investigated by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended, or limited in any way?
 Yes No (If yes, please provide copies of complaint and disposition documents.)
41. Has any hospital ever restricted or revoked your privileges or invoked probation for any cause other than incomplete charts?
 Yes No
42. Have you ever been indicted and/or convicted of a crime other than minor traffic violations?
 Yes No
43. Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)?
 Yes No
44. Have you been involved in a malpractice claim, suit, or incident in the past 10 years?
 Yes No If yes, how many?

If you answer yes to #44, please provide complete details on the Claim Information Form on page 13. Complete a separate form for each claim.

TYPE OF PRACTICE

45. What is your practice structure and your relationship, if any, with others in your practice?
 Individual Individual with DBA
 Individual with a solo corporation Other
Describe
46. Do you employ any physicians besides yourself in your practice?
 Yes No If yes, list below with details.
47. Do you independently contract with any entities or physicians not insured by The Doctors' Company?
 Yes No If yes, list below with details.

A. If you are an independent contractor, please complete the following statement:

My association with

Group/Physician Name

is that of an Independent Contractor, and the relationship conforms to the guidelines of the Internal Revenue Service.

Signature

Date

Group Name

Carrier

A current Declarations Page or Certificate of Insurance for the above group must be attached.

48. Are you employed by any physicians or entities not insured by The Doctors' Company?

Yes No If yes, list below with details.

Four horizontal lines for listing details of employment.

If yes to #46, 47, or 48, indicate the names and addresses of all such groups, clinics, professional corporations, partnerships, commercial enterprises, government, or public entities. Show the date of affiliation, status of employment, hours worked (weekly), number of physicians at each of the entities, percentage of your practice this represents, and if malpractice insurance is provided for this work. If more than one facility, please explain in the Remarks Section, page 11.

RETROACTIVE COVERAGE

49. If your current policy or any previous policies are claims-made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage) from that carrier, there will be no coverage for any claim from any act or omission that took place during that period of claims-made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims-made policy. Retroactive coverage insures you for claims made against you for incidents that took place while your previous claims-made insurance was in effect, but that were not brought to your attention until after the effective date of The Doctors' Company's policy.

Retroactive coverage does not cover claims that have been filed against you and/or reported to the previous insurers prior to the effective date of the policy with The Doctors' Company. Any claims and all conduct, circumstances, or incidents that could reasonably be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

INITIALS REQUIRED



I have read and understand the above statement. Please Initial Date

A. Will you purchase an extended reporting endorsement (tail coverage) from your current carrier?

Yes No

B. If no, do you wish to purchase retroactive coverage from The Doctors' Company? Yes No
If yes, please complete the following:

C. Desired retroactive date:
(You must attach a copy of the most recent Declarations Page from your present carrier indicating the original effective date of coverage and the current paid-through date.)

D. Are you, as of this date, aware of any claims against you that have not been reported to your present or prior insurer(s)?

Yes No

E. Does your current carrier consider a claim to be a:

Report of a medical incident or Formal demand for money

F. Are you, as of this date, aware of any conduct, circumstances, or incidents that occurred during the period of coverage listed below that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)?

Yes No

INITIALS REQUIRED



I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier.

Initials Date

**CLAIM
INFORMATION
FORM**

Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please 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. Allegation

6. Date of Incident
Month Day Year

7. Report Date
Month Day Year

8. Location

9. Insurance Carrier

10. Other Defendants

11. Present Status Open Claim Loss of \$ Settlement
 Closed Claim Date Closed Judgment

12. Condition and diagnosis at time of incident:

13. Dates and description of professional services rendered:

14. Condition of patient subsequent to professional services (and dates of follow-up visits) if known:

**SIGNATURE
REQUIRED**



I hereby declare the above information is complete and true to the best of my knowledge and belief.

Signature Date

PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them, my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors' Company, an Interinsurance Exchange.

This proxy is solicited on behalf of the management of the Exchange and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.

You may revoke this proxy by giving the Exchange written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

**SIGNATURE
OPTIONAL**



Signature

Type or Print Name

Street

City State Zip

Date

(If undated, the date of receipt will be inserted by The Doctors' Company. Address any question you may have to the Secretary of the Exchange.)

**SUBSCRIBER
AGREEMENT
AND
POWER OF
ATTORNEY**

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors' Company, an Interinsurance Exchange ("the Exchange"), and agrees with the Exchange and with other Subscribers, through their Attorney-in-Fact, The Doctors' Management Company ("the Attorney") to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by the Exchange's Board of Governors.
2. Subscriber designates and appoints the Attorney to be its true and lawful agent and Attorney-in-Fact to act in its name, place, and stead and in the name of the Exchange, to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of the Exchange and the business of interinsurance. Subscriber adopts and approves the Management Agreement between the Exchange and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.
3. Subscriber delegates to the Board of Governors of the Exchange authority to negotiate all the terms and conditions of the Management Agreement between the Exchange and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or Exchange.
4. Subscriber further delegates to the Board of Governors of the Exchange all necessary and proper powers to conduct, manage, and control the affairs and business of the Exchange, subject to those retained by law or through the Rules and Regulations of the Exchange, or as they may be further amended at the Annual Meeting of Subscribers.
5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.
6. Subscribership begins with the commencement of the policy period of a claims-made insurance policy issued by the Exchange and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of the Exchange.
7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to "Attorney" shall then be deemed to include such successor Attorney-in-Fact.
8. The principal offices of the Exchange and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.
9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word "Subscriber" is used, it refers to all members of the Exchange, including the Subscriber who has signed this document.

**SIGNATURE
REQUIRED**



Executed this day of 20

Signature

Print or Type Name