



MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION – PHYSICIAN (CLAIMS MADE)

INSTRUCTIONS:

- 1. Answer all questions. If a question is not applicable, state NOT APPLICABLE. If the answer to any question is none, state NONE.
2. If space is insufficient to answer any questions fully, attach a separate sheet.
3. Application must be signed and dated.

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, Social Security #, Date of Birth, Home Address, Home Phone, E-mail, M.D. D.O., Sex: Male Female

CONTACT INFORMATION

Business Address, Business Phone, Business Website, Contact Name, Contact Email, Street & Number, City, County, State, Zip Code, Business Fax, Contact Title

EDUCATIONAL SUMMARY

Indicate ALL time periods from medical school through residency or fellowship

Table with 5 columns: School and Location, To, From, Degree, Specialty, and Sub-specialty. Rows include Medical School, Internship, Residency, Residency/Fellowship.

MEDICAL LICENSE AND BOARD CERTIFICATION INFORMATION

EACH INSURED IS REQUIRED TO PROVIDE US WITH ANY CHANGES IN THE STATUS OF HIS/HER LICENSURE AND BOARD CERTIFICATION.

Primary State License #, Expiration Date, Active?, Are you Board Certified?, Certification Date, Certification Number, Recertified?, Date, Specialty, If not, have you previously attempted the exam?, How many times?, Are you Board Eligible?, Do you plan to take the Board Exam?, Date?, Please name the medical board(s) to which the above apply:

CLAIMS HISTORY

A COMPLETE CLAIM/SUIT ADDENDUM FOR EACH INCIDENT NOTED BELOW MUST BE ATTACHED FOR THE APPLICATION TO BE PROCESSED. LIST ALL CLAIM(S) INFORMATION FOR THE PAST FIVE (5) YEARS.

- 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?
If yes, how many?

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? \_\_\_\_\_

- 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).

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

### INSURANCE REQUESTED

1. Are you requesting coverage in:  Texas  Oklahoma

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

3. I request that my professional liability coverage be effective at 12:01 a.m. on \_\_\_\_/\_\_\_\_/\_\_\_\_  
(the policy effective date)

4. Limits of Liability requested:  
Please check ONE (Each loss limit/ aggregate limit):  100,000 / 300,000  500,000/1,500,000 (TX only)  
 200,000 / 600,000 (TX only)  1,000,000/1,000,000 (OK only)  
 300,000 / 900,000 (TX only)  1,000,000/3,000,000  
 500,000 / 1,000,000

5. Retroactive Date requested: \_\_\_\_/\_\_\_\_/\_\_\_\_

If current coverage is a claims-made policy and you are applying for prior acts coverage **please provide a copy of your current declaration sheet from the carrier.** In this situation, subject to approval, the retroactive date will be the retroactive date documented on the declaration sheet.

If current coverage is a claims-made policy and an extended reporting endorsement (tail coverage) has been or will be purchased from your current carrier, the retroactive date will be the policy effective date referenced above.

If current coverage is an occurrence policy **please provide a copy of your current declaration sheet from the carrier.** In this situation, the retroactive date will be the policy effective date referenced above.

6. Do you desire coverage for a Solo Professional Association?  Yes  No

Name \_\_\_\_\_

7. 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 \_\_\_\_\_

8. Are you requesting coverage for the group entity?  Yes  No

If yes, we will need for you to complete our Entity application.

9. Are you requesting prior acts coverage for the group entity?  Yes  No If yes, retroactive date? \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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? \_\_\_\_\_%

**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)

## 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       Part-time (# of hours \_\_\_\_\_)       Other \_\_\_\_\_
2. My specialty is: \_\_\_\_\_ Sub Specialty: \_\_\_\_\_
3. Which of the following best describes your practice? Please check ONE of the following:
- A. No surgery or obstetrical procedures. This category allows coverage for the incision of superficial abscesses, or 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 \_\_\_\_\_
4. Do you provide ER coverage?  Yes  No
- Please specify your responsibilities:
- Call coverage required for privileges only       Primarily practice in the ER
- Expanded call coverage-please explain and list hours per week and responsibilities
- \_\_\_\_\_
5. Are all of your films over-read by radiology?  Yes  No
6. Does your practice include the treatment of inmates at a prison or jail?  Yes  No
- If yes, what percentage of your practice does this comprise? \_\_\_\_\_%
- Are you requesting coverage for this practice?  Yes  No
7. Do you see patients in nursing homes?  Yes  No
- If yes, what percentage of your practice does this comprise? \_\_\_\_\_%
8. Do you perform spinal or general anesthesia on your patients or patients of other physicians, dentist or oral surgeons?  Yes  No
- If yes and your specialty is not Anesthesiology, for what procedures? \_\_\_\_\_
- Do you perform the procedures in:       Office       Out patient facility       Hospital
9. Describe in detail any and all fracture treatment in which you engage: \_\_\_\_\_
- \_\_\_\_\_
10. Do you perform any chronic pain management procedures?  Yes  No
- If yes, we will need you to complete our Pain Management questionnaire.
11. If your specialty is not Radiology, do you perform telemedicine?  Yes  No
- If yes, we will need you to complete our Telemedicine questionnaire.

12. Please check any of the following aesthetic procedures that are included in your practice:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hair transplant  | <input type="checkbox"/> Sclero or varicose vein therapy | <input type="checkbox"/> Cosmetic Steroid injections |
| <input type="checkbox"/> Face implants    | <input type="checkbox"/> Breast augmentation             | <input type="checkbox"/> Laser resurfacing           |
| <input type="checkbox"/> Hair removal     | <input type="checkbox"/> Botox injections                | <input type="checkbox"/> Collagen injections         |
| <input type="checkbox"/> Eye liner tattoo | <input type="checkbox"/> Eyelid lifts                    | <input type="checkbox"/> Dermabrasion                |

If you checked any of the above, we will need you to complete our In-Office Aesthetics Questionnaire.

13. Please check any of the following that are included in your practice:

- |  |   |
|--|---|
| <input type="checkbox"/> Norplants                         | <input type="checkbox"/> Pedicle screws         |
| <input type="checkbox"/> Chelation therapy                 | <input type="checkbox"/> Hair analysis          |
| <input type="checkbox"/> Liposuction / Liposelection       | <input type="checkbox"/> Weight loss procedures |
| <input type="checkbox"/> Prescription of weight loss drugs |   |

If you checked any procedures above, please explain in detail below what procedural techniques are used, when the procedures are performed and the training you have received for such procedures.

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**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, 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.

Does 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

**GENERAL INFORMATION**

- 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
- Have you ever been or are you now under review by any entity, organization or peer review board?  Yes  No
- Have you ever been or are you now being investigated, charged with, or convicted of a felony or state jail felony?  Yes  No
- Do you hold any medical directorship(s)?  Yes  No

5. 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
6. 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
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. \_\_\_\_\_
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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: \_\_\_\_\_
- Are you requesting 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.
- \_\_\_\_\_
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### 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, 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.

### 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 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 application for prior acts coverage must be approved by Underwriting Management.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**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.).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_