



MD Anderson Resident or Fellow 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

MD Anderson Contact Name _____

MD Anderson Contact Email _____ M.D. Anderson Contact Phone# _____

Office Contact Title _____ Office Contact Fax# _____

Home Residency/Fellowship Name _____

Home Residency/Fellowship E-mail _____

Home Residency/Fellowship Phone# _____ Home Residency/Fellowship Fax# _____

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: Retroactive Date:	Occurrence / Claims Made (Circle one)

PRACTICE HISTORY

1. I am an _____ Of a _____ PA
 Employee Hospital Partnership
 Independent Contractor Other _____ Corporation
 Self-Employed
 Other _____

Name of Practice _____ Address _____ City _____ State _____ Zip Code _____

Date(s) you begin working for the practice listed above? _____

2. In what specialty (ies) do you practice? _____

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 _____

If you will be doing something other than what is listed above, please explain fully: _____

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. _____



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.).

