



Florida Doctors Insurance Company
Short-Form Application for Physicians and Surgeons
To be submitted with completed Approved Application from another carrier

1. The following information is intended to update the attached _____ application that I completed
 (carrier name)
 on ____ / ____ / _____, and which is considered to be a part of this request for new coverage.

2. Name: _____ MD DO _____
 First Middle Last License Number

3. Effective Date Requested _____ Desired Retroactive Date _____ Policy Limits _____

Indicate reason for termination of latest policy: _____

4. Primary Practice Address (This will be used as your mailing address unless otherwise specified)

Number Street City State Zip % of Practice time at this location

Telephone # Fax # E-Mail Address

5. List additional practice locations including all offices, nursing homes, urgent care clinics, surgery centers and any other non-hospital locations. Please identify additional location (i.e., additional private practice office, nursing home, clinic, etc.) and show % of total practice.

6. List all other practitioners (i.e., physicians, nurse practitioners, physician assistants, chiropractors, etc.) with whom you are associated and describe the association.

7. I do not want coverage under this policy for the part of my medical practice listed below (include proof of existing coverage)

8. Are you Board Certified? Name of Board _____ Date Certified _____ N/A _____

9. Medical specialty currently practiced _____ Sub-specialty _____

List any unusual procedures that you perform within or outside of your specialty: _____

10. Please indicate your average weekly patient load _____ and total weekly practice hours _____

11. Do you: (Explain all "Yes" answers in the Remarks Section)

- a. Treat patients that are admitted to nursing homes by other physicians? YES NO
- b. Provide direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital? YES NO
- c. Perform terminations of pregnancy? YES NO
- d. Treat or intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? YES NO
- e. Treat patients for weight reduction or control, other than prescribing exercise? YES NO

If you have performed Bariatric Procedures in the past and are no longer performing these procedures, please provide the date in which you stopped performing these procedures. _____

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information and completed Approved Application constitutes my application for insurance with Florida Doctors Insurance Company (FLDIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FLDIC in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by FLDIC and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by FLDIC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Resource Network, individuals and FLDIC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by FLDIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FLDIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FLDIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FLDIC.

Date

Signature of Applicant MD/DO

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or FLDIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

Fraud Statement
Section 817.234(1)(b), Florida Statutes
(if applicable)

The statute requires the statement to contain in substance the following language:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Insurance coverage is subject to underwriting review and approval and premium payment. No coverage exists until an initial premium deposit is received and a Binder or Coverage Summary Page, together with any applicable endorsements, has been issued by FLDIC to the policyholder.

FLORIDA DOCTORS INSURANCE COMPANY
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Jacksonville, Florida 32256
FAX: 904-296-1013
Phone: 800-FLA-DOCS

www.FLDIC.com

INCIDENT/CLAIM INFORMATION

All incidents/claims reported to current and prior carriers should be reported on this form (including incidents/claims which occurred during residency).

1. Name of patient: _____ 2. Age: _____

3. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____

4. Details of allegation(s): _____

5. Date of incident: _____ 6. Report date: _____

7. Insurance carrier: _____

8. Name of your defense attorney: _____

9. Other defendants: _____

10. Present status of claim (check applicable answer and fill in amounts where needed)

Precautionary/Incident report only
Reserve Amount \$ _____

Out of court settlement:
Date Paid _____ Amount Paid \$ _____
mm/dd/yy

Suit threatened, no action taken
Reserve Amount \$ _____

Dropped by claimant
Summary judgment in your favor
Court trial in your favor

Court settlement:
Date Paid _____ Amount Paid \$ _____
mm/dd/yy

11. Location of incident: _____

12. Condition and diagnosis at time of incident: _____

13. Dates and description of treatment rendered: _____

14. Condition of patient subsequent to treatment (and DATES OF FOLLOW-UP TREATMENT) _____

15. Was the corporation sued: YES NO

If Pending, Reserve Amount \$ _____

Was payment made on its behalf? YES NO If Yes, amount paid \$ _____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed: _____ Date Signed: _____
