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**APPLICATION FOR  
 PROFESSIONAL LIABILITY  
 INSURANCE  
 PHYSICIANS & SURGEONS  
 CLAIMS-MADE COVERAGE**

**Submitted By:**  
 Producer: \_\_\_\_\_ Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please complete this application in ink and answer all questions. An incomplete application cannot be processed. If a question does not apply to your practice, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please use the space provided on the last page of this application or attach a separate page. Completion of this application neither binds coverage or guarantees that a policy will be issued.

**THE FOLLOWING MUST BE INCLUDED WITH THIS APPLICATION:**

- This fully completed application, signed and dated by you within 45 days of the desired effective date.
- Copy of your current professional liability insurance Declarations Page and currently valued loss experience.
- Copy of your Curriculum Vitae.
- Copies of all advertising that you use, including Yellow Page ads
- Copy of your business letterhead
- Supplementary Applications, Claim Information Supplement(s) and additional documentation as needed

**I. GENERAL INFORMATION**

1. Print Name: _____		Social Security No. _____		2. Professional Designation: _____		3. Date of Birth: _____	
				<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> D.P.M.			
4. Business Name: _____		% of Ownership _____		5. Type of Practice: _____			
				<input type="checkbox"/> Solo Practice <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership (On a separate sheet, please identify partners) <input type="checkbox"/> Employed Physician <input type="checkbox"/> Other: (Specify) _____			
6. Do you use any "Doing Business As" (d/b/a) name? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If YES, specify:</b> _____							
7. Primary Practice – Street Address: (If more than one location, list on additional sheet)				Number of years at this location: _____			
8. City: _____		County: _____		State: _____		Zip: _____	
9. Billing Address (If different from above): _____		City: _____		State: _____		Zip: _____	
10. Office Telephone: _____		Fax: _____		Residence Telephone: _____		E-Mail Address: _____	

**MEDICAL TRAINING AND PRACTICE HISTORY**

11. Medical Specialty: _____		Percent of Practice: _____		12. Medical Sub-Specialty: _____		Percent of Practice: _____	
		%				%	
	Hospital / College	City & State	Completed?	Year			
Medical School			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Internship			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Residency			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Additional Residency			<input type="checkbox"/> Yes <input type="checkbox"/> No				
Fellowship			<input type="checkbox"/> Yes <input type="checkbox"/> No				

13. Are you a U.S. citizen?  Yes  No **If NO**, please provide a copy of documents confirming your status.

14. Are you a Foreign Medical School Graduate?  Yes  No Date of ECFMG certification: \_\_\_\_\_

15. Are you currently Board Certified?  Yes  No Name of Board: \_\_\_\_\_

16. Date you began practicing \_\_\_\_\_. Within the last five (5) years have your practice characteristics, procedures performed, or business association(s) changed?  Yes  No **If YES**, please describe on additional sheet.

17. List all primary office locations where you have practiced in the last ten (10) years? (Use separate sheet if more space is needed)

Street Address & City	County	State	Dates – From / To

18. Please list below all hospitals where you have staff privileges. (If no hospital privileges, attach protocol for patient hospital admission).

Hospital	City / State	County	% of Practice

19. List states where you practice:	Medical License Number(s):	DEA License Number(s):	% of practice in each state:

20. Please indicate the number of CME hours you have obtained in the past two years: \_\_\_\_\_

**II. OFFICE STAFF**

21. Do you employ, contract with or supervise any physician(s) or surgeons(s)?  Yes  No **If YES**, advise of number and attach current certificate(s) of insurance.

22. Do you employ, contract with or supervise any non-physician health care extenders?  Yes  No **If YES, enter information below:**

	Number		Number	Others (Please Describe)	Number
Nurse Practitioner		Laboratory Technician			
Physician Assistant		CRNA			
Surgeon Assistant		Midwife			
Pharmacist		Nurses			

**III. PRACTICE INFORMATION**

23. Average Number of patients seen each week: \_\_\_\_\_ Weekly practice hours: \_\_\_\_\_ Percentage of Locum Tenens work: \_\_\_\_\_%

24. Please list any medical association membership(s): \_\_\_\_\_

25. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center?  Yes  No **If YES**, please describe on separate sheet.

26. Do you perform abortions?  Yes  No **If YES**, indicate number each month: \_\_\_\_\_ Type:  Elective  Therapeutic  
 Where performed? (Check all that apply)  Office  Hospital  Other (Explain on separate sheet)  
 Maximum Gestation Age? \_\_\_\_\_

28. Does your practice include the following (Check all that apply)?

- No Surgery No surgery, with the exception of incision of sebaceous boils and cysts. Incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.
- Minor Surgery Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive). *No general anesthesia.*
- Major Surgery Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It also includes removal of tumors (except skin tumors), reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.
- Obstetrics If checked, please indicate annual:  
Number of vaginal deliveries: \_\_\_\_\_ Number of cesarean sections: \_\_\_\_\_  
Number of Home or Non-Hospital Deliveries: \_\_\_\_\_ (Please describe on separate sheet)
- Elective Plastic Surgery Please describe procedures and annual number performed on separate sheet

29. Do you perform any of the following procedures?

Acupuncture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laparoscopies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amniocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laser Treatments Via Endoscope?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amputations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Forceps Deliveries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angiography?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignant Lesion Surgical Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriography?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mastoidectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting in surgery on other than your own patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Middle or Inner Ear Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting in surgery on your own patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mid-Forceps Delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blepharoplasty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	MOHS Micrographic Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Augmentation or Reduction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myleography?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breech Deliveries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Needle Biopsies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Catherizations? (Right Heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical Biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Norplant Insertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical Cautery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity/Weight Control Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chelation Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Office Gynecology?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Peels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oophorectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cleft Lip or Palate Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Open Reduction of Fractures? (Plating and Pinning)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Trials?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ophthalmologic Surgery? (Laser or other)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Closed Reduction of Fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collagen Lip Injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Surgery? (Including Spinal Surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Surgery? (No Spinal Surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complex Flaps and Grafts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Otoplasty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Conization of Cervix?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pedicle Screw Insertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Culdocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Augmentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnostic Radiology?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dilation and Curettage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pericardiocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electroshock Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Eyeliner Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endometrial Biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Care into Second Trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endoscopic Retrograde/Cholangiopancreatography?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Care into Third Trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Episiotomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experimental Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy? (Radium Implants)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastric Bubble Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reconstructive Plastic Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hair Transplant Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scalp Reduction Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Risk Pregnancies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sex Change Operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperbaric Chamber Treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sterilization Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suction Lipectomy Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interphalangeal Joint Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombectomy of Arteries and Veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hysterectomies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxemia Management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney, Ureter and Bladder Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

30. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked?  
IF YES, please describe on separate sheet.

Yes  No

31. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? IF YES, please describe on separate sheet.

Yes  No

32. Are you now, or have you ever been involved in any Professional Liability claim or suit? <b>IF YES, a Claim Information Supplement form must be completed for each claim.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Are you aware of any circumstances that might lead to a claim or suit? <b>IF YES, complete a Claim Information Supplement for each circumstance.</b> Has this information been reported to a current or prior insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
34. Has your Professional Liability insurance ever been refused, canceled or non-renewed? <b>IF YES, please explain on a separate sheet. (Response not required in the State of Missouri)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? <b>IF YES, please explain on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? <b>IF YES, please complete supplemental application.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
37. Have you ever been charged with, or convicted of a crime other than minor traffic violations? <b>IF YES, please explain on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
38. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s) or a state licensing authority? <b>IF YES, please explain on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
39. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? <b>IF YES, please explain on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
40. Do you own or operate a Laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES, (a) Does the laboratory provide services solely for your patients?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (b) <i>If not limited to your patients, please explain on separate sheet.</i>	
41. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? <b>IF YES, please explain on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
42. Do you now or have you ever treated prisoners in a state, federal or any correctional institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No
43. Do you practice as a company doctor (excluding treatment of workers compensation patients)? <b>IF YES, what products are manufactured by the company?</b> _____ Do you review or establish plant / employer safety standards? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide medical treatment to company employees? <input type="checkbox"/> Yes <input type="checkbox"/> No Company name: _____ Location: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
44. Does your practice include weight reduction/control by other than diet and exercise? <b>IF YES, please complete the information below or attach separate sheet if needed:</b> a. What percentage of patients are treated exclusively for weight control? _____% b. List injections used for weight control: _____ c. If you prescribe or dispense drugs for weight control, please list drugs and describe protocols: _____ d. Describe any other weight control procedures, including surgery, that you provide to your patients: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
45. Do you authorize any collection agency, at it's own discretion, to file a claim or suit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
46. Do you work in an Emergency Room for other than maintaining hospital privileges? Please indicate the average number of hours you work in the Emergency Room each month: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
47. Are you a sports team physician or health care provider? <b>IF YES, check all that apply:</b> <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Professional <input type="checkbox"/> Other: _____ Name and location of team(s): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
48. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director, or are you under contract to provide professional services, at any Nursing Home or similar facility? <b>IF YES, describe percentage of your practice and name(s) of nursing home facilities:</b> _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

49. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director of a hospital or hospital department; sanitarium; ambulatory care clinic with bed and board facilities; health maintenance organization; preferred provider organization; or any other business enterprise?  <b>IF YES</b> , please identify, provide address, and explain details on a separate sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
50. Do you serve in a "Gatekeeper" capacity (that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization)?  <b>IF YES</b> , please advise of percentage of your practice devoted to Gatekeeper activity: _____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
51. Do you engage in tele-medicine activity? <b>IF YES</b> , please describe on separate sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
52. Do you prescribe drugs or provide diagnosis via the internet? <b>IF YES</b> , please describe on separate sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
53. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? <b>IF YES</b> , please describe on separate sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**IV. ANESTHESIA / OFFICE SURGERY**

54. Do you perform or assist in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis? <b>IF YES</b> , please complete the questions below:  a. Description and annual number of procedures: _____  b. Annual number of procedures with: General Anesthesia: _____ Spinal or Caudal Anesthesia: _____ Other: _____  c. Anesthesia administered by: _____  d. Distance to nearest hospital: _____  e. Description of life saving equipment/supplies: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**V. COVERAGE INFORMATION**

55. Please list your previous professional liability insurance carrier(s) for the last five years and supply information requested below:

Insurance Company	Policy Limits	Coverage Dates	Type of Policy	Premium
		From: To:	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
		From: To:	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
		From: To:	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
		From: To:	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	

56. Have you ever practiced without professional liability insurance?  Yes  No IF YES, specify dates:

57. **Effective Date Desired:** \_\_\_\_\_ **Retrospective Date Desired:** \_\_\_\_\_  
*Important: Declarations Page of your current policy must be attached if a retrospective date is requested. THE COMPANY MAY NOT PROVIDE DESIRED DATES.*

58. **Policy Limits Desired:**  \$100,000/\$300,000  \$200,000/\$600,000  \$250,000/\$750,000  \$1,000,000/\$3,000,000  
 Other: \_\_\_\_\_

**VI. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE**

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations.

This applicant understands that incorrect information could void coverage.

The applicant requests that this application for insurance coverage be submitted for consideration to all appropriate insurance companies. Accordingly, the applicant authorizes and directs any person or organization whatsoever to release and furnish to the Company all information requested which may relate to the applicant's insurability. The applicant also consents to the review by the Company of any incidents or occurrences likely to result in a malpractice allegation or claim. The applicant agrees to cooperate in the review of claims which apply to the coverage requested.

Any person who knowingly and with intent to defraud an insurance company or other person, files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

**Notice to New York Applicants:** any person who knowingly and with intent to defraud any insurance company or other person 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

THE APPLICANT UNDERSTANDS THAT COMPLETION OF THIS APPLICATION NEITHER BINDS COVERAGE NO GUARANTEES THAT A POLICY WILL BE ISSUED.

