



Submitted by: _____ (Agency)

General Information – All Applicants must complete questions 1 - 23

1. Name: _____
 First Middle Last Professional Designation
2. Practice Address: _____
 Street City State Zip
3. Practice County: _____
4. Additional Practice Locations? YES NO
 NOTE: If YES, list each separate address, including county, on attachment
5. Date of Birth: ____ / ____ / ____
6. Preferred Mailing Address: Same or _____
 Street City State Zip
7. Preferred Billing Address: Same or _____
 Street City State Zip

Policy Information (Occurrence Policy)

8. Requested Effective Date: ____ / ____ / ____ To: July 1, 20____
 NOTE: All effective dates are subject to underwriting approval.
9. Limits Requested: 250,000 / 750,000 Maximum
 100,000 / 300,000 Minimum

10. Requested Payment Plan: Advance Installments (not available for a policy period of less than 6 months)

License, Training & Current Practice Information

11. Florida License Number: _____
 NOTE: Attach a copy of your Florida License
12. Other State License Number(s): _____
 Do you currently practice in any of these states? YES NO
 NOTE: If YES, attach narrative explaining this practice and scope of duties performed.

13. Hospitals where you currently hold privileges:

Hospital	City/County	Type of Privileges	% of Practice

14. What is your medical or surgical specialty? _____
- Do you have a sub-specialty? YES NO If YES: _____
- Do you limit your practice to the above specialty and/or subspecialty? YES NO Explain: _____
- Do you practice full time? YES NO NOTE: If NO, complete and attach Limited Practice Supplement.



15. In the last ten (10) years,
 (a) Have you discontinued major surgical procedures? (*Explain on separate sheet*) YES NO
 (b) Has anything changed in your practice? (*Explain on separate sheet*) YES NO
16. Are you American Board Certified? YES NO Name of Board: _____
17. Do you work in an emergency room or intensive care unit? YES NO If YES, how many hours per week? _____
 Hospital Privileges only? YES NO
18. List Medical School training locations:

	College/ Hospital	State/Country	Year Completed
Medical School			
Residency			

19. Please check the box that best describes your practice affiliation(s):

- Independent Contractor
- Employee Name of Employer: _____
- Individual Professional Association or Corporation Legal Name of Association _____
or Corporation

20. Are you applying for Partnership/Corporation/Association coverage? YES NO

Note: If YES, please complete and attach Partnership/Corporation/Association Professional Liability Application.

Employee Information

21. a. As an individual, I have NO employees or contractors
- b. As an individual, I HAVE employees and/or contractors (Complete 21c)
- c. An employee additional charge applies to all individual health care providers in all classifications employing the following:

Exceptions: No charge for

Independent contractors

Employees of your corporation or professional association

	# Employed	# Contracted
1. Physician, Surgeon, Dentist, Chiropractor or Podiatrist	_____	_____
2. Certified Nurse Midwife / Licensed Midwife	_____	_____
3. Nurse Practitioner	_____	_____
4. Assistant – Physician/Surgeon	_____	_____
5. Nurse Anesthetists	_____	_____
6. Radium Technicians	_____	_____
including diagnostic x-ray, lab or pathological	_____	_____
7. Radiation Therapy Technicians	_____	_____
8. Physical Therapist	_____	_____

If you have selected any employees from the list at left you must complete their practice information on page 3.



Employee Practice Information *Attach additional sheet if needed*

Names of Employed Physicians, Surgeons, Dentists,
Chiropractors or Podiatrists

Specialty/Invasive Procedures
(See page 4)

No Surgery Minor Major

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Names of Employed Nurse Midwives

Number of births (previous 12 month period)

Names of Employed Nurse Practitioners, Nurse
Anesthetists

Specialty

Names of employed Physician/Surgeon Assistants,
Radium/ Radiation Techs or Physical Therapists

Specialty



Physicians and Surgeons

Select from the following any surgical procedures you perform:

- NONE
- Minor Surgery OTHER THAN incision of boils and superficial abscesses or suturing of skin and superficial fascia
- Assisting in major surgery on YOUR OWN patients
- Assisting in major surgery OTHER THAN your own patients
- Major Surgery
- Normal Obstetrical procedures NOT considered to be major surgery
- Plastic Surgery – reconstructive
- Plastic Surgery – cosmetic

Select from the following any techniques or procedures you perform:

- NONE
- Acupuncture (other than acupuncture anesthesia)
- Angiography, or
Arteriography, or
Catheterization – arterial, cardiac or diagnostic
Exceptions:
 1. *The occasional emergency insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers.*
 2. *Urethral catheterization*
 3. *Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.*
- Discograms
- Myelography
- Pneumoencephalography
- Lymphangiography
- Phlebography
- Colonoscopy
- Endoscopic Retrograde Cholangiopancreatography
- Pneumatic or mechanical esophageal dilation
Exceptions:
 1. *Bougie*
 2. *Olive*
- Laparoscopy (Peritoneoscopy)
- Radiation Therapy
- Lasers – Used in therapy
- Shock Therapy
- Needle Biopsy – Including lung and prostate
Exceptions:
 1. *liver*
 2. *kidney*
 3. *bone marrow*
- Radiopaque Dye Injections: into blood vessels, lymphatics, sinus tracts or fistulae
Exceptions:
Does not apply to Radiologists
- See patients during the first and second trimester of pregnancy
- See patients during the third trimester of pregnancy

PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOUR PRACTICE: (attach explanation)

- Telemedicine / Teleradiology
- Spa Services i.e. Cosmetic fillers, peels (superficial, medium, deep), tattoo removal
- Pain Management (noninvasive non-drug techniques? noninvasive pharmacologic techniques? invasive techniques?)



Dentists

Specify Practice:

- General Dentistry Oral Surgery Other

Select from the following any techniques or procedures you perform:

- NONE
Dental Implants How many per year?
Removal of bone impacted wisdom teeth How many per year?
Removal of tissue impacted wisdom teeth How many per year?
Perform operative dentistry on patients rendered unconscious...
Perform general dentistry on patients under the influence of an intravenous or intramuscular sedation...
Cosmetic procedures or spa services i.e. botox, dermal fillers etc. (please specify)
X-Ray Therapy
OTHER (please specify)

Nurses, Midwives

Select from the following:

- Licensed Practical Nurse
Registered Nurse
Advanced Registered Nurse Practitioner
Certified Registered Nurse Anesthetist
Directly supervised by an Anesthesiologist? YES NO
Licensed Midwife *Number of births? If none, explain:
Certified Nurse Midwife *Number of births? If none, explain:
*Report # of births for 12 month period prior to application date on page 7 (# of births as reported to FL Dept of Health, Office of Vital Statistics).

Physician or Surgeon Assistant

Specify Practice:

Chiropractors

Do you perform acupuncture? YES NO
If YES explain:

Podiatrist / Chiropodist

Specify Practice:
Do you perform surgery? YES NO

Physical Therapist and Assistants

Specify Practice:

Naturopaths

YES



Probations, Suspensions & Revocations

22. Within the past ten (10) years:
- a. Have you ever been placed on probation by any licensing board? YES NO
 - b. Has your license to practice or your permit to prescribe drugs ever been suspended in any state? YES NO
 - c. Has your license to practice or your permit to prescribe drugs ever been revoked in any state? YES NO
 - d. Has any hospital restricted or suspended your privileges? YES NO
 - e. Has any hospital revoked your privileges? YES NO

NOTE: *If yes, attach documents related to the above actions.*

Claims Information

23. Within the past ten (10) years:
Has any claim or suit for alleged malpractice been brought against you? YES NO

NOTE: *IF YES, YOU MUST COMPLETE the Claims Information. "SEE ATTACHED" is unacceptable.*

Provide the following information for each claim or suit brought against you within the past TEN years.

Incident Date	Insurance Carrier Name	Plaintiff Name	Status of Suit or Claim		Amount of Indemnity Loss or Reserve
			Open	Closed	

IMPORTANT

I authorize the release and exchange of information involving, but not limited to, claim matters between my professional society or association, previous insurance carrier, hospital or clinic and the Florida Medical Malpractice Joint Underwriting Association.

I understand and agree that any policy, binder or other agreement for the insurance herein applied for will be subject to the following provisions:

Assessable Policy Provision

This policy has been issued by the company under the temporary joint underwriting plan established by The Medical Malpractice Reform Act of 1975 (Chapter 75-9, Laws 1975) and is subject to the provisions of the Act. The Act provides, and the named insured agrees, that in the event an underwriting deficit exists at the end of any year the joint underwriting plan is in effect, the named insured shall pay to the company a premium contingency assessment not to exceed one third of the annual policy premium payment paid by the named insured to the company. The named insured further agrees that any assessment shall be made at the direction of the Board of Governors of the company. The act further provides that the company shall cancel the policy of any policyholder who fails to pay the premium contingency assessment.

Participating Policy Provision

The named insured shall participate in the earnings of the company, to such extent and upon such conditions as shall be determined by the Board of Governors of the company in accordance with law and as made applicable to this policy, provided the named insured shall have complied with all the terms of this policy with respect to the payment premium.

Application Fraud Provision

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

The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

Binding Authority Provision

An authorized agent may immediately bind coverage on behalf of the Florida Medical Malpractice Joint Underwriting Association, but only upon the agent's receipt of both: 1) a fully completed application and 2) the appropriate premium payment.

Signature of Applicant

Professional Designation

Date of Signature

IMPORTANT: This application must be signed by both the applicant and the producer

Signature of Producer

2-20 or 9-20 License #

Date of Signature

Name of Agency/ Independent Agent

Phone #

Fax#

Agency Tax ID #

E-Mail:

Agency Mailing Address

City

State

Zip

Assigned Servicing Carrier: The Medical Protective Company