**HOME OFFICE**

**26255 American Drive**
**Southfield, MI 48034-2438**

**( 800 ) 482-2726**

# MEDICAL PROFESSIONAL LIABILITY APPLICATION

## APPLICANT INSTRUCTIONS

**A. All questions must be answered completely. Please type or print clearly in ink.**
**B. The entire application including supplemental forms (if applicable) must be signed in ink and dated by the applicant.**
**C. Any yes responses, please provide explanation or additional information in the space provided at the end of the application.**

**Requested Policy Effective Date: _____**

## GENERAL INFORMATION

Applicant's Name: _____ ☐ M.D. ☐ D.O.
(First) (Middle) (Last) (Check One)

Mailing Address: _____
(Street) (City) (County) (State) (Zip)

Office Address: _____
(Street) (City) (County) (State) (Zip)

Phone Numbers: Office: ( ) - - Home: ( ) - Cell: ( ) -

Fax: ( ) - Date of birth: Social Security #: - - DEA license:

Specialty: _____ E-mail address: _____

Business manager or contact person: _____ Phone number: _____

## COVERAGE SELECTION

1. List previous insurance companies for the past ten (10) years:

| *Company* | *From* | *To* | *Type ** | *Limits* | *Retro Date *** | *Deductible* | *Premium* |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

2. Claims-Made coverage:

a. Do you want Prior Acts coverage? If so, please indicate the Retro Date: _____.

b. If prior acts coverage is not being requested, are you purchasing an Extended Reporting Period Endorsement (tail coverage)? ☐ YES ☐ NO

***If YES, please provide a copy of that tail coverage (endorsement).***

c. Requested Limits of Liability of:

☐ $100,000 Incident Limit Per Named Insured/$300,000 Aggregate Limit Per Named Insured
☐ $200,000 Incident Limit Per Named Insured /$600,000 Aggregate Limit Per Named Insured
☐ $300,000 Incident Limit Per Named Insured /$900,000 Annual Aggregate Per Named Insured
☐ Other (Claims-Made option only):

d. Deductible: ☐ None ☐ $5,000 ☐ $10,000 ☐ Other: _____ .

3. Are you currently a resident/fellow requesting coverage for moonlighting? ☐ YES ☐ NO

4. Are you applying for Part-time coverage? ☐ YES ☐ NO

***If YES, please complete the included Part-time Coverage Supplemental Application in its entirety.***

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## APPLICANT INFORMATION

1. Do you practice in any location other than what is indicated in the General Information section above? ☐ YES ☐ NO

2. Are you a U.S. Citizen? ☐ YES ☐ NO
*(If no, please indicate your status and date of entry into USA)*

3. Describe your medical education:

| Medical School | (Name & Country) | Degree | Dates From / To |
|---|---|---|---|
| | | | |

If graduated from a foreign school, are you ECFMG Certified? ☐ YES ☐ NO
*(If no, please explain using the space provided at the end of this Application)*

4. Internship (Hospital) Dates From/To

_____ _____

5. Residencies:

| | ***Hospital/Specialty*** | | ***Dates From /To*** |
|---|---|---|---|
| a. | | | to |
| b. | | | to |
| c. | | | to |

6. Board Certifications

| ***Board*** | ***Year Certified*** |
|---|---|
| | |
| | |

a. If you are not board certified, are you board eligible? ☐ YES ☐ NO
*(If no, please explain using the space provided at the end of this Application)*

b. Have you ever been denied board certification? ☐ YES ☐ NO

7. Hospital Staff Affiliations: Please list all hospitals or other patient care facilities at which you are currently a staff member.

| ***Facility Name*** | | ***City/State*** |
|---|---|---|
| | | |
| | | |

*(If you are a staff member at additional patient care facilities, please use space provided at the end of this Application)*

**Privileges:** Please describe.

Type/Extent: _____

Limitations/Restrictions: _____

8. Please provide the following information for any active medical licenses for any state other than the state shown in General Information on Page 1 of this application:

| ***State*** | ***License #*** | ***Expiration Date*** |
|---|---|---|
| | | |
| | | |

9. Answer the following:

| | | **YES** | **NO** |
|---|---|---|---|
| a. | To your knowledge, is your license to practice currently under investigation? | ☐ | ☐ |
| b. | Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine? | ☐ | ☐ |
| c. | Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or a mental disorder or mental illness? | ☐ | ☐ |
| d. | Have you ever been charged with or convicted of Driving Under the Influence? | ☐ | ☐ |
| e. | Have you been convicted of any criminal act by any state or federal authority? | ☐ | ☐ |
| f. | Has any physician or patient filed a complaint against you with a medical society, governmental agency or any other professional society? | ☐ | ☐ |
| g. | Have you ever had any state medical license or federal narcotic license revoked, suspended or voluntarily surrendered? | ☐ | ☐ |
| h. | Have you ever had your hospital staff or similar privileges refused, restricted, modified, suspended or voluntarily surrendered? | ☐ | ☐ |
| i. | Have you ever had your membership in a professional society refused, suspended, or revoked? | ☐ | ☐ |
| j. | Have you ever had your professional liability insurance refused, canceled, or non-renewed? | ☐ | ☐ |
| k. | Do you know of any incident, facts, circumstances, acts, errors or omissions which could reasonably be expected to result in a professional liability claim? | ☐ | ☐ |
| l. | Have you ever had a claim or been sued for medical malpractice? ***If yes, please complete the included Claims Supplemental Application for any pending, paid, and/or reported files resulting in death, for the last 10 years)*** | ☐ | ☐ |

## PRACTICE INFORMATION

1. List all locations where you have practiced in the last ten (10) years prior to the Application, with the current or most recent first. Please explain any lapses.

| ***Institution/Organization*** | ***City*** | ***State*** | ***Dates From/To*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

2. Please describe, and provide dates for any major changes in your practice in the last ten years, such as changes of special significant procedures initiated or no longer performed:

_____

_____

_____

3. a. Do you engage in any of the following activities–check all that apply *(Please note that some of these activities may not be covered; please refer to your agent if any of these apply)*:

☐ Utilization Review–Location: _____

☐ Medical Director/Advisor–Location: _____

☐ Legal Review (Expert Witness)–Location: _____

☐ Insurance Company Review–Location (other than mandatory 2nd opinions): _____

☐ Supervision of Residents, PA's, CNM, NP or Other Non Physician Providers: _____

☐ Independent Contractor–Name of Employer. _____

*(If you are involved in any of the above activities, please attach a narrative outlining your duties and responsibilities)*

b. Type of Practice–check box(es) that apply:

☐ Individual ☐ Individual Corporation ☐ Employee (non-shareholder)
☐ Partnership ☐ Multi-Person Corporation ☐ Independent Contractor
☐ Other–Describe:_____

(1) If you have an individual professional corporation, please state the name: _____

(2) If you practice in, or are employed by a corporation, partnership, or association, please state the formal business name of the enterprise: _____

(3) Complete the following information on ALL shareholders, partners, or associates:

| ***Name*** | ***Specialty*** | ***Insurance Carrier*** |
|---|---|---|
| | | |
| | | |
| | | |

(4) Do you want coverage for your Professional Organization? ☐ YES ☐ NO

If yes, what type of limits are you requesting? ☐ Sharing limits ☐ Separate limits

***If separate, please complete the Professional Organization Supplemental Application***.

c. Do you employ or retain any physicians? ☐ YES ☐ NO

If **YES**, complete the following for each:

| ***Name*** | ***Insurance Carrier*** | ***Independent Contractor*** | ***Salaried Employee*** |
|---|---|---|---|
| | | ☐ | ☐ |
| | | ☐ | ☐ |

d. Do you contract with residents, fellows or non-physician health care providers to render professional medical services, or offer internship or fellowship programs? ☐ YES ☐ NO
If **YES**, do you obtain Certificates of Insurance? ☐ YES ☐ NO
If **No,** are you requesting coverage for these non-physician health care providers? ☐ YES ☐ NO

e. Do you employ or contract with non-physician health care providers, such as physician assistants, nurse practitioners, etc.? ☐ YES ☐ NO

(If **YES**, list below Name(s) of Provider(s)/Title.)

Name/Title: _____ Name/Title: _____

Name/Title: _____ Name/Title: _____

If **Yes**, do you obtain certificates of insurance? ☐ YES ☐ NO

If **No,** are you requesting coverage for these non-physician health care providers? ☐ YES ☐ NO

4. Please answer the following questions:

a. Does your name appear together on the office stationery (letterhead, statements, or prescription blanks) with any other physician(s)? ☐ YES ☐NO

b. Do you share and/or commingle patients' files and charts with any other physician(s)? ☐ YES ☐NO

c. Do you share employees (other than clerical) with any physician(s)? ☐ YES ☐NO

d. Do you see any other physician's patients or cover for any other physician's practice? ☐ YES ☐NO

e. Do you and any other physician(s) hold yourselves out in some manner that the public would have reason to believe that you and any other physician(s) are associates or partners? ☐ YES ☐NO

5. Indicate your medical specialty:

_____ Percentage of practice %

_____ Percentage of practice %

Indicate your sub-specialties:

6. Do you perform surgery at any location other than the hospital(s) you listed where you have staff privileges? ☐YES ☐NO

***If YES, please explain.***

7. a. Please indicate below your best estimate of the **NUMBER** of the following procedures you expect to perform, or in which you will participate in, within the next year, beginning with the date of your requested coverage:

| | | | |
|---|---|---|---|
| _____ | Abortion – first trimester | _____ | Discograms |
| _____ | Abortion – after first trimester | _____ | Electromyography |
| _____ | Acupuncture | _____ | Endoscopy (other than proctoscopy or sigmoidoscopy) |
| _____ | "Alternative medicine" or "complementary medicine" procedures (as viewed by most physicians) Please describe: | | Please describe:_____ |
| _____ | Amniocentesis | _____ | Endoscopic Retrograde Cholangiopancreatomography-ERCP |

_____ Anesthesia
_____ General
_____ Spinal
_____ Epidural
_____ Other – Please describe: _____
_____ Angiography/Angioplasty
_____ Arteriography
_____ Assisting in major surgery – own patients
_____ Assisting in major surgery – other than own patients
_____ Bariatric procedures
_____ Breast implants and/or reduction
_____ Bronchoscopy
_____ Blepharoplasty
_____ Brachytherapy
Catheterization :
_____ Cardiac Right Heart
_____ Cardiac Left Heart
_____ Arterial
_____ Urinary
_____ Other – Please describe: _____
_____ Chelation therapy
_____ Cholangiogram
_____ Cholecystectomy
_____ Circumcision
_____ Colonoscopy
_____ Cryosurgery – Please describe: _____
_____ Cystoscopy
_____ D & Cs
_____ Deliveries: Vaginal
_____ Deliveries: Cesarean
_____ Deliveries: Vaginal after Cesarean (VBAC)
_____ Dermatological procedures
_____ Botox injection
_____ Chemical peels
_____ Chemabrasion
_____ MOHS surgery
_____ Dermabrasion
_____ Fat transfer
_____ Hair transplant
_____ Laser hair removal
_____ Laser skin resurfacing

Eyeliner pigmentation
_____ Fluoroscopy
_____ Fracture reductions – closed
_____ Fracture reductions – open
_____ Gastroscopy
_____ Hemorrhoidectomy:
Internal Hemorrhoidectomy
_____ External Hemorrhoidectomy
_____ Hysterectomy
_____ Intravenous Pyelogram (IVP)
_____ Laparoscopy- Please describe:
_____ Laser surgery – Other – Please describe:
_____ Liposuction
_____ Lumbar puncture
_____ Myelography
_____ Ophthalmology – Invasive procedures
_____ involving the eye
Pacemaker insertion
_____ Pain Management:
_____ Cordotomy
_____ Dorsal root gangliotomy
_____ Facet blocks
_____ Medication only
_____ Nerve root blocks
_____ Pump implantation
_____ Sphenopalatine lesioning
_____ Spinal injections
_____ Thoracic sympathectomy
_____ Trigeminal lesioning
_____ Penile implants
_____ Pre-natal care – Trimester: _____
_____ 1st Trimester 2nd Trimester 3rd Trimester
Prolotherapy
_____ Radial keratotomy (Lasik Surgery)
_____ Radiation oncology
_____ Sclerotherapy Surface veins Deep veins
_____ Shock therapy (ECT)
_____ Spinal surgery
_____ Temporomandibular joint surgery
_____ Thoracentesis
_____ Tonsillectomy
_____ Total joint replacement

| | |
|---|---|
| _____ Microdermabrasion | _____ Tubal ligations |
| _____ Silicone injection | _____ Vasectomy |
| _____ Tattoo removal | _____ Venography |
| | _____ Weight control by means other than diet or exercise - Please describe: _____ |
| | _____ **I DO NOT PERFORM OR EXPECT TO PERFORM ANY OF THESE PROCEDURES** |

b. Please indicate below the **PERCENTAGE** of your surgical practice, if any, that involves the following types of surgery:

| | |
|---|---|
| _____ % Abdominal | _____ % Neurosurgical |
| _____ % Bariatric | _____ % Obstetrical |
| _____ % Cardiac | _____ % Ophthalmological |
| _____ % Cardiovascular disease | _____ % Orthopedic – including spinal surgery |
| _____ % Colon/rectal | _____ % Orthopedic – without spinal surgery |
| _____ % Emergency Medicine | _____ % Plastic – cosmetic |
| _____ % Gastroenterology | _____ % Plastic – reconstructive |
| _____ % General | _____ % Thoracic |
| _____ % Gynecologic | _____ % Traumatic |
| _____ % Hand | _____ % Urologic |
| _____ % Head and Neck | _____ % Vascular |
| _____ % | _____ % Vascular – Peripheral |
| _____ % | _____ % |
| _____ % | _____ % |
| _____ % | _____ % |
| _____ % | _____ % |
| | _____ % |

8. Are there any procedures you perform that have not been covered by this Application? ☐ YES ☐ NO
*(If **YES**, please list the name of the procedure(s) and number of each performed annually )*

9. Are you currently treating or do you intend to treat any patient by means of an experimental, investigational or non-traditional drug or therapy? ☐ YES ☐ NO
***If YES, please attach a copy of the protocol and a copy of the patient consent form.***

10. Do you have a contract to treat or review treatment for jail or prison inmates? ☐ YES ☐ NO
***If coverage is currently provided by another carrier, please provide evidence of that other coverage.***

11. Do you have a contract to treat patients at nursing home facilities, other than you own patients? ☐ YES ☐ NO

12. Are you providing home health? ☐ YES ☐ NO

13. Do you work in an emergency room? ☐ YES ☐ NO
If **YES**, how many hours on average per week? _____
If **YES**, for what institution? _____
***If coverage is currently provided by another carrier, please provide evidence of that other coverage.***

14. If you are not a radiologist, do you take and/or interpret your own X-rays or perform other imaging procedures? ☐ YES ☐ NO
If **YES**, estimated number per year: _____
Does a radiologist over-read your X-rays? ☐ YES ☐ NO

15. Do you practice medicine in any internet or telemedicine program? ☐ YES ☐ NO

16. Does your practice have a website? ☐ YES ☐ NO
If **YES**, please provide the website address: _____

17. Please indicate your average number of patients seen per week: _____

18. Please indicate your average number of hours practiced per week: _____
(including on call, charting, teaching, phone consultations, etc. )

19. a. As a condition to maintaining your hospital affiliations, are you required to provide on-call services? ☐ YES ☐ NO
    b. Do any of your hospitals provide any medical professional liability insurance coverage to you for your on-call services? ☐ YES ☐ NO
    ***If YES, attach a Certificate of Insurance.***

20. a. Are you (1) a partner, shareholder, owner, proprietor, superintendent, administrative or executive officer, or medical director of any hospital, sanitarium, clinic with bed and board facilities, skilled nursing facility, convalescent hospital, surgical center, laboratory, health maintenance organization, preferred provider organization, or similar health care provider, or (2) a member of a peer review or other committee of any of the entities or organizations named in clause (1)? ☐ YES ☐ NO
    b. Are you an owner or do you have ownership interest in a blood bank, laboratory, or hemodialysis unit? ☐ YES ☐ NO
    (If **YES** to a. or b. above, complete the following:)
    i. Name and address of the facility: _____
    ii. Designate the exact capacity in which you serve (e.g. owner in whole or part, executive officer, administrator. departmental or ancillary service supervisor, physician with teaching responsibilities): _____
    iii. Do you have coverage for this practice? ☐ YES ☐ NO
    If **YES**, what is the name of your insurance carrier? _____
    iv. Number of hours per week in this capacity? _____

21. Are you involved in the design or manufacture of any "medical device" that is sold or used by physicians in connection with medical practice? ☐ YES ☐ NO
(*If **YES**, describe device and extent of its use.)*

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## DOCUMENTS TO ATTACH:

☐ Copy of board certification
☐ Curriculum vitae (CV)
☐ Current loss runs from previous carrier(s)
☐ Copy of letterhead

- ☐ Copy of current owner declarations, if applicable.
- ☐ Procedure Supplemental Application, if applicable
- ☐ Professional Organization Application , if applicable

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## ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer, _____, both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to: **Star Insurance Company, 26255 American Drive, Southfield, MI 48034-6112.**

Initial Here: _____

## DUTIES AND OBLIGATIONS OF APPLICANT

***Please Read Carefully***

In making this Application, the Applicant agrees the Company may, and is intended to, rely on the truth, completeness, and current accuracy of the facts and information submitted in this Application in determining whether to insure or renew the insurance of the Applicant, and, if so, at what premium rate and on what other terms and conditions. The Applicant further represents to the Company that the facts and information submitted in this Application and attachments were carefully compiled by the Applicant, or under the Applicant's supervision, and that they are true, complete, and current as of the date submitted.

The execution and submission of this Application shall not bind the Company or its agents to the issuance of insurance, nor shall it bind the Applicant to the acceptance of a policy. However, in the event a policy is issued by the Company and accepted by the Applicant, all of the representations in this Application shall be binding upon the Applicant.

The Company reserves the right to amend the terms, conditions and limitations of any policy issued as a result of this Application, if subsequent to the date of this Application, but prior to the inception date of such policy, there are any alterations to the information contained herein. In the event of such alteration, the Applicant agrees to provide immediate written notice to the Company and such notice shall attach to and form a part of this Application.

## APPLICANT'S REPRESENTATIONS, WARRANTIES AND AUTHORIZATION

I understand that, if granted prior acts coverage or retroactive coverage on my professional liability policy, such coverage will apply only to liability arising out of an occurrence which happened prior to the effective date of the policy and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

1. any claim which has been reported to another insurance carrier prior to the effective date;
2. any claim known to the insured at the effective date which has not been reported to a prior carrier;
3. any claim that may arise out of an incident which has not been reported to another insurance carrier prior to the effective date; or
4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.

I specifically represent and warrant to the insurer that the information provided in this Application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this Application or that might be material to the acceptance of the risks described to the underwriter in this Application. I understand and acknowledge that this completed Application shall be considered an integral part of any insurance policy issued to me by the insurer. I further agree that any false or misleading statement(s) in this Application shall be grounds for the insurer to cancel and void coverage at its sole and absolute discretion.

*Signature of Individual Applicant* Date

*Signature of Agent* Date

## AUTHORIZATION FOR RELEASE

I authorize all former liability insurers to furnish Star Insurance Company with all available information concerning my prior underwriting and claims history. I agree that the release of such information, even if erroneous or partial, shall not result in liability to the insurers.

*Signature of Individual Applicant* Date

*Please print name here*

## SPACE FOR ADDITIONAL INFORMATION

***Question #***

# RISK MANAGEMENT SUPPLEMENTAL APPLICATION

Name of Applicant:

1. Indicate if the patient care records obtained in your office reflect the following:
   a. Any weekly/monthly/quarterly systems to monitor legibility of chart? ☐ Yes ☐ No
   b. Documentation of HIPAA review with patient? ☐ Yes ☐ No
   c. Do you obtain signed patient consent forms for any invasive procedures done in your office? ☐ Yes ☐ No
   d. Documentation of offering preventative options for age specific patients? ☐ Yes ☐ No
   e. Do you have special sheets for the monitoring of chronic conditions? ☐ Yes ☐ No
   f. Lab reports with physician initials indicating a review prior to filing the medical record? ☐ Yes ☐ No
   g. Patient records dictated and transcribed? ☐ Yes ☐ No
      If YES, do you review for accuracy and initial? ☐ Yes ☐ No
   h. Do you obtain signed patient consent forms for all surgical procedures? ☐ Yes ☐ No

2. a. Do you have a consistent system to demonstrate timely sharing of results with patients and documented plan for further follow through?

   ☐ Yes ☐ No

2. b. Do you have a system for the follow through when dealing with critical lab values? ☐ Yes ☐ No

2. c. Do you have a tracking system to monitor maintenance of labs/tests sent out?

   ☐ Yes ☐ No

3. a. How are patients notified with routine labs/tests?

   ☐ Telephone ☐ Letter ☐ Office Visit

3. b. How are patients notified with critical labs/tests?

   ☐ Telephone ☐ Letter ☐ Office Visit

4. Are medical records retained and retrievable as required by the statute of limitations in your state?

   ☐ Yes ☐ No

5. Are you involved in any investigation or research studies in your office that are not part of an approved hospital project? ☐ Yes ☐ No

   If **YES**, please provide details on a separate page.

6. a. Do you have written policies and procedures to help with consistency of practice?

   ☐ Yes ☐ No

6. b. If "Yes" to 6.a., do you have quality monitoring to ensure employees are working within their scope of practice?

   ☐ Yes ☐ No

7. a. Do you dispense any prescription medications (not including free samples) from your office? ☐ Yes ☐ No

   b. If **YES**, are patients provided an option to purchase prescriptions from your office or an outside pharmacy? ☐ Yes ☐ No

8. a. Is there a written job description for all professional employees in your office?

   ☐ Yes ☐ No

8. b. Do you conduct background checks for new employees? ☐ Yes ☐ No

9. a. Are staff credentials reviewed regularly according to the job description and responsibilities?

   ☐ Yes ☐ No

9. b. Do you conduct yearly evaluations?

   ☐ Yes ☐ No

| | |
|---|---|
| 10. Does your receptionist forward all clinical questions from patients to you or to the nurse(s)?<br>☐ Yes ☐ No | 11. Do you document in the medical record all telephone contacts with patients, including time and dates?<br>☐ Yes ☐ No |
| 12. Do you have an answering service, if applicable, and the on-call physicians?<br>☐ Yes ☐ No | 13. Do the physicians in your group take calls for only those in your practice or specialty?<br>☐ Yes ☐ No |

14. Do the physicians that rotate the on-call schedule with you follow the same procedure of documenting in the medical record (e.g., telephone contact, advice, treatment and follow-up plan)?

☐ Yes ☐ No

15. a. Do all physicians that accept on-call service for your patients have access to your patients' medical records? ☐ Yes ☐ No

b. Do you have an EMR system? ☐ Yes ☐ No If **YES**, do the physicians have access to records when away from the office? ☐ Yes ☐ No

c. Are the physicians taking charts out of the office, such as to other locations, hospital, home, etc.?

☐ Yes ☐ No

16. a. Do you have access to patient medical records when you are on-call for other physicians?

☐ Access at all times ☐ Access during office hours only ☐ No access

16. b. If **YES**, do you have access to these records when away from the office?

17. a. Do you have contractual relationships such as HMO, PPO, IPA, etc? ☐ Yes ☐ No

b. If **YES**, do any of the contracts listed above contain indemnity or "hold harmless" clauses?

☐ Yes ☐ No

c. If **YES**, have these contracts been reviewed by your business attorney for undue personal and professional exposure? ☐ Yes ☐ No

d. If a contract exists, do you know the procedure to terminate a patient relationship?

☐ Yes ☐ No

18. a. Do you contract with any firms to provide you with on-site risk management services? If **YES**, please attach a copy of the Risk Management evaluation. ☐ Yes ☐ No

b. Do you have any monitoring or audit review for billing? ☐ Yes ☐ No

19. Have you participated in risk management seminars during the last 12 months? If **YES**, please attach a copy of your certificate of completion. ☐ Yes ☐ No

20. Do you have a process for incident reporting and monitoring of events reported? ☐ Yes ☐ No

I declare that the information submitted herein is true and accurate. I understand that it becomes a part of my Professional Liability Application.

_____ _____

*Signature of Applicant* *Date*

_____ _____

*Signature of Agent* *Date*

# CLAIMS INFORMATION SUPPLEMENTAL APPLICATION

NOTE: A separate form must be completed for each claim or suit reported.

Name of Applicant:

| 1. Name: | Age | Sex of patient: | 2. Date of first consultation: |
|---|---|---|---|

3. Physical condition and diagnosis at the first consultation date above: (Please Explain)

4. Brief description of treatment leading to allegation, including dates of treatment given and nature of same (Explain):

5. Allegations made against you (Explain):

| 6. Date of Incident: | 7. Date you received notice of claim: |
|---|---|

8. Subsequent condition or health of patient:

9. Current status of claim:

☐ **OPEN** ☐ **CLOSED** Date:_____

Lawsuit filed? ☐ Yes ☐ No ☐ Dismissed ☐ Judgment ☐ Settled

Amount of claimant's demand: $ _____ Total amount paid on claim: $ _____

**Amount paid on your behalf: $ _____**

| 10. Did you report this claim:<br>☐ Yes ☐ No | 11. If yes, what insurance company was involved: |
|---|---|

12. Name(s) of other defendants:

13. To whom may we refer for further information about this claim:

I declare that the information submitted herein is true and accurate. I understand that it becomes a part of my Professional Liability Application.

_____ _____

*Signature of Applicant* *Date*

_____ _____

*Signature of Agent* *Date*

## PART-TIME COVERAGE SUPPLEMENTAL APPLICATION

Name of Applicant: I am requesting part-time coverage effective:

Please describe your practice and circumstances that qualify you for part-time coverage consideration:

| *EMPLOYER AND/OR HOSPITAL-ADDRESS* | *# HRS. PER WEEK* | *SPECIALTY* |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**SUMMARY OF ALL OTHER MEDICAL PRACTICE OR EMPLOYMENT**

I also work at, but request NO coverage for the following locations:

| *EMPLOYER AND/OR HOSPITAL-ADDRESS* | *# HRS. PER WEEK* | *SPECIALTY* |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

I declare that the information submitted herein is true and accurate. I understand that it becomes a part of my Professional Liability application.

*Signature of Applicant* *Date*

*Signature of Agent* *Date*