Physicians and Surgeons Professional Liability Application

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON A CLAIMS MADE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED ACCURATELY AND COMPLETELY.

Please type or print clearly.

- ➜ Answer ALL questions completely, leaving no blanks. If any question, or part thereof, does not apply, print "N/A" in the space.
- ➜ If you need more space for your responses, continue on the attached Additional Information Form.
- ➜ This application must be completed, dated and signed by the proposed insured.

The Following Must Be Included With This Application:

1. Copy of your current professional liability insurance declarations page.
2. Copy of your Curriculum Vitae.
3. Copy of your current medical license.
4. Copy of your business letterhead.

Section I - General Information:

Name: _____Suffix: _____ ☐ M.D. ☐ D.O.
First Middle Last

Home Address:
_____
Number and Street City State Zip Code

Date of Birth: _____/_____/_____ Social Security#: _____

Gender: ☐ Male ☐Female

Primary Practice Address:
_____
Number and Street City State Zip Code

BusinessPhone:_____BusinessFax:_____

E-mail Address:
_____

Section II - Education and Training:

Provide a comprehensive listing of all education and training you have experienced. Any gaps in dates or splits in training must be explained in a separate written commentary.

A. Medical School:

School	City	State	Country	Degree	Date Completed

If Foreign Medical School Graduate, are you certified by the educational council for foreign medical school graduates or have you completed the fifth pathway program? Yes☐ No☐

B. Additional Education:

Internship:

Hospital	City	State	Dates(from/to)	Type

Residency:

Hospital	City	State	Dates(from/to)	Type
Hospital	City	State	Dates(from/to)	Type

Fellowship or Other Training:

Hospital	City	State	Dates(from/to)	Type
Hospital	City	State	Dates(from/to)	Type

C. License Information:

_____ ☐ Active ☐ Inactive ☐ Pending ☐ Restricted ☐ Revoked/Suspended
State License #

_____ ☐ Active ☐ Inactive ☐ Pending ☐ Restricted ☐ Revoked/Suspended
State License #

_____ ☐ Active ☐ Inactive ☐ Pending ☐ Restricted ☐ Revoked/Suspended
State License #

D. Board Certification:

American Board Certified: **Yes☐** **No☐** **Specialty Board:**_____
Date __/__/__

If not board certified when does your eligibility expire? _____

If expired, please explain: _____

_____

When do you plan to take your board exam? _____
_____
_____
_____

E. Continuing Medical Education:

How many Category 1 CME credit hours have you received within the past 3 years? _____

How many of the above credits were for risk management? _____

F. Professional Society Memberships:

National:_____State:_____
County:_____Other:_____

Section III – Practice Information:

A. Practice Description:

Nameof Corporation, Partnership or Other Legal Entity(ies):_____

Name of DBA or Fictitious Name:_____

Website Address of Practice:_____

Entity Type:
☐ Multi-Shareholder Corporation, Partnership, LLC
☐ Solo Incorporated – no employed or contracted physicians
☐ Solo Incorporated – with employed or contracted physicians
☐ Solo Unincorporated / Sole Proprietor

☐ Other_____

Employment Status:
☐ Shareholder / Partner
☐ Employee
☐ Independent Contractor
☐ Solo Unincorporated / Sole Proprietor
☐ Other _____

Total Number of Physicians in Group: _____

Do you employ any of the following mid-level practitioners? If yes, indicate how many.
Coverage is not included for any of these practitioners. If coverage is desired, please complete a separate ancillary application for each practitioner.

Physicians Assistant	☐ Yes ☐ No	_____ Number
Nurse Practitioner	☐ Yes ☐ No	_____ Number
Certified Registered Nurse Anesthetist	☐ Yes ☐ No	_____ Number
Certified Nurse Midwife	☐ Yes ☐ No	_____ Number
Optometrists	☐ Yes ☐ No	_____ Number

List all other personnel that you employ:

☐ RN's	_____ Number	☐ Other	_____ Type _____ Number
☐ LPN's / LVN's	_____ Number	☐ Other	_____ Type _____ Number
☐ Medical Assistants	_____ Number	☐ Other	_____ Type _____ Number

B. Current Practice Locations:
The % of practice for B. 1-3 combined should total 100%

1. Office Locations:

Number and Street	City	State	Zip Code	County	% of practice

2. Hospital Locations:

Name	City	State	County	Description of Privileges	% of practice

3. Other Facility Locations: (i.e. Surgi-Centers, Emergi-Centers, Lab, Nursing Home, Correctional Facility, Clinic)

Name	Description	City	State	County	% of Practice

C. Previous Practice Locations: (List most recent first and explain any gaps in dates)

City	State	Description (office, hosp. etc.)	Specialty	Dates (from/to)

Section IV – Coverage Information:

A. Coverage Requested:

Requested Effective date of Policy: from:_____/_____/_____ to: _____/_____/_____

Requested Retroactive Date: _____/_____/_____

Policy Limits Requested: ☐ $1M / $3M ☐ $1M /$4M (CT only)
☐ Other_____

Is there any part of your practice that is covered by any other professional liability policy? **Yes** ☐ **No** ☐

If yes, please provide details and copy of declaration page of policy:

_____

Have you ever practiced without insurance? **Yes** ☐ **No** ☐

B. Coverage History:

Please list all previous policies for medical professional liability carried during the past 10 years, beginning with your current carrier.

	Insurance Carrier	Policy Period	Limit of Liability	Coverage Type	Retroactive Date	Deductible Amount	Tail Purchased	Policy Premium
1.		From: To:		☐Claims Made ☐Occurrence			☐Yes ☐No	
2.		From: To:		☐Claims Made ☐Occurrence			☐Yes ☐No	
3.		From: To:		☐Claims Made ☐Occurrence			☐Yes ☐No	
4.		From: To:		☐Claims Made ☐Occurrence			☐Yes ☐No	

Section V – Practice Profile:

A. Specialty and Procedures:

What is your primary specialty? _____% of practice? _____

What is your sub-specialty? _____% of practice? _____

Have you changed specialties? **Yes**☐ **No**☐
If yes, please provide details:_____
_____

Are you entering private practice for the first time? Yes☐ No☐

Date you entered private practice_____/_____/_____

Avg. # patients seen per week _____ Hours per week _____ Walk in patients per week _____

Check one of the following that best describes your practice:

☐ No Surgery: Other than incisions of boils and superficial abscess, or suturing of skin or superficial fascia.

☐ Minor Surgery: Inclusive of the above, including assisting in major surgery on your own patients, but not including major surgery as defined below. Also includes gynecological procedures not constituting major surgery, tonsillectomies and adenoidectomies.

☐ Major Surgery: Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen, or pelvis or any other operation which, because of the

condition of the patient or the length or circumstances of the operation, presents a distinct hazard to life. Also includes removal of tumors, open bone fractures, amputations, cesarean sections, removal of any gland or organ, plastic surgery, any operation performed using general anesthesia and assisting in major surgery on patients other than your own.

Indicate the percentage of your surgical practice devoted to the following surgical activities:

_____% Abdominal _____% Hand _____% Plastic – Cosmetic

_____% Bariatric _____% Head and Neck

_____% Plastic – Reconstructive _____% Cardiac

_____% Neurosurgical _____% Thoracic

_____% Colon/Rectal _____% Ophthalmological

_____% Traumatic _____% General

_____% Orthopedic – including spinal surgery _____% Vascular

_____% Gynecological _____% Orthopedic – without spinal surgery

_____% Other _____
(describe)

Please check any procedure you perform in your practice:

☐Abortions
☐Acupuncture
☐Adenoidectomies
☐Angiography
☐Angioplasty
☐Arthroscopy
☐Arteriography
☐Assistance in major surgery
☐On own patients
☐On patients of others
☐Biopsy (Endoscopic)
☐Blepharopigmentation
☐Blepharoplasty – Brow lifts
☐Breast Implants
☐Bronchoscopy
☐CABG
☐Catheterization, Cardiac
☐Catheterization,
☐Dilation and curettage
☐ERCP
☐Fracture reductions - closed
☐Fracture reductions - open
☐Gastrointestinal Endoscopy
☐General/Spinal/Caudal anesthesia
☐Pulse oximetry
☐End tidal CO^2 analyzer
☐Gynecological Surgery (major)
☐Hemorrhoidectomies
☐High Risk Obstetrics
☐Laparoscopic cholecystectomies
☐Laparoscopy
☐Laser surgery / therapy
☐LASIK Surgery
☐Liposuction
☐Lithotripsy
☐Lymphangiography
☐Phenol facial peels
☐Phlebography
☐Pneumoencephalography
☐Polypectomy
☐Prenatal practice
☐See patients during 1st trimester
☐See patients during 2nd trimester
☐See patients during 3rd trimester
☐Radial/Laser Keratotomy
☐Radiation therapy
☐Radiopaque dye injection
☐Shock therapy
☐Silicone Injections
☐Sigmoidoscopies
☐Less than 60 cm
☐Greater than 60 cm
☐Skin Flap/Grafts
☐Tubal ligations

Diagnostic

☐Catheterization, Intervention
☐Cataract surgery
☐Chelation therapy
☐Colonoscopies
☐Cryosurgery (other than external lesions)
☐Deliveries (annual number)
Vaginal _____
C-sections _____
VBAC's _____
☐Diagnostic embolization
☐Myelography
☐Needle biopsy
☐Nerve blocks (list sites)
_____
_____
_____
_____
☐Pacemakers
☐Peritoneoscopy
☐Vasectomies
☐Weight Control Therapy/Surgery
☐Bariatric Surgery
☐Medication-weight control
☐Other weight control procedures
_____
_____
☐Other surgical techniques
_____
_____
_____

Have you made any changes to your practice in the past 10 years? Please explain what services/specialties/procedures you added or deleted and when:

_____
_____
_____

B. Practice – General Questions:

Any "yes" answers require a separate written explanation and supporting documentation.

1. Do you provide medical information or advice, interpret films, prescribe medications or sell any products or services through any telecommunications, video, internet or other communication system where you are not face to face with a patient? ☐ Yes ☐ No

2. Do you practice any experimental, investigational or other unconventional therapies including any alternative medicine practice? ☐ Yes ☐ No

3. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? ☐ Yes ☐ No

4. Do you treat or review treatment of Federal prison inmates? ☐ Yes ☐ No

5. Do you treat non-federal prison inmates? ☐ Yes ☐ No
   If yes, indicate percentage of practice _____%

6. Do you treat professional athletes? ☐ Yes ☐ No

7. Do you teach or supervise residents? ☐ Yes ☐ No
   If yes, is this exposure covered by another policy? ☐ Yes ☐ No

8. Do you work in a hospital emergency room? ☐ Yes ☐ No
   If yes, please provide average hours worked per week _____

9. Do you own or operate a Lab that provides services for patients other than your own? ☐ Yes ☐ No

10. Are you providing professional services at any Nursing Home or Long Term Care facility? ☐ Yes ☐ No
    If yes, indicate percentage of practice _____%

11. Do you endorse any products or participate in any activity which offers professional advice to the public (i.e. newspaper columns, broadcasts, etc.)? ☐ Yes ☐ No

12. Do you use a collection agency which has the authority to file collection suits without your knowledge? ☐ Yes ☐ No

13. Do you devise or review plant/employer safety standards? ☐ Yes ☐ No

C. Professional History:

Any "yes" answers require a separate written explanation and supporting documentation.

1. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

2. Have you ever had your medical license or narcotics license revoked, suspended, restricted, or voluntarily surrendered in any state? ☐ Yes ☐ No

3. Have you ever had your privileges at any hospital, institution or managed care organization revoked, suspended or restricted or have you been placed on probation in any state? ☐ Yes ☐ No

4. Have you ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency? ☐ Yes ☐ No

5. Have you ever been suspended, restricted, or put on probation by any governmental health program such as Medicare or Medicaid? ☐ Yes ☐ No

6. Have any fee or professional relations complaints been registered against you with your medical associations, hospitals, or state licensing authorities? ☐ Yes ☐ No

7. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? ☐ Yes ☐ No

8. Has any insurance company ever canceled, refused to renew, restricted coverage through endorsements to the policy or only offered coverage to you with a deductible or in a higher rating plan? ☐ Yes ☐ No

9. Has any allegation or claim ever been made against you regarding sexual harassment, sexual intimacy, exploitation or sexual assault in the conduct of your practice or otherwise? ☐ Yes ☐ No

10. Have you ever intentionally altered or falsified patient records or made any change, correction, or addition without properly noting it as such? ☐ Yes ☐ No

Section VI - Claim Information:

Please complete and attach a supplemental claim form for each claim, potential claim or suit.

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? _____
If yes, have these been reported to your insurer? ☐ Yes ☐ No

Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? ☐ Yes ☐ No

If yes, how many? _____
If yes, have these been reported to your current insurer, or any prior insurer?

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in the above questions in Section VI – Claim Information are excluded from the proposed coverage.

Section VII - Signature

I hereby certify that all of the information provided in this application, including any supplemental information requested and provided, is true and correct. I authorize the release and exchange of all information considered relevant by Darwin Professional Underwriters, Inc and its affiliates (the "company") to the underwriting of this application and authorize any exchange of information between agents, government licensing agencies, any professional society or association of which I am a member, hospitals, health insurers, managed care organizations. I agree to indemnify and hold harmless from liability or expense any organization or individual supplying information to the company in good faith.

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature: _____ Date: _____/_____/_____

Printed Name:_____

ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application.

Page #	Question #	Comments
		Signature: **Date:**

SUPPLEMENTAL CLAIM FORM

Physician Name:_____

Name of Claimant: _____ Age: _____
Gender: ☐ Male ☐ Female

Date of Incident or Care Rendered: _____

Date Claim Reported: _____/_____/_____

Present Status: ☐ Open ☐ Closed with no payment on____/____/____

☐ Closed with payment on ____/_____/_____

If closed with payment: Amount paid: $_____ ☐ Settlement ☐ Judgment

Insurance Carrier: _____

Relationship to claimant (primary, assisting, consulting, etc.): _____

Other Defendants: _____

Please describe the condition and diagnosis of the patient prior to receiving your professional services:

_____

_____

_____

Please describe the treatment you provided:

_____

_____

_____

Condition of patient subsequent to receiving your professional services:

_____

_____

_____

Allegation:

_____

I hereby declare that the above is complete and true to the best of my knowledge and belief and understand that coverage may be voided in the event it is learned that information provided above is not indeed factual and was known to me to be false.

Signature: _____ Date: _____/_____/_____