



**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
Medical School				
Internship				
Residency				
Residency/Fellowship				

## LICENSE INFORMATION

Please provide documentation of your license from the Texas Medical Board.

On what date did you attain your original license? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date you plan to complete your residency/fellowship? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

State(s) where licensed    State \_\_\_\_\_ License # \_\_\_\_\_                      State \_\_\_\_\_ License # \_\_\_\_\_

State(s) where practicing    State \_\_\_\_\_ Percent of practice \_\_\_\_\_%                      State \_\_\_\_\_ Percent of practice \_\_\_\_\_%

Extent of practice outside your home state                      \_\_\_\_\_%

## 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):      100,000 / 300,000      200,000 / 600,000

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Are you affiliated with a group?      Yes      No  
 If yes, check type of group:      Professional Association (PA)      Partnership      Corporation      Office Share

Limited Liability Partnership (LLP)      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

**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. **My specialty is:** \_\_\_\_\_
  
  2. Check all pertaining to moonlighting responsibilities:
    - Emergency room coverage. Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
    - Minor emergency center coverage. Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
    - Walk-in clinic coverage. Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
    - Part-time coverage for private practice physician. Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
  
  3. I will be responsible for the following:
    - Admitting and following hospital patients. Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
    - Office Visits Only. Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
    - Minor surgery (suturing minor lacerations, I &Ds). Will you have direct supervision?    Yes    No By whom? \_\_\_\_\_
    - Other procedures relating to your specialty \_\_\_\_\_
  
  4. If you will be doing some other type moonlighting than those listed above, please explain fully: \_\_\_\_\_  
\_\_\_\_\_
  
  5. If you will not have direct on-site supervision for any of the moonlighting you will be doing, will a full-time physician be available by phone?  
Yes    No
- How many miles away will they be? \_\_\_\_\_ miles
- Estimated number of hours you will work per week: Average \_\_\_\_\_ Maximum \_\_\_\_\_
- List the names and locations of places where you will work: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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 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.).

\_\_\_\_\_  
\_\_\_\_\_  
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