



Medical Professional Liability Insurance Application

I warrant that all information in this application is true and complete and understand that this application form shall be the basis for endorsing my employer's/supervisor's Medical Professional Liability contract with American Physicians Insurance Company.

INSTRUCTIONS:

1. Answer all questions. If a question is not applicable, state NOT APPLICABLE.
2. If space is insufficient to answer any questions fully, attach separate sheet.
3. Application must be signed and dated.
4. If the answer to any question is none, state NONE.
5. Please submit a written protocol and (if seeking vicarious coverage) proof of individual coverage. Application will not be considered complete without these items.

PLEASE TYPE OR PRINT IN BLACK INK AND ANSWER ALL QUESTIONS IN DETAIL. COVERAGE WILL NOT BE CONSIDERED UNTIL APPLICATION IS COMPLETED AND SIGNED.

PERSONAL INFORMATION

Full Name _____ Sex: Male Female

Social Security # _____ Date of Birth ____/____/____

Place of Birth _____ Are you a U.S. Citizen? Yes No

Home Address _____ Street & Number _____ City _____ County _____ State _____ Zip Code _____

Home Phone _____ E-mail _____

CONTACT INFORMATION

Business Address _____ Street & Number _____ City _____ County _____ State _____ Zip Code _____

Business Phone _____ Business Fax _____

Business Website _____

Office Contact Name _____ Office Contact E-mail Address _____

Office Contact Title _____

Office Contact Phone _____ Office Contact Fax _____

Administrator Name _____ Administrator E-mail address _____

Administrator Phone _____ Administrator Fax _____

EDUCATIONAL SUMMARY

Indicate ALL time periods from medical school through residency or fellowship

	School and Location Include city, state, & country	To	From	Degree, Specialty, and Sub-specialty
Dental/Medical School				
Residency or Additional Training				

LICENSE INFORMATION

Please provide information on ALL state medical licenses you now hold or have held. Please attach copies of ALL of your current licenses. Each insured is required to provide us with any changes in the status of his/her licensure.

Primary License information:

Texas License # _____ Expiration Date ____/____/____ Active? Yes No

Other State Licenses:

State: _____ License # _____ Expiration Date ____/____/____ Active? Yes No

Licensed to prescribe or dispense narcotics in the state(s) of _____ Federal DEA # _____

Are you ABMS Board Certified? Yes No Certification Date ____/____/____ Certification Number _____

Recertified? Yes No Date ____/____/____ Specialty _____

If not, have you previously attempted the exam? Yes No How many times? _____

Are you Board Eligible? Yes No Do you plan to take the Board Exam? Yes No Date? ____/____/____

Please name the medical board(s) to which the above apply: _____

CLAIMS HISTORY

PLEASE NOTE THAT A COMPLETE CLAIM/ SUIT ADDENDUM IN THE APPLICANT'S OWN WORDS FOR EACH INCIDENT NOTED BELOW MUST BE ATTACHED FOR THE APPLICATION TO BE PROCESSED

LIST ALL CLAIM(S) INFORMATION FROM JANUARY 1, 2003 TO THE PRESENT

- All claims listed on your application must have been reported to your prior insurer(s).
- All claims not listed on your application must have been reported to your prior insurer(s).
- A claim, potential claim, incident, or lawsuit reported to a previous insurer is not covered by American Physicians Insurance Company. Furthermore, under no circumstances or event will any coverage apply to any claim, potential claim, incident, or lawsuit which is known or which may arise out of any incident which is known by any named insured, physician extender, or ancillary personnel as of the effective date of this policy. It is your responsibility to report all claims, potential claims, incidents or lawsuits, which are known or which may arise out of an incident which is known, to your previous insurer(s).

1. Are you now or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising from the rendering of, or failure to render professional services?

Yes No

If yes, how many? _____ A number must be specified along with the corresponding narrative(s)

2. If you are a member of a Partnership, Professional Corporation or Professional Association, do you have knowledge of any claims or potential claims arising from the rendering of, or failure to render professional services involving former or present partners, members of the corporation, or any former or present employee of the Corporation, Partnership, or Professional Association?

Yes No

If yes, how many? _____ Have these been reported to your previous insurer(s)? Yes No

Claims listed as part of this application are not considered claims reported to us.

INSURANCE REQUESTED

Have you previously applied for or have you ever had coverage with us in the past? Yes No

I request that my professional liability coverage be effective at 12:01 a.m. on _____/_____/_____.
(The "Policy Effective Date")

1. Limits of Liability requested:
Please check ONE (Each loss limit/ aggregate limit):

<input type="checkbox"/> 100,000 / 300,000	<input type="checkbox"/> 500,000 / 1,000,000
<input type="checkbox"/> 200,000 / 600,000	<input type="checkbox"/> 500,000 / 1,500,000
<input type="checkbox"/> 300,000 / 900,000	<input type="checkbox"/> 1,000,000 / 3,000,000

2. If current carrier coverage is a claims-made policy, PLEASE SELECT ONE OF THE FOLLOWING:
 - I **AM** applying for prior acts coverage. I request a retroactive date of ____/____/____
OR
 - An extended reporting endorsement (tail coverage) has been or will be purchased from my current carrier. In this situation, the retroactive date will be the policy effective date above. **Please provide a copy of the extended reporting endorsement.**

3. If current carrier coverage is an occurrence policy:
 - An extended reporting endorsement has not and will not be purchased, and I am **NOT** applying for prior acts coverage.

4. Do you desire coverage for a Solo Professional Association? Yes No Name _____
If yes, please provide articles of incorporation, certificate of association or assumed name certificate.

5. Are you affiliated with a group? Yes No
If yes, check type of group:

<input type="checkbox"/> Professional Association (PA)	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Office Share
<input type="checkbox"/> Limited Liability Partnership (LLP) <input type="checkbox"/> Other _____			

Are you a Partner/Shareholder Employee Independent Contractor (please provide a copy of your contract)

Other _____

Business Name of Group	Address	City	State	Zip Code
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6. Are you requesting coverage for the group entity? Yes No
7. Are you requesting prior acts coverage for the group entity? Yes No If yes, retroactive date? ____/____/____
8. **Have you ever had any gaps in coverage?** Yes No

If yes, explain _____

Please note: Prior Acts coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

I represent, warrant, agree and understand that coverage provided will be for claims reported after the policy effective date. The medical incident must also have occurred after the policy retroactive date. I will have no right to report claims, suits or medical incidents that occurred prior to the policy retroactive date, and you will have no obligation to indemnify or defend me for any medical incident occurring prior to such date. I represent and warrant that I have no knowledge of any medical incidents, claims or suits arising from the rendering of, or failure to render, professional services by me or by any person for whose acts or omissions I am legally responsible, except as noted in the Claims Information section. I understand that "medical incident" shall mean an act or omission arising out of your rendering or failing to render professional services from which a claim might arise. I also represent that any medical incident, claim or suit noted herein has been reported to my current or prior insurance carrier. All applications for prior acts coverage must be approved by Underwriting Management.

CURRENT PROFESSIONAL LIABILITY INFORMATION

**Please complete the following indicating your Professional Liability carrier(s) since your requested retroactive date.
PLEASE ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR CURRENT POLICY OR A CERTIFICATE OF INSURANCE ISSUED FROM YOUR CURRENT CARRIER REFERENCING YOUR CURRENT POLICY.**

Professional Liability Carrier	Limits of Liability	Dates Insured	Type
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To:	Occurrence / Claims Made

PRACTICES AND PROCEDURES

Check the appropriate box and elaborate when necessary (If more space is needed, please use Supplemental Information section)

1. Full-time private practice Employed by Federal Govt. Military Part time # of hours _____ Other _____

2. **My specialty is:** _____ **Sub Specialty:** _____

3. Anesthesia used: Nitrous or locals only IM/IV sedation General

4. Do you administer anesthesia (other than local)? Yes No

5. Do you administer sedation? Yes No

- Conscious sedation Deep sedation
 Enteral conscious sedation Other _____

Please list applicable permits _____

6. Do you administer analgesia intravenous, intramuscular, subcutaneous, or inhalation techniques or perform endotracheal intubation? Yes No

If yes, list method of administration and agents _____

TECHNIQUES (IV, IM, SUBQ, INHALATION, ETC.):

AGENTS:

7. Do you have oxygen available? Yes No

8. Do you have a pulse oximeter available? Yes No

Please list other available monitoring equipment: _____

9. Please list the resuscitative equipment you have available in the office to support an adverse reaction or medical emergency.

EQUIPMENT:

MEDICATIONS:

10. Are you certified in ACLS (Advanced Cardiac Life Support)? Yes No

11. Are you certified in CPR or BLS (Cardiopulmonary Resuscitation or Basic Life Support)? Yes No

12. Do you perform procedures on patients who are under anesthesia or sedation which has been given by or ordered by other dentists, physicians, or CRNAs? Yes No

13. Do you work with anesthesiologists or CRNAs who do not have malpractice insurance? Yes No

14. If you practice as a general dentist, do you perform :

Placement of Oral Implants? Yes No

Orthodontics (more than interceptive)? Yes No

15. Do you perform any cosmetic, plastic or reconstructive procedures? Yes No

Including the following:

Blepharoplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Primary repair of cleft lips and palates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liposuction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rhinoplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Otoplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rhytidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other _____

16. Do you perform procedures that are not normally within the realm of your specialty but which you are trained and credentialed to perform? Yes No

(Please provide documentation of the courses taken, credits received, and training for these procedures.)

17. Does your practice include the treatment of inmates at a prison or jail? Yes No

If yes, please list the name of the facilities _____

If yes: Full-time? Yes No

18. Does the involved agency provide professional liability coverage for you? Yes No

If yes, state the amount of the coverage: _____

PRACTICE HISTORY

1. List each county in which you practice:

2. Do you currently practice in any other state(s)? Yes No

If yes, which state(s)? _____ What percentage of your practice? _____%

3. Have you ever practiced in another state? Yes No

If yes, which state(s)? _____

List the dates _____

Indicate for all time periods since dental or medical school, residency and/or any fellowship when and where you have practiced. Please note and explain any periods when you did not practice.

Specialty	City, State	Beginning Month/Year	Ending Month/Year

HOSPITAL PRIVILEGES OR AFFILIATIONS

Please list ALL hospitals and ambulatory surgery centers at which you have privileges:
(Please indicate current privileges as one of the following: active, active/provisional, courtesy, consulting, temporary, or application in process)

Facility Name	City, County	Current Privileges

ALLIED HEALTH PROFESSIONALS

Note that vicarious liability coverage for the below staff will not be provided automatically. Please contact APIE Physicians Services.

Does your association employ supervise contract

CLASSIFICATION	NUMBER	INSURANCE CARRIER(S)	LIMITS OF INSURANCE(S)
Licensed Dental Hygienists	_____	_____	_____
Interns, Residents, or Fellows	_____	_____	_____
Nurse Anesthetists (CRNAs)	_____	_____	_____
Dental Assistants	_____	_____	_____
Other	_____	_____	_____

Do you utilize CRNAs who are not employed and supervised by anesthesiologists? **Yes** **No**

GENERAL INFORMATION

1. Have any of the following, now or ever, been under review, under investigation, revoked, denied, suspended, voluntarily surrendered, or in any way limited?

- Your license to practice dentistry/medicine Yes No
- Your permit to prescribe or dispense drugs Yes No
- Your hospital privileges Yes No
- Your Medicare/Medicaid accreditation, certification, or Medicare/Medicaid license Yes No

2. Have you ever been or are you now under review by any entity, organization or peer review board? Yes No

3. Have you ever been or are you now being investigated, charged with, or convicted of a felony or state jail felony? Yes No

4. Do you hold any medical directorship(s)? Yes No

5. Have you ever been, or are you now, being treated for:

- Chronic illness or physical disability, which may limit your abilities to practice Yes No
- Alcoholism or narcotic addiction Yes No
- Mental illness Yes No

6. Have you ever been advised that your medical professional liability insurance would or might be declined, non-renewed, or accepted on special terms? Yes No

7. Have you ever been or are you now an employee of or do any contract work for any Federal, State, local or government agency? Yes No

If "yes", please give details, including whether professional liability insurance is provided for you.

8. Are you currently an employee of or do contract work for any other entities, including other physicians, emergency room (s), or minor emergency medical organizations for which you are paid? Yes No

If yes, please list _____

Do you require coverage for this practice? Yes No

9. If you answered "yes" to any question in the General Information section, please explain in detail below or attach an explanation to this application. _____

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with the company, American Physicians Insurance Company. All statements are my own representations and are true, to the best of my knowledge. I have not knowingly withheld any information that is calculated to influence the judgment of the Company in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance on the truth of my representations. I understand that no insurance will be afforded unless and until this application is approved by the company 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 the company. 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, and individuals. 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 the evaluation of information so received from whatever source.

I understand that, if I am insured by the company, 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 the company and any party furnishing information pursuant to this authorization is entitled to rely on the representation of the company that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to the company.

Signature

Print Full Name

Date

PLEASE COMPLETE ENTIRE APPLICATION, AND SUBMIT WITH COPY OF PROTOCOLS AND COPY OF INDIVIDUAL CERTIFICATE OF INSURANCE.

INCOMPLETE APPLICATIONS WILL BE RETURNED

NOTE: Signature of this form does not bind the Applicant or the Company and no insurance coverage will be considered to be in effect until the applicant has received a confirmation in writing, duly executed by the company.



Claim/Suit Information Addendum

COMPLETE ONE CLAIM/SUIT INFORMATION ADDENDUM IN THE APPLICANT'S OWN WORDS FOR EACH INCIDENT, CLAIM OR SUIT.
PLEASE PRINT ALL INFORMATION.

Doctor's Name _____

1. Name, age, and sex of patient/claimant _____

2. Date(s) of treatment and/or surgery which led to the allegations against you (month/year) _____

3. Nature of the allegations in the claim or suit, or description of medical incident _____

4. Specify incident or claim report date(s) _____

5. Specify if a suit was ever filed: Yes No If yes, provide (month/year) _____

6. Name of the other doctor(s) and hospital(s), if any, involved in claim or suit _____

7. Disposition or current status of incident, claim or suit

- Incident only.
- OPEN CLAIM-Indicate case value established by insurance company, if known \$ _____
- CLOSED CLAIM-Was payment made? Yes No If yes, when ____/____/____
- If no, was claim or suit withdrawn? Yes No
- If payment was made, indicate amount of settlement \$ _____ award \$ _____
- Amount paid on your behalf: _____

8. Name of insurance company defending you _____
Policy Number _____

9. Narrative description of the medical facts (must include, but is not limited to, the type of treatment and/or surgery; and your involvement, i.e., consultant, assistant in surgery, E.R. physician, primary surgeon, resident, etc.).

