



Medical Professional Liability Insurance Supplemental 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.

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 _____ M.D. D.O. Sex: Male Female

SS # _____ DOB ____/____/____

1. Are you a U.S. citizen? (If not, attach copies of current alien work permit and visa) ___ Yes ___ No

2. I am currently engaged in practice as (specialty): _____

3. I am ABMS BOARD CERTIFIED: ___ Yes ___ No. My specialty is _____

4. I am a: ___ FULL TIME practitioner ___ PART TIME practitioner (working _____ hours per week) _____ Other

5. Are you licensed to prescribe or dispense controlled substances? ___ Yes ___ No Federal DEA No. _____

(Optional for Arkansas applicants)

6. Have you made any change in your type of practice or specialty? ___ Yes ___ No If yes, explain: _____

Have you added or deleted any non-invasive or invasive procedures? ___ Yes ___ No If yes, explain: _____

Have you made any changes in the location(s) in which you practice? ___ Yes ___ No Location _____

7. Do you desire coverage for a Solo Professional Association? ___ Yes ___ No Name _____

Have you become a member of a partnership, association or corporation? ___ Yes ___ No

If yes, give members names, their insurers, and limits of insurance carried: _____

8. Is your license to practice medicine or your permit to prescribe or dispense drugs currently, or has it ever been, under review, denied, revoked, suspended, voluntarily surrendered, or in any way limited? ___ Yes ___ No

If yes, explain: _____

9. Are you now, or have you ever been, under review or disciplined by any organization, including hospital committees, state boards, or any other medically related group? ___ Yes ___ No

If yes, summarize incident(s) and reason(s): _____

10. Have you any physical disability or chronic illness? ___ Yes ___ No If yes, explain: _____

11. Have you been investigated, charged with or convicted of a crime? ___ Yes ___ No If yes, describe and give punishment: _____

12. Have you been treated for alcoholism, narcotic addiction or mental illness? ___ Yes ___ No If yes, explain: _____

13. Has any insurer canceled or refused professional liability insurance to you? ___ Yes ___ No

14. Has there been any change in the physicians, surgeons, CRNAs, physician assistants, nurse midwives, or nurse practitioners you employ or are responsible for supervising? ___ Yes ___ No

15. Do you utilize in your practice CRNAs who are not employed and supervised by anesthesiologists? ___ Yes ___ No

16. Are all of your films over-read by radiology? ___ Yes ___ No

17. **What is the limit of insurance you are requesting?** _____ **Requested coverage effective date** ___/___/___

18. 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.**

19. 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.

20. Are you now, or have you ever been involved, directly or indirectly in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ___ Yes ___ No

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

21. Do you have any objection to the Peer Review Committee investigating any information contained in this application, including information relating to your professional medical history and credentials? ___ Yes ___ No

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.

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.

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.).

