ADMIRAL INSURANCE COMPANY 520 PIKE STREET, SUITE 2929 SEATTLE, WA 98101 PHONE (206) 467-6511 – FAX (206) 467-6557 INTERNET: WWW.ADMIRALINS.COM	PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

1. **Full Name of Applicant:** ______________________________

2. **Principal Office Address:** ______________________________
   County: ______________________________

3. **Home Address:** ______________________________
   ____

4. **Social Security #:** ____________________ **DEA #:** ____________________

5. **List the States and License Numbers where you practice:** ______________________________
   ____

6. **Date of Birth:** ____________ **Place of Birth:** ______________________________

7. **Are you a U.S. Citizen? _____ Yes _____ No If NO, please indicate your status and date of entry into the United States:** ______________________________

8. **What is your medical or surgical specialty:** ______________________________
   What percentage of your practice is dedicated to this specialty? ____________________

9. **What is your sub-specialty:** ______________________________
   What percentage of your practice is dedicated to this specialty? ____________________

10. **Do you limit your practice to the above specialties? _____ Yes _____ No If No, what other specialties do you practice? Provide details.** ______________________________
    ____

11. **Are you American Board certified? _____ Yes _____ No**
    Medical Specialty: ____________________ **Date Certified:** ____________
    Medical Specialty: ____________________ **Date Certified:** ____________

12. **Type of Practice (check all that apply)**
    _____ Individual **_____ Employee** **_____ Member of Multi-person Corp or Assoc**
    _____ Individual Corporation **_____ Partnership** **_____ Other** ____________________

13. **What is your total annual revenue?** **____ $100,000 or less** **____$250,001-$499,999**
    ____ $100,001 - $250,000 **____$500,000 or more**

14. **Please provide the names of all facilities that you practice at and your interest in each facility.**
    <u>Name of Clinic or Facility and Location</u> **<u>Interest (Owner, Partner, Employee?)</u>**
    ____
    ____
    ____
    ____

    ***Attach a separate attachment if necessary.**

15. **Are you seeking coverage for your work at all of the above facilities? _____ Yes _____ No If No, please list those facilities for which you do not require coverage and explain why coverage isn't needed.** ____________
    ____
    ____

16. Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.

	Employed	**Contracted**	**Carry their own Med Mal policy?**
Physicians Assistants	________	________	____ Yes ____ No
Nurse Practitioners	________	________	____ Yes ____ No
Surgical Technicians	________	________	____ Yes ____ No
CRNA's	________	________	____ Yes ____ No
Chiropractors	________	________	____ Yes ____ No
RN's	________	________	____ Yes ____ No
LPN's, Nurse Aides	________	________	____ Yes ____ No
Other: ______________________	________	________	____ Yes ____ No
Other: ______________________	________	________	____ Yes ____ No

***Please attach copies of dec pages on above professionals that carry their own malpractice policies.**

17. Are all of the above individuals licensed in accordance with applicable state and federal regulations? _____ Yes _____ No <u>If NO, please attach explanation.</u>

18. List the hospitals at which you are currently a staff member: ____

____

____

19. Briefly describe the type and extent of your hospital privileges:____

____

20. Are you the Chief or Head of a hospital department? _____ Yes _____ No If YES, which department(s):

____

21. Are you the medical director of a nursing home or assisted living facility? If so, please provide the name of the facility:

____

22. Are you the medical director of any other facilities? If so, please provide the names of each facility:

____

____

23. From what Medical School did you graduate? ____
City, State and Country of Medical School ____
Degree: ____ Year of Graduation: ____________
If foreign medical school graduate, are you certified by the Educational Council for Medical School Graduates? _____ Yes _____ No. If YES, state the year: ___________

24. Internship? _____ Yes _____ No If Yes, complete the following:
Location: ____________________ Dates: From ___________ To ___________
Type: _______________________ Completed? _____ Yes _____ No

25. Residency? _____ Yes _____ No If YES, complete the following for each:
Location: ____________________ Dates: From ___________ To __________
Type: _______________________ Completed? _____ Yes _____ No
Location: ____________________ Dates: From ___________ To __________
Type: _______________________ Completed? _____ Yes _____ No

26. Where have you practiced your profession since completion of training:
In ____ From _______ To _______
In ____ From _______ To _______
In ____ From _______ To _______

27. **Additional Medical Training? _____ Yes _____ No If Yes, provide details including type, location, and date of training:** ____

____

28. **Have you participated in any continuing medical education program(s) within the past five years? _____ Yes _____ No If YES, please provide details:** ____

____

29. **Indicate memberships in professional societies:** ____

____

____

30.	**Do you perform one or more of the following:**	**Yes**	**No**
A.	**Endoscopic Procedures, other than sigmoidoscopy or proctoscopy. If Yes, describe:** __________________ ____	_____	_____
B.	**Catheterization, other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel. If Yes, describe:** _________________________ ____	_____	_____
C.	**Arteriography, lymphangiography, myelography or phenmoencephalography?**	_____	_____
D.	**Interventional radiology-percutaneous transluminal angioplasty or embolization?**	_____	_____
E.	**Radiation therapy, including radium implants? If Yes, describe:** ______________________________	_____	_____
F.	**Chemobrasion or dermabrasion?**	_____	_____
G.	**Hair Transplantation or Suturing of Hairpieces?**	_____	_____
H.	**Mohs Micrographic surgery? If YES, describe:** ____	_____	_____
I.	**Acupuncture? If YES, describe:** __________________	_____	_____
J.	**Prenatal care and normal deliveries? If YES,**	_____	_____
	Do you perform home deliveries?	_____	_____
	Do you only perform prenatal care?	_____	_____
	Do you supervise nurse midwives? If YES, when do you refer: __________ **weeks gestation**	_____	_____
K.	**Dilation and curettage?**	_____	_____
L.	**Needle Biopsies? If YES, describe:** _______________	_____	_____
M.	**Electroshock therapy or hypnosis? If YES, describe:** ____	_____	_____
N.	**Radial keratotomy, excimer laser PRK, LASIK or any other surgical vision correction procedure?**	_____	_____

Do you perform any of the following? (continued)	**Yes**	**No**

		Yes	No
O.	**Surgery, other than incision of boils and superficial abscesses or suturing skin and superficial fascia? If Yes, please attach a list of all surgical procedures.**	_____	_____
P.	**Non-spontaneous, induced abortions? If YES, What is maximum trimester?___________________**	_____	_____
Q.	**Vasectomies or reversal of vasectomies?**	_____	_____
R.	**Hysterectomies? If YES, do you perform laparoscopic**	_____	_____
	hysterectomies?	_____	_____
S.	**Cholecystectomies? If YES, do you perform laparoscopic**	_____	_____
	cholecystectomies?	_____	_____
	If YES, how many performed as of this date: ________		
T.	**Tonsillectomies and/or Adenoidectomies?**	_____	_____
U.	**Caesarian sections?**	_____	_____
V.	**Spinal Surgery? If you also perform chemonucleolysis, check here: ____ and/or percutaneous lumbar disectomy, check here: _____**	_____	_____
W.	**Administration of general, spinal or caudal block anesthesia?**	_____	_____
X.	**Open reduction of fractures?**	_____	_____
Y.	**Organ transplantation? If YES, describe: ____________ ____**	_____	_____
Z.	**Sex Change Operations?**	_____	_____
AA.	**Weight Reduction Surgery including gastric bypass or other stomach banding procedures? If YES, which procedures? __________________________________ ____**	_____	_____
BB.	**Experimental research, surgical research, or experimental therapy in human patients? If YES, describe:_________**	_____	_____
CC.	**Cosmetic/Plastic Surgery? If YES, complete the following:**	_____	_____
	Do you perform breast augmentation?	_____	_____
	Do you perform breast reductions?	_____	________
	Do you perform liposuction? If YES, what is the maximum amount of cc's removed? ________________	_____	_____
	Do you perform fat recycling? If YES, in what parts of the body? ___________________________________	_____	_____
	Do you perform vaginoplasty or labiaplasty?	_____	_____
	Do you use silicone implants? If Yes, in which parts of the body: ___________________________________	_____	_____
	Do you perform Botox injections? If Yes, in which parts of the body: ___________________________________	_____	_____
DD.	**Penile lengthening or enhancement procedures?**	_____	_____

Do you perform any of the following? (continued) **Yes** **No**

EE. Any other surgical procedures not shown above? _____ _____
Please describe.________________________________
____

***PLEASE ATTACH A LIST OF ALL SURGICAL PROCEDURES YOU PERFORM**

31. Do you perform surgery in your office? _____ Yes _____ No If YES, please list. ________________________
____
____

32. Do you perform surgery in other non-hospital facilities? _____ Yes _____ No (If YES, what type of facility and list the surgical procedures: ____
____

33. In the course of surgery does a Board Certified Anesthesiologist provide the anesthesia? _____ Yes _____ No
If No, please provide details. ____
____

34. Do you do any hospital emergency room work? _____ Yes _____ No If YES, Is the emergency room care:
Only for your own patients? _____ Yes _____ No
Required for staff privileges? _____ Yes _____ No
How many hours per month: _________________
Does the hospital cover you for malpractice while you work in the emergency room? _____ Yes _____ No
Are you requesting coverage for your emergency room work? _____ Yes _____ No

35. Do you assist in surgery:
On your own patients? _____ Yes _____ No
On patients of others? _____ Yes _____ No

36. If your practice includes plastic surgery, specify the percentage of your practice devoted to:
_____% Traumatic Surgery _____% Cosmetic/Elective Surgery

37. If your practice includes weight reduction/control (other than by diet and exercise), specify the percentage of patients that are exclusively weight control: __________%.
Do you prescribe any weight control drugs? _____ Yes _____ No If YES, list drugs prescribed. ____________
____
____
Do you dispense supplements for weight control? _____ Yes _____ No If Yes, list supplements dispensed. ___
____
____
Do you use injections for weight control? _____ Yes _____ No If YES, list drugs injected:_________________
____

38. Have you or any of your employees:	**Yes**	**No**
A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Attach a copy of Complaint and Consent Order document if applicable.	_____	_____
B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____

Have your or any of your employees? (continued)	**YES**	**NO**

C. **Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction?** _____ _____

D. **Ever had any state profession license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?** _____ _____

E. **Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?** _____ _____

F. **Ever failed any medical licensing or specialty organization examination?** _____ _____

G. **Do you have any chronic illnesses or defects? If Yes, please describe. ________________________________** _____ _____

39. **Do you supervise any individuals other than your own employees? _____ Yes _____ No If YES, please provide detailed explanation of your responsibilities, relationship and whether or not these individuals have their own medical malpractice coverage: ____**

____

____

40. **Are you under contract to any individual, firm or corporation other than your own? _____ Yes _____ No** **<u>If YES, attach explanation including details of responsibilities. If this contract contains a hold harmless agreement then attach a copy of the contract language.</u>**

41. **Are you in the employ of, or under contract to any governmental entity? _____ Yes _____ No If YES, please provide details and outline your duties.____**

____

42. **Do you offer professional advice to the public such as through a website, radio or TV broadcasts, newsletters, etc? _____ Yes _____ No If YES, please provide details. ____**

____

43. **Do you advertise your professional services in any manner other than a simple listing in a telephone directory? _____ Yes _____ No If YES, please provide details and attach copies of all advertising brochures.**

____

____

44. **Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? _____ Yes _____ No If YES, please provide details. ______________________________________**

____

45. **Average Weekly Patient Load: ____________________ Total Patients Annually: ______________________**
Total surgeries performed annually: ____________________

46. **Average number of hours worked per week: ____________________**

47. **Do you anticipate any changes in your practice? _____ Yes _____ No If YES, please describe: ____________**

____

____

48. **List the prior medical malpractice insurance carried for each of the past 5 years beginning with most current:**

INSURANCE COMPANY	**LIMITS OF LIABILITY**	**POLICY PERIOD**	**PREMIUM**	**RETRO DATE**

***Attach a copy of the declarations page of your most recent policy.**

49. **Do you own, operate or provide professional services for, or at, any health care facility or business enterprise not already clearly described in this application? _____ Yes _____ No If YES, please describe: ___________**

____

50. **Has any claim or suit for alleged malpractice been brought against you?_____ Yes _____ No**
If YES, how many total claims or incidents: _____________
Please complete the Supplemental Claim Information Form attached to this application for each and every claim. Also, please attach 10 years of currently valued company loss runs.

51. **Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? _____ Yes _____ No If Yes, please complete the Supplemental Claim Information Form attached to this application for each and every claim.**

52. **Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? _____ Yes _____ No If Yes, please provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.**

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

____ **_______________________**
Signature of Applicant **Date**

Please attach the following documents to this application:

- **C.V. or resume**
- **Five years of currently valued company loss runs**
- **Copies of any disciplinary actions, stipulation orders or probation documents**
- **Copies of declarations pages for all employees or contractors that carry their own med mal**
- **Copy of applicant's most current declarations page**

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

1. **Name of applicant/named insured:** ____
____

2. **Name of other parties or defendants named in suit:** ______________________________
____
____

3. **Date of alleged error or occurrence, or contact date:** ______________________________

4. **Date claim was made:** ____

5. **Name of claimant:** ____

6. **Name of Insurance Company handling your claim:** _________________________________

7. **Present status of claim or final disposition:** ___________________________________
____
____
Circle One: CLOSED OPEN

8. **Defense costs paid to date inclusive of any deductible:** ____________________________

9. **If closed, total loss paid, inclusive of any deductible:** ____________________________

10. **If claim is open or pending, what are the insurers reserves?**
Defense: _________________________ **Loss:** _________________________

11. **Description of case and events including allegations and assessment of liability:** __________
____
____
____
____
____

12. **Claimants last settlement demand:** ____

_______________________________ _______________________________________
Date **Signature**