

Section II - Insurance Coverage Information

10. Limits of Liability requested (check one)

- \$250,000/\$750,000
- \$500,000/\$1,500,000
- \$1,000,000/\$3,000,000

11. Prior acts coverage requested? Yes No

(A copy of your current policy's declaration page must be attached)

12. Requested effective date _____

Requested retroactive date _____

If you currently have a claims made policy and have not requested prior acts, please explain why:

Section III – Insurance Information – Current and Previous

13. Name of present insurance carrier: _____

Expiration date: _____

14. List all carriers that have previously provided insurance to you **during the last 10 years:**

Company Name	Date first insured	Last date insured	Retro Date

Section IV - Medical Education and Training

15. Area of Specialty (please list all that apply with percent of practice for each specialty listed): _____

16. Does your practice include (circle all that apply): Surgery? Minor Surgery? No Surgery?

17. Are you board certified? yes no. If no, please explain. _____

Please list all board certifications: _____

18. Have you ever been denied Board certification? Yes (provide details on lines below) No

Details regarding denial of Board Certification *(if you answered "yes" above)* _____

19. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation date Mo./Yr. completed
If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, date certified:		If no, please explain:	

20. All internship/residency training undertaken and dates, whether completed or not:

Institution/ City/State/Country	Specialty	Mo/Yr Completed
Internship:		
Served residency at:		
Served fellowship at:		

Section V - Scope and Nature of Practice or Employment

21. List all locations where you have practiced since formal training. Please explain any period(s) of inactivity. Attach explanatory sheet if necessary.

Location (city and state)	Dates From/To

22. List all locations where you now work or expect to work. (Mail will be sent to address #1 below unless otherwise indicated)

Employer/Facility Name	Street	City	County	State	Zip	Phone
#1						
#2						
#3						

23. Please indicate (if applicable) total hours worked per week at each office location for the following activities:

		Location #1	Location #2	Location #3
		Hours per week	Hours per week	Hours per week
A	Actual patient care, including record keeping and hospital rounds			
B	Administrative duties			
C	Surgeries and assists			
D	House calls and nursing home visits			
E	Utilization review			
F	Teaching			

24. If total hours are reduced, please check reason:

- semi-retired
 disability
 pregnancy
 dependent care
 majority of practice insured elsewhere
 other _____

25. List all facilities and hospitals where you have staff or courtesy privileges.

Facility Name and Location	Department	Type of Privileges	Dates From/To

26. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of major surgery:

	% of Practice		% of Practice
Abdominal		Ophthalmological	
Bariatric		Orthopedic – including spinal surgery	
Cardiac		Orthopedic – without spinal surgery	
Colon/Rectal		Pediatric - Surgical	
General		Plastic – Cosmetic	
Gynecologic		Plastic – Reconstructive	
Hand		Thoracic	
Head and neck		Traumatic	
Neurosurgical		Urologic	
Obstetrical		Vascular	

27. Please indicate below your best estimate of the **number** of the following procedures you expect to perform, or in which you will participate, in the next 12 months, beginning with the date of your requested coverage (use additional sheet for description).

Procedure	# of Procedures	Procedure	# of Procedures
Abortion – first trimester		Hemorrhoidectomy:	
<i>Hospital</i>		<i>Internal</i>	
<i>Clinic</i>		<i>External</i>	
<i>Office</i>		Herniorrhaphy	
Abortion – after first trimester		Laparoscopy	
<i>Hospital</i>		<i>Diagnostic (please describe)</i>	
<i>Clinic</i>			
<i>Office</i>		<i>Surgical (please describe)</i>	
Acupuncture			
Adenoidectomy		Laser Surgery	
“Alternative medicine” or “complementary medicine (as viewed by most physicians) Please describe:		<i>Indicate what type of surgery:</i>	
Anesthesia – obstetrical		Lasik Surgery	
<i>General</i>		Liposuction	
<i>Spinal</i>		Liposuction, Tumescant	
<i>Epidural</i>		Lumbar puncture	
Anesthesia – non-obstetrical		Manipulation therapy	
<i>General</i>		Myelography	
<i>Other (please describe)</i>		Needle aspirations	
Angiography		Needle biopsy	
Angioplasty		Pacemaker insertion	
Arteriography		Pre-natal care	
Assisting in major surgery – own patients		Radial keratotomy	
Assisting in major surgery – other than own patients		Radiation	
Baker’s Chemical Peel		<i>Diagnostic</i>	
Breast implants		<i>Therapeutic</i>	
Breast reduction		Scalp Reductions	
Catheterizations		Sclerotherapy, peripheral	
<i>Cardiac</i>		Sclerotherapy, deep vein	
<i>Arterial</i>		Shock therapy	
<i>Swan-Ganz</i>		Spinal surgery	
<i>Other – Please describe:</i>		Tattoo removal	
Chelation therapy		Thoracentesis	
Chemabrasion		Tonsillectomy	
Chemical peel		Total joint replacements	
Chemotherapy		Tubal ligations	
Colonoscopy		Vasectomy	
Cosmetic implantation or injection of silicone or other materials – <i>Please describe:</i>		Venography	
Cosmetic: office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts – <i>please indicate type of surgery:</i>		Weight control by means other than diet or exercise – <i>please describe:</i>	

Procedures (continued)	# of Procedures	Any other procedure you reasonably believe will be of interest to a medical professional liability insurer (<i>complete boxes below</i>)	# of Procedures
Deliveries – include estimated number done annually			
<i>Cesarean deliveries</i>			
<i>Vaginal after cesarean</i>			
D & Cs			
Discograms			
Electromyography			
Endoscopy (other than proctoscopy or sigmoidoscopy) <i>Please describe:</i>			
Experimental or investigative procedures (please attach protocol used and state whether or not you follow FDA guidelines in administering this)			
Eyeliners Pigmentation			
Fracture Reductions - closed			
Fracture Reductions - open			
Hair transplants, or other hair growing or replacement techniques			
I DO NONE of THESE PROCEDURES			

28. Are you employed by someone else? Yes No If YES, please answer the following:

a. Name of employer _____

b. Name of employer's professional liability insurer _____

29. Do you share office space with someone else? Yes No
 IF YES, please list name of individual(s), with which you share office space _____

IF YES, do you share employees? Yes No

IF YES, do you see each other's patients? Yes No

30. Please indicate the number of people you employ or who practice with you by the following categories:

Lab or X-Ray technicians		Nurse practitioners*	
Medical assistants		Physicians or surgeons**	
Nurses		Physician assistants*	
Nurse anesthetists*		Surgical assistants*	
Nurse midwives*		Other (Please specify)	

* a Non-Physician Health Care Provider Application must be completed for each person in this category.

** a Physician/Surgeon Application must be completed for each person in this category.

Please provide a full listing (name and degree) of all personnel indicated by * or **.

31. Do you have a position for which no coverage is required, or for which you are insured with another carrier? Yes No
 (if YES, indicate activity, entity and location to be excluded and indicate hours worked at this position only)
-
-
-

Section VI – Practice and Procedures – General Questions

32. Do you perform surgery in your office? Yes No

If yes, please list the specific procedures: _____

- Is general anesthesia administered for these (or any) office procedures? Yes No

If yes, by whom _____ and with what training? _____

What specific emergency equipment do you have available? _____

How far is this location from the nearest hospital with emergency services? _____

33. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office? Yes No

34. Do you work in an emergency room? Yes No

If yes, how many hours on average per week _____ and for what institution? _____

If coverage is to be provided by a carrier other than *Healthcare Underwriters Group*, please provide evidence of other coverage.

35. Do you perform cosmetic plastic surgery? Yes No

If YES, please list on a separate sheet all of the procedures you perform. Also, please attach a copy of all advertising materials related to your cosmetic plastic surgery. **Information attached?** Yes No

36. Do you perform invasive pain management procedures? Yes No

If yes, please list the procedures you perform and indicate if each is done in a hospital or an office.

37. Do you provide any services over the internet or through a telemedicine program? Yes No

38. Do you use a collection agency? Yes No
If yes, does the collection agency have authority to file collection suits at its discretion? Yes No

Section VII – Professional History

39. Are you in military service or employed full-time by the federal government? Yes No

40. Do you work for a correctional facility (jail)? Yes No

41. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked? Yes No

42. A. Has any state ever refused you a license to practice medicine? Yes No
 B. Has any state ever restricted, suspended or revoked your license to practice medicine? Yes No
 C. Have you ever voluntarily surrendered a license to practice medicine? Yes No
 D. Has any state ever placed you on probation or restricted your practice? Yes No
 E. To your knowledge, is your license to practice currently under investigation? Yes No
43. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? Yes No
44. 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? Yes No
45. Are you currently or have you ever been treated for a psychiatric condition, alcoholism or substance abuse? Yes No
46. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? Yes No
47. Has your professional liability coverage ever been cancelled, restricted, non renewed, or have you withdrawn an application for insurance to avoid declination? Yes No
48. Has coverage for professional liability ever been refused or accepted under special terms? Yes No
49. Has a complaint against you ever been submitted to any State Licensure Board or are you currently under investigation by any regulatory authority? Yes No

If you answered yes to any of questions 39 through 49, please explain on a separate sheet, and provide full documentation from any agency involved.

Section VIII - Claims

50. Have you ever had a claim or other action based on any alleged professional negligence brought against you, or have you been accused of professional negligence? Yes No
If yes, how many? _____
 If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage? Yes No
51. Do you have knowledge of any claims, potential claims, circumstances that could possibly result in claims, or suits in which you may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim? Yes No
If yes, how many _____?
 If yes, has this incident (these incidents) been reported to a prior insurer? Yes No

Please provide completed details for each incident/claims on the Supplemental Claims Information Form and attach to this application for both questions 50 and 51. The name of the patient, date of incident, report date of claim, details of what happened and why, insurer of the incident, and disposition to include any indemnity payment, as well as current status must be included.

Any claims, potential claims, or circumstances that could possibly result in a claim or suit, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services by you, your staff or professional corporation from the date this application is signed to the effective date requested in this application must be reported to your current carrier and will not be covered by any policy issued to you based on this application.

Section IX – Signature and Additional Information

All of the above information is true to the best of my knowledge and belief. I authorize the release of any underwriting, credentialing and/or claim information from (and release from any and all liability for the provision of information) all prior and current insurers, all professional societies or associations, any state licensing authority, any hospitals, or any credentialing agency to *the company* and its subsidiaries, or agents, or Attorney-in-Fact.

Please include the following with your application:

- Copy of C.V.
- Current declarations page or certificate of insurance
- Copy of letterhead
- Current or most relevant medical license
- Board Certification or Recertification
- Completed supplemental claim form(s)

The company reserves the right to reject any application that does not meet its underwriting standards.

NOTICE TO FLORIDA APPLICANTS: 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.

Signature of Applicant **Date**

Florida Licensed Agent Signature **License Number** **Date**

Supplemental Claims Information
This form should be completed for each claim or incident.
Attached separate sheet if necessary.

Name of Physician: _____

1. Claimant's / plaintiff's name/age/sex: _____

2. Date(s) care rendered: _____

3. Date claim was reported to carrier: _____

4. Were there additional defendants? Yes No

IF YES, Please list: _____

5. Status open closed Date claim closed _____

6. IF CLOSED, how was claim resolved? Check answer:

Jury Trial Mediation Settlement Dismissed Other

7. IF CLOSED, was any indemnity payment or award made? yes no

If yes, total amount of settlement: \$ _____

Amount paid on your behalf: \$ _____

8. Name of insurance company _____

9. Allegations made against you:

10. Type of treatment, result of treatment, your involvement:

11. Subsequent condition or health of patient:

Date This Form Completed

Signature of Applicant