



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

	<u>Employed</u>	<u>Contracted</u>	<u>Carry their own Med Mal policy?</u>
Physicians Assistants	_____	_____	___ Yes ___ No
Nurse Practitioners	_____	_____	___ Yes ___ No
Surgical Technicians	_____	_____	___ Yes ___ No
CRNA's	_____	_____	___ Yes ___ No
Chiropractors	_____	_____	___ Yes ___ No
Nurse Practitioners	_____	_____	___ 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 **If NO, please attach explanation.**

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
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?  Yes  No   
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.  Yes  No

B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No

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 If YES, attach explanation including details of responsibilities. If this contract contains a hold harmless agreement then attach a copy of the contract language.

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:
- | <u>INSURANCE COMPANY</u> | <u>LIMITS OF LIABILITY</u> | <u>POLICY PERIOD</u> | <u>PREMIUM</u> | <u>RETRO DATE</u> |
|--------------------------|----------------------------|----------------------|----------------|-------------------|
|                          |                            |                      |                |                   |
|                          |                            |                      |                |                   |
|                          |                            |                      |                |                   |
|                          |                            |                      |                |                   |

\*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. Data of alleged error or occurrence, or contact date: \_\_\_\_\_
  4. Data 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**

\_\_\_\_\_  
Agent Name

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Agency Phone Number