American Physicians Insurance Company

1301 SOUTH CAPITAL OF TEXAS HIGHWAY SUITE C-300, AUSTIN, TEXAS 78746
phone (800) 252-3628 or (512) 328-0888 fax (512) 314-4398 web www.api-c.com

MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION – PHYSICIAN (CLAIMS MADE)

This application is ONLY for physicians who are residency trained, Board Certified and have had NO claims asserted against them in the past six years. Be sure to read and sign information on reverse.

Name___________________________________ ☐ M.D. ☐ D.O. SSN_________________ DOB___________ Specialty________________________

Business Address____

Business Phone __________________________ Email____

Home Address____Home Phone_____________________________

	School and Location Include city, state and country	To	From	Degree, Specialty, and Sub-specialty
Medical School				
Internship				
Residency				
Residency/Fellowship				

Area of Board Certification_________________________ Date of Certification___________________ Requesting coverage in ☐Texas ☐Oklahoma

Limits of Liability Requested (each loss/aggregate) ☐ 100,000 / 300,000 ☐ 200,000 / 600,000 (TX only) ☐300,000 / 900,000 (TX only) ☐ 500,000 / 1,000,000 ☐500,000 / 1,500,000 (TX only) ☐1M / 1M (OK only) ☐ 1M / 3M

Retroactive Date Requested________________(Must provide copy of current declaration page if retroactive date is prior to effective date of policy)

Do you desire coverage for a Solo Professional Association? If so, please provide name____

Are you affiliated with a group? If so, please provide name____

List all hospitals and ambulatory surgery centers at which you have privileges____

____

List each county in which you practice___________________________________ List any other states in which you have practiced________________

Indicate for all time periods since medical school, residency and/or fellowship when and where you have practiced. Please note and explain any periods when you did not practice medicine.			
Specialty	**City, State**	**Beginning (Month/Year)**	**Ending (Month/Year)**

Which ONE of the following best describes your practice?

- ☐ A. No surgery or obstetrical procedures. This category allows coverage for the incision of superficial abscesses, suture of skin or superficial fascia, or similar procedures.
- ☐ B. Minor surgery or assisting in major surgery. This category does not include major surgery or obstetrical procedures, but does include emergency room medicine.
- ☐ C. Perform major surgery or obstetrical procedures.
- ☐ D. Other ____

Please read the following carefully and check any included in your practice

- ☐ Cosmetic Procedures
- ☐ Chelation therapy
- ☐ Liposuction / Liposelection
- ☐ Prescription of weight loss drugs
- ☐Spinal or general anesthesia
- ☐ Medical Directorship
- ☐ Hair analysis
- ☐ Weight loss procedures
- ☐ Treatment of inmates
- ☐ Chronic pain management
- ☐ ER coverage for privileges only
- ☐ Primary practice in ER
- ☐ Expanded call coverage
- ☐ Treatment of patients in nursing homes
- ☐ Telemedicine

Are all of your films overread by radiology?____

Do you or your association ☐ employ ☐ supervise ☐ contract

CLASSIFICATION	**NUMBER**	**INSURANCE CARRIER(S)**	**LIMITS OF INSURANCE(S)**
Physicians or Surgeons	________	______________________	______________________
Interns, Residents or Fellows	________	______________________	______________________
Nurse Anesthetists (CRNAs)	________	______________________	______________________
Licensed Physician Assistants	________	______________________	______________________
Certified Nurse Midwives	________	______________________	______________________
Certified Nurse Practitioners	________	______________________	______________________
RN/LVN	________	______________________	______________________
Physical Therapists	________	______________________	______________________
Other	________	______________________	______________________

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

I have not had any claims asserted against me, either as an individual or a member of a group, in the past six years.

____

Signature Date

I have no knowledge of any claims, potential claims, suits or incidents likely to result in a claim, which could be brought against me resulting from the rendering of or failure to render professional services.

____

Signature Date

The following statement applies if you are or ever have been a member of a Partnership, Professional Corporation or Professional Association:
I have no knowledge of any potential claims arising from the rendering of or failure to render professional services involving former or present partners, member of the Corporation or any former or present employees of the Corporation, Partnership or Professional Association.

____

Signature Date

PURCHASING GROUP INTENT TO JOIN (Texas Applicants Only)

The undersigned Individual hereby consents to join a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. The current insurance policies issued for this group are underwritten by American Physicians Insurance Company (API).

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with the company, API. 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.

CLAIMS MADE STATEMENT OF UNDERSTANDING

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 API 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. I understand that “medical incident” shall mean an act or omission arising out of 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 application for prior acts coverage must be approved by Underwriting Management.

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Signature Date

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

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