

Medical Professional Liability Insurance—Claims-Made Physician Application



ProAssurance Indemnity Company, Inc. • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 608.828.1100

With your fully completed, signed and dated application, please submit the following information:

1. Current coverage verification (i.e., declaration page, certificate of insurance).
2. Written verification of the purchase of an extended reporting endorsement (tail) from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Current loss runs from prior insurance companies or explanation as to why they are not available.
5. Copy of curriculum vitae (CV).
6. Copy of Continuing Medical Education (CME) Programs completed in the past three years.

Note: Submission of a complete application confers no obligation upon the Company to bind coverage.

1. Personal Information

Name: _____ Degree: _____
FIRST MIDDLE LAST

Social Security Number: _____ Date of Birth: _____ Gender: Male Female

Email Address: _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Medical License Number(s):	State	License Number	Expiration Date	% of Practice
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all State Medical Associations you currently belong to: _____

Please provide additional license information in the space provided at the end of the application.

2. Practice Location

Practice Name: _____ Employment Date: _____/_____/_____
MONTH DAY YEAR

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Billing Address: _____

Contact Name: _____ Title: _____

Contact Email Address: _____

Please list other practice locations:

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ % of Practice: _____

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ % of Practice: _____

Please list additional practice locations in the space provided at the end of the application.



3. Coverage Requested

- A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR
- B. Please indicate your desired level of coverage.
 Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
 Excess Coverage Limits (where available): _____
- C. Deductible amount (where available): \$ _____
 Indemnity Only Indemnity & Expense None
- D. Do you desire coverage for a practice entity? Yes No
 If yes, we require a corporate application to be completed.
- E. Will you be carrying additional professional liability insurance with another company? Yes No

4. Prior Acts Coverage

(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

- A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes No
 Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR
- B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes No
 If yes, please describe the changes in your practice, including all applicable dates in the space provided at the end of the application.

5. Education, Training and Certification

A. Please list the name and location of all medical schools attended:

Institution and Location	Dates Attended	Degree Obtained
_____	_____	_____
_____	_____	_____

- B. If degree was granted from a foreign medical school, are you ECFMG certified? Yes No
 - i. Have you ever failed the ECFMG examination? Yes No
 If yes, please explain in the space provided at the end of the application.

C. Please list all internships, residencies, or fellowships.

Internship

Institution Name: _____
 Institution Location: _____
 Rotating Transitional Straight (Specialty: _____)
 Dates Attended: From _____ To _____
MM/DD/YY MM/DD/YY

- Did you successfully complete this program? Yes No
 If no, please explain in the space provided at the end of the application.

Residency

Institution Name: _____
 Institution Location: _____
 Specialty/Department: _____ Dates Attended: From _____ To _____
MM/DD/YY MM/DD/YY

- Did you successfully complete this program? Yes No
 If no, please explain in the space provided at the end of the application.

Fellowship

Institution Name: _____

Institution Location: _____

Type of Fellowship: _____ Dates Attended: From _____ To _____
MM/DD/YY MM/DD/YY

Did you successfully complete this program? Yes No

If no, please explain in the space provided at the end of the application.

Please indicate here if you attended more than one medical/professional school or participated in additional programs to those listed above and include information in the space provided at the end of the application.

D. Are you board certified? Yes No

i. If yes, please indicate which board and specialty/subspecialty:

American Board of _____

American Osteopathic Board of _____

ii. If not boarded, when do you plan to take your boards? _____

iii. Are you required to recertify? Yes No

If yes, please provide date of recertification: _____

iv. Have you ever failed a board certification or recertification examination? Yes No

If yes, how many times? _____ (Oral) _____ (Written)

E. Please indicate your current life support certification information:

ACLS Certified BCLS Certified ATLS Certified PALS Certified

6. Practice Information

A. What is your present specialty? _____ % of Practice: _____

B. What is your present sub-specialty? _____ % of Practice: _____

C. Have there been any changes in your specialty, procedures, or practice activity within the past five years? Yes No

If yes, please describe in the space provided at the end of the application.

D. How many patients do you see on average per week? _____

E. How many hours do you practice on average per week? _____

(Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision, and on-call hours involving patient contact, whether direct or by telephone.)

F. Do you practice any of the following?

Ayurvedic Medicine

Chinese Medicine (including Acupuncture)

Holistic Medicine

Homeopathic Medicine

Naturopathic Medicine

G. Do you perform medical or surgical procedures in an office-based surgical suite? Yes No

H. Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine program? Yes No

If yes, what percentage of your practice does this constitute? _____%

i. Do you provide these services to patients in states outside your primary practice location? Yes No

If yes, please provide a list of states: _____

I. Do you provide services to any nursing home or similar facility? Yes No

If yes, what percentage of your practice do these services constitute? _____%

Please list the name of the facility(ies): _____

J. Do you provide services to any local, state, or federal correctional facility? Yes No

If yes, what percentage of your practice do these services constitute? _____%

Please list the name of the facility(ies): _____

K. Do you, or will you, staff an emergency department? Yes No

If yes, is the emergency department work required to maintain hospital staff privileges? Yes No

i. How many hours per month do you practice in the emergency department? _____

- L. Do you have an agreement/contract to provide care at:
 Nursing Home
 Correctional Facility
 Emergency Department
- M. Are you a sports team physician for any high school, college, university, semi-professional or professional team? Yes No
 If yes, provide the name of the institution or team: _____
- N. Do you or your employees provide home health or mobile health care services? Yes No
 If yes, please explain in the space provided at the end of the application.
- O. Do you serve as a Medical Director? Yes No
 If yes, please list the name of the facility(ies): _____
- i. Is professional liability insurance provided by the facility for your duties as Medical Director? Yes No
 If yes, please provide proof of coverage.
- P. Have you participated in a clinical trial within the last ten years? Yes No
 If yes, please provide details in the space provided at the end of the application.
- Q. Are you employed full-time or part-time by the Federal, State, or Local Government? Yes No
 If yes, please provide the nature of such employment in the space provided at the end of the application.
- R. Are you on active duty in the U.S. Military Service? Yes No

S. Procedures

- i. Please review *each* section for any procedures that apply to your practice. This information is used for rating purposes; the procedures are not grouped by rating classification.

Anesthesia, Physical Medicine, Rehabilitation/Pain Management Procedures

- Anesthesia (check type and where administered)
- | | <u>Hospital</u> | <u>Surgical Suite</u> | <u>Office</u> |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Caudal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Moderate (Conscious) Sedation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> General | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Spinal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Lumbar Puncture
- Pain Management
- | | |
|--|---|
| <input type="checkbox"/> Medication Only | <input type="checkbox"/> Thoracic Sympathectomies |
| <input type="checkbox"/> Spinal Cord Stimulators | <input type="checkbox"/> Implantation/Removal of Drug Infused Pumps |
| <input type="checkbox"/> Facet Blocks | <input type="checkbox"/> Sphenopalatine Lesioning |
| <input type="checkbox"/> Selective Nerve Root Blocks | <input type="checkbox"/> Trigeminal Lesioning |
| <input type="checkbox"/> Rhizotomy | <input type="checkbox"/> Cordotomies |
| <input type="checkbox"/> Spinal Injections | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dorsal Root Gangliotomies | |
- Trigger Point Injections

Radiology Related Procedures

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Fluoroscopy | <input type="checkbox"/> Radiology – Interventional |
| <input type="checkbox"/> Mammography | <input type="checkbox"/> Radiation/X-ray Therapy |
| <input type="checkbox"/> Myelography | <input type="checkbox"/> Radiopaque Dye |

Cosmetic/Dermatological Procedures

- | | |
|---|---|
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Laser Skin Resurfacing |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Laser Vein |
| <input type="checkbox"/> Chemabrasion | <input type="checkbox"/> Lipodissolve/Mesotherapy |
| <input type="checkbox"/> Collagen Injections | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Cryosurgery (superficial only) | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Dermatopathology (diagnostic) | <input type="checkbox"/> Silicone Injections |
| <input type="checkbox"/> Fat Transfer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hair Transplants | |

Surgical (Invasive) Procedures

- Angioplasty
- Assist in surgery
 - On Own Patients
 - On Patients of Others
- Bariatric Surgery
- Bronchoscopy
- Cardiac Surgery
- Cholecystectomy
- Circumcision (other than newborns)
- Colonoscopy
- Colposcopy
- Cryosurgery (other than external lesions)
- D&C
- Endoscopic Laser Therapy
- Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy, and Cystoscopy
- ERCP/EGD/ERC
- Fracture Reductions
 - Open
 - Closed
- Hand Surgery
- Head and Neck Surgery
- Hemorrhoidectomy
- Hernia Repair
- Hyperbaric Medicine/Wound Care

- Hysterectomy
- Hysteroscopy
- Left Heart Catheterization
- Obstetrics/Gynecology – Major Surgery
- Vaginal Deliveries Number Per Year: _____
- C-Sections Number Per Year: _____
- VBAC Number Per Year: _____
- Ophthalmology Surgery
- Orthopedic – Major Surgery
- Spines
- No Spines
- Otorhinolaryngology – Major Surgery
- Including Elective Cosmetic Procedures
- Penile Implants
- Permanent Pacemaker
- Plastic – Major Surgery
- Robotic Surgery
- Roux-en-y (non-bariatric)
- Thoracic Surgery: _____% of Practice
- Tonsillectomy/Adenoidectomy
- Tubal Ligation
- Transgender Surgery
- Trauma Surgery
- Vascular Surgery: _____% of Practice
- Vasectomy

Other Procedures

- Abortions
- Angiography/Arteriography
- Breast Biopsy
- Chelation Therapy (for other than heavy metal poisoning)
- Echocardiography
- ECT (Shock Therapy)
- Fertility Treatment
- Hormonal Gender Conversion (other than genetic)

- Independent Medical Exams: _____% of Practice
- Lithotripsy
- Neonatology
- Percutaneous Vertebroplasty
- Prenatal Care
- Prolotherapy
- Weight Control: _____% of Practice
- Medications Prescribed (please list): _____

- ii. If none of the above procedures apply to your practice, please initial here: _____
- iii. Do you perform procedures that are outside the customary scope of practice within your specialty? Yes No
 If yes, please list procedures: _____

- iv. Do you perform any diagnostic or therapeutic procedures which have been introduced to the medical profession within the past two (2) years? Yes No
 If yes, please provide the name of the procedures in the space provided at the end of the application.

7. Information on Paramedical Employees

Any person licensed, certified, or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician is considered a Paramedical, including the following:*

- Anesthesiologist Assistant
- Certified Nurse Anesthetist (CRNA)
- Certified Nurse Practitioner (CNP)
- Cytotechnologist
- Emergency Medical Technician (EMT)
- Nurse Midwife
- Optometrist
- Perfusionist
- Physician Assistant (PA)
- Psychologist
- Surgical Assistant (SA)

- A. Do you supervise paramedical employees as defined above who are under your employ? Yes No
- B. Do you or any member of your group currently supervise paramedical employees as defined above who are not in your employ? Yes No

***Any paramedical desiring coverage must submit a paramedical application. A separate charge may apply. Coverage may not be available in all states.**

8. Hospital Affiliations and Privileges

A. Please list all hospitals where you have active privileges or a pending application.

Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ End Date: _____/_____/_____
	MONTH YEAR MONTH YEAR
Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ End Date: _____/_____/_____
	MONTH YEAR MONTH YEAR
Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ End Date: _____/_____/_____
	MONTH YEAR MONTH YEAR
Hospital Name: _____	Percentage of your patients admitted into this facility: _____%
Location: _____	Privileges: Active <input type="checkbox"/> Pending <input type="checkbox"/>
Department: _____	Start Date: _____/_____/_____ End Date: _____/_____/_____
	MONTH YEAR MONTH YEAR

B. Has any group or hospital suspended, restricted or refused your staff privileges, or have you ever voluntarily surrendered or limited your privileges? Yes No
If yes, please describe in the space provided at the end of the application.

9. Professional Liability Insurance and Claims History

A. List current and former professional liability information. (Please provide a minimum ten year history.)

Name of Insurance Company (current): _____

Practice/Employer: _____ Location: _____

Policy Type: Claims-Made Occurrence Policy Limits: _____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____

MONTH DAY YEAR

Did you purchase/receive a reporting endorsement (tail coverage)? Yes No

Name of Insurance Company: _____

Practice/Employer: _____ Location: _____

Policy Type: Claims-Made Occurrence Policy Limits: _____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____

MONTH DAY YEAR

Did you purchase/receive a reporting endorsement (tail coverage)? Yes No

Name of Insurance Company: _____

Practice/Employer: _____ Location: _____

Policy Type: Claims-Made Occurrence Policy Limits: _____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____

MONTH DAY YEAR

Did you purchase/receive a reporting endorsement (tail coverage)? Yes No

B. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes No
If yes, please describe in the space provided at the end of the application.

C. Have you ever been involved in a medical professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes No

- D. Other than the situations indicated in 9.C. above, are you aware of any of the following circumstances:
- i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes No
 - ii. A letter from an attorney regarding your treatment of a patient? Yes No
 - iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes No
 - iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes No
- E. Have all circumstances in question 9.D. above been reported to your current or prior professional liability carrier? Yes No N/A*
- If yes, how many? _____ Please attach documentation of all such reports.
- If no, please explain in space provided at the end of the application.
- *For purposes of this question, N/A means that you answered "No" to each subpart of question 9.D.

10. Personal History

If you answer yes to any of the following questions, provide complete details in the section at the end of the application or on a separate sheet.

- A. Has your license to practice medicine or your permit to prescribe drugs *ever* been denied, revoked, suspended, voluntarily suspended, or otherwise investigated or limited in any way? Yes No
- B. Have you *ever* appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes No
- C. Have you *ever* had a patient, patient's family member, or patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes No
- D. Have you *ever* been convicted of, pled guilty to, or pled no contest to, or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? Yes No
- E. Have you *ever* been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness, including but not limited to depression and/or chronic fatigue? Yes No
- F. Have you *ever* been accused of sexual misconduct of any kind? Yes No
- G. Do you have any physical handicap or chronic illness? Yes No
- H. Has membership in any professional association or society ever been revoked or refused? Yes No

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Purchasing Group Intent to Join

The undersigned insured hereby consents to join the Ascension Health Risk Purchasing Group Inc., a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant's Signature: _____ Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Physician's Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

- 1. Patient's Name:
2. Date Reported to Insurance Company:
3. Name of Insurance Company:
4. Name and Address of the Attorney Assigned to Your Case:
5. Date of Incident and Your Treatment:
6. Allegations:

7. What is the present condition of the patient?

8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

9. Status of claim (check applicable answer):

- Suit threatened, no action taken
Suit filed, but dropped by claimant
Summary Judgment in your favor
Suit settled Out-of-Court
Date claim paid:
Amount paid:

- Court outcome in your favor
Jury verdict
Directed verdict
Court outcome in favor of plaintiff
Jury verdict
Directed verdict
Amount of Loss:

- Awaiting mediation
Awaiting court action
Reserve Amount:

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? If yes, amount was: \$ Yes No

Name (Printed):

Signature: Date: