THEDOCTORSCOMPANY
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# CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

For Allied Personnel

PROTECTING PHYSICIANS SINCE 1976

## Questions?


call Bob DeSimone ...
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San Diego, CA, 92122

## APPLICATION INSTRUCTIONS & CHECKLIST

We have provided the following checklist to assist you in completing your application. Please verify all required information to assist us in processing your application promptly and efficiently. This application for insurance consists of the Application, a Remarks Section, a Claims/Incident Supplement Form, and Agreements & Notices.

☐ All questions must be answered. If you do not know the answer to a particular question, please note that in the Remarks Section.

☐ If you wish to explain any of your answers, please use the Remarks Section. If you need additional space, please continue your answers on your letterhead and attach it to the application.

☐ Claims information should be provided for a 10-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current company loss runs.

☐ Be sure that all documents are signed and dated where indicated.

☐ Please enclose a copy of the following:

a) Copy of your license.

b) Certificate of training.

c) Copy of your practice protocols.

d) Copy of your CV

**If you need additional forms or have any questions about the application process, please call** The Doctors Insurance Agency at (800) 464-2986.

This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional service, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the premium. No coverage exists until the premium is received and a binder or coverage summary, together with any endorsements that may apply, has been issued to the first named insured.

## MEDICAL GROUP DETAILS

Entity/Medical Group name *(or physician name and personal corporation/DBA if solo)*: ______________________

Requested coverage effective date as at 12:01 A.M. *(MM/DD/YYYY)*: ______________

☐ Request is to join a physician or group with policy number: ______________

*OR*

☐ New request. *Attach this application with associated Physicians and Surgeons application(s).*

## GENERAL INFORMATION

Practitioner type: ☐ Ancillary – Own limits ☐ Ancillary – Shared limits

Application for: ☐ Certified Nurse Midwife ☐ Certified Registered Nurse Anesthetist ☐ Anesthesia Assistant ☐ Nurse Practitioner ☐ Optometrist ☐ Physician Assistant

## PERSONAL INFORMATION

Last Name ______________ First Name ______________ M.I. ______ Suffix ______

Social Security Number ______________ National Provider Identifier ______________

Date of Birth *(MM/DD/YYYY)* ______________ Gender: ☐ Male ☐ Female

Home Address - Number and Street ______________________

City ______________ State ______ Zip Code ______ Home Phone ______________

E-mail Address ______________________

## REQUESTED COVERAGE

**1.** Employment Date *(MM/YYYY)* ______________ **2.** Current policy expires on *(MM/DD/YYYY)* ______________

**3.** A. Do you intend to purchase an extended reporting endorsement (tail coverage) from your current carrier? ☐ Yes ☐ No

B. If no, do you wish to purchase retroactive coverage? ☐ Yes ☐ No

C. If you wish to purchase retroactive coverage, please indicate your retroactive date. *(MM/DD/YYYY)* ______________

## MEDICAL SPECIALTY

Please indicate your medical specialty: ______________________

Supervising physician (if any): ______________ Supervision: ☐ Direct ☐ Indirect

Describe nature and extent of supervision provided by above-named supervising physician:

______________________

______________________

## EDUCATION

Please provide information regarding your medical education.

**INSTITUTION OR PROGRAM:**

Name of Institution ______________________________

City ______________________ State ________ Country ______________

Start Date *(MM/YYYY)* ______________ Finished Date *(MM/YYYY)* ______________

DEGREE/CERTIFICATION ______________________________

**OTHER:**

Name of Institution ______________________________

City ______________________ State ________ Country ______________

Start Date *(MM/YYYY)* ______________ Finished Date *(MM/YYYY)* ______________

DEGREE/CERTIFICATION ______________________________

## LICENSES

Please indicate your medical licenses:

A. License State ______________ Number ______________________

License Status: ☐ Inactive ☐ Restricted ☐ Revoked/Suspended ☐ Active ☐ Temporary

B. License State ______________ Number ______________________

License Status: ☐ Inactive ☐ Restricted ☐ Revoked/Suspended ☐ Active ☐ Temporary

C. License State ______________ Number ______________________

License Status: ☐ Inactive ☐ Restricted ☐ Revoked/Suspended ☐ Active ☐ Temporary

## PRACTICE PROFILE

1. Indicate your average number of practice hours per week. __________ (Include office hours, administrative activities, direct patient care, surgery, consultation, etc., with the exception of hours on call.)

2. Estimate number of patients seen in clinical practice on an average weekly basis. _________

3. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary office locations (including but not limited to telemedicine or Internet medicine)? ☐ Yes ☐ No

   A. If yes, indicate all states where you see patients or where the patients being treated reside:

   State ________ State ________ State ________ State ________ State ________ State ________

   B. Are you licensed to practice in each of these states? ☐ Yes ☐ No

   C. What percentage of your total practice does this extra-state activity constitute? ________%

4. Are you employed full time or part time by the federal, state, or local government, or are you on active military duty? ☐ Yes ☐ No

   If yes, please explain the nature of your employment and why you desire coverage: ____________________________________________

   ____________________________________________________________________________________

5. A. Do you “moonlight” at any other facilities? ☐ Yes ☐ No

   B. Do you provide any services at a hotel, spa, or health club? ☐ Yes ☐ No

   If yes, please explain: ____________________________________________________________________

   ____________________________________________________________________________________

6. Do you anticipate any changes in your specialty or practice activities (including but not limited to the addition or deletion of procedures, change in number of hours per week you practice, and in health care provider staff) in the next year? ☐ Yes ☐ No

   If yes, please explain: ____________________________________________________________________

   ____________________________________________________________________________________

7. Do you have an employment agreement or contract? ☐ Yes ☐ No

8. Does your employment/practice ever require that you be present in the operating room to assist in the performance of surgical procedures? ☐ Yes ☐ No

9. Does your employment/practice ever require that you be present in the operating room to observe? ☐ Yes ☐ No

10. Does your employment/practice ever require that you be present in the operating room for any other purposes? ☐ Yes ☐ No

## EMPLOYMENT HISTORY

Please indicate your complete employment history.

☐ I have had no prior practice.

A. Entity Name ____________________

Number and Street ____________________

City ____________________ State ________ Zip Code ________ Office Phone ____________

Start Date *(MM/YYYY)* ____________________ End Date *(MM/YYYY)* ____________________

B. Entity Name ____________________

Number and Street ____________________

City ____________________ State ________ Zip Code ________ Office Phone ____________

Start Date *(MM/YYYY)* ____________________ End Date *(MM/YYYY)* ____________________

C. Entity Name ____________________

Number and Street ____________________

City ____________________ State ________ Zip Code ________ Office Phone ____________

Start Date *(MM/YYYY)* ____________________ End Date *(MM/YYYY)* ____________________

## INSURANCE HISTORY

☐ I have had no prior insurance.

To ensure that there are no gaps in coverage, please list previous medical professional liability insurance carried during the past ten (10) years, beginning with your current carrier. Attach a copy of the Declarations page from your most recent policy.

A. ☐ Claims Made ☐ Occurrence Was extended reporting coverage (tail) purchased? ☐ Yes ☐ No

Policy Period: From *(MM/DD/YYYY)* ____________________ To *(MM/DD/YYYY)* ____________________

Insurer ____________________

Limits: Per Claim $ ____________________ Aggregate $ ____________________

B. ☐ Claims Made ☐ Occurrence Was extended reporting coverage (tail) purchased? ☐ Yes ☐ No

Policy Period: From *(MM/DD/YYYY)* ____________________ To *(MM/DD/YYYY)* ____________________

Insurer ____________________

Limits: Per Claim $ ____________________ Aggregate $ ____________________

C. ☐ Claims Made ☐ Occurrence Was extended reporting coverage (tail) purchased? ☐ Yes ☐ No

Policy Period: From *(MM/DD/YYYY)* ____________________ To *(MM/DD/YYYY)* ____________________

Insurer ____________________

Limits: Per Claim $ ____________________ Aggregate $ ____________________

## ELIGIBILITY

If you answer yes to any of the following questions, **please give full details in the Remarks Section of the application**. Include dates and copies of related documents.

| | Question | YES | NO |
|---|---|---|---|
| **1.** | Have you ever been evaluated for, recommended for treatment of, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management issues, or any mental illness, including but not limited to depression and/or chronic fatigue? *(If yes, please accompany this application with a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status.)* | ☐ | ☐ |
| **2.** | Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? *(If yes, please accompany this application with a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status.)* | ☐ | ☐ |
| **3.** | Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you? **NOTE MISSOURI APPLICANTS DO NOT RESPOND.** | ☐ | ☐ |
| **4.** | Have you ever appeared before, been investigated by, entered into any consent agreement with, or do you have an investigation currently in progress or pending by any state licensing board, board of medical examiners, DEA, or other governmental or regulatory agency? *(If yes, please provide copies of complaint and disposition documents.)* | ☐ | ☐ |
| **5.** | Has your license to practice or your DEA/narcotics license ever been denied, revoked, suspended, placed on probation, or limited in any way? | ☐ | ☐ |
| **6.** | Has any physician, patient, or insurance plan ever filed a complaint against you with any medical association/ society or foundation, consumer protection agency, Chamber of Commerce, or Better Business Bureau? | ☐ | ☐ |
| **7.** | Has your participation in any governmental or nongovernmental health program (e.g., Medicare, Medicaid, HMO, PPO, and/or any managed care program) ever been suspended, placed on probation, terminated, or limited in any way? | ☐ | ☐ |
| **8.** | Have your staff privileges at any hospital or health care facility ever been suspended, revoked, voluntarily surrendered, placed on probation, or in any way restricted, or do you have an investigation relative to your staff privileges pending or in progress at any hospital or health care facility? | ☐ | ☐ |
| **9.** | Have you ever been refused hospital or health care facility staff privileges? | ☐ | ☐ |
| **10.** | Has your membership in any professional society or association ever been refused, censured, suspended, placed on probation, or revoked? | ☐ | ☐ |
| **11.** | Have you ever been convicted of, pled guilty to, or entered into a plea agreement for a violation of any law or ordinance (including driving while under the influence of alcohol or any other substance) other than traffic offenses? | ☐ | ☐ |
| **12.** | Have you ever been accused of sexual misconduct of any kind in your professional capacity? | ☐ | ☐ |
| **13.** | Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors, or public health insurance payors, including but not limited to Medicare or Medicaid? | ☐ | ☐ |
| **14.** | Have you been a party to a malpractice claim, suit, or incident in the past 10 years? An incident is a circumstance involving your professional services that you know or believe, or by diligent inquiry you would have a reasonable basis to know or believe, may give rise to a claim. (*If you answer yes, please provide complete details on the Claims/Incident Supplement Form. Complete a separate form for each claim.)* | ☐ | ☐ |

## ELIGIBILITY

| | YES | NO |
|---|---|---|
| **15.** Other than the claims/suits/incidents indicated in question 14 above, are you aware, after reasonable inquiry, of any of the following circumstances in the past 10 years that might reasonably lead to a claim or suit being brought against you even if you believe that claim or suit would be without merit, including: | | |
| A. A request for records from a patient and/or attorney related to an adverse outcome? | ☐ | ☐ |
| B. A letter from an attorney regarding your medical treatment of a patient? | ☐ | ☐ |
| C. Patient or family member expressed dissatisfaction with or complained about the outcome of a procedure, treatment, or diagnosis? | ☐ | ☐ |
| D. Any other circumstances that might be reasonably expected to lead to a claim or suit? | ☐ | ☐ |
| **16.** Are there any circumstances that might be reasonably expected to lead to a claim or suit (even if you believe the possible claim or suit would be without merit) that have not been reported to your current or prior medical professional liability carrier? | ☐ | ☐ |
| **17.** Have you contracted, either now or in the past, to treat patients or review treatment at correctional facilities? | ☐ | ☐ |

If yes, please explain:______________________________________________

______________________________________________

| | | |
|---|---|---|
| **18.** Do you provide medical services at any long-term care facility, skilled nursing facility, or nursing home? | ☐ | ☐ |

If yes:

A. How many patients do you treat per month, on average? _______

| | | |
|---|---|---|
| B. Are you under contract to provide medical services at any long-term care facility, skilled nursing facility, or nursing home? | ☐ | ☐ |

## REMARKS SECTION

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

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______________________________________________

## CLAIMS/INCIDENT SUPPLEMENT FORM

This section should be completed only if you answered yes to question 14 on page A•5. Please photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. All questions must be answered or marked Not Applicable (N/A).

Name of Patient ______________________________

Age at time of incident ______________ Gender: ☐ Male ☐ Female

Your relationship to patient (e.g., attending physician, primary surgeon, assistant surgeon): ______________________________

Date of Incident *(MM/DD/YYYY)* ______________ Date Reported to Carrier *(MM/DD/YYYY)* ______________

Location: ______________________________

Insurance Carrier(s): ______________________________

Other Defendants: ______________________________

Defense Counsel: ______________________________
*City* *State* *Telephone*

Plaintiff's Counsel: ______________________________
*City* *State* *Telephone*

Present Status: ☐ Incident Only ☐ Pending Suit ☐ Closed with Settlement
☐ Closed with Judgment ☐ Closed with No Indemnity Payment

Please explain status: ______________________________

______________________________

Date Closed *(MM/DD/YYYY)* ______________ Amount Paid $ ______________

To your knowledge, was any settlement or judgment paid by another party involved (i.e., your P.A., P.C., partners, employees, hospital, etc.)? ☐ Yes ☐ No

If yes, amount of settlement or judgment $ ______________

Allegation(s) (as stated by patient/plaintiff): ______________________________

______________________________

Applicant's response to allegation(s): ______________________________

______________________________

Conditions and diagnosis at time of treatment: ______________________________

______________________________

Dates and description of treatment rendered: ______________________________

______________________________

______________________________

Condition of patient subsequent to treatment (include dates and follow-up treatment): ______________________________

______________________________

Were there any issues regarding altering or directing others to alter (whether changing, clarifying, updating, completing, or destroying) any patient or business records pertaining to this claim? ☐ Yes ☐ No

If yes, please explain: ______________________________

Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: ______________________________

______________________________

**I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

**X** ______________________________ ______________________________
Signature Date

## AGREEMENTS & NOTICES

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information or material misrepresentation will cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application—in ink—and returned the original to the company with the required payment.

(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: I understand that in connection with this application for insurance, the company may review my credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. The company may use a third party in connection with the development of my insurance score.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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 Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, 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 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.

Notice to Louisiana 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 fines and confinement in prison.

Notice to Maine 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 denial of insurance benefits.

Notice to Missouri Applicants: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application you should not respond.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to 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 New York 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 $5,000 (five thousand dollars) and the stated value of the claim for each such violation.

## AGREEMENTS & NOTICES

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he or 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.

Notice to Oklahoma Applicants: WARNING: 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. The absence of such a statement shall not constitute a defense in any prosecution.

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.

Notice to Tennessee 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 include imprisonment, fines, and denial of insurance benefits.

Notice to 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 include imprisonment, fines, denial of insurance benefits, and civil damages.

Notice to West Virginia 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 fines and confinement in prison.

***SIGNATURE REQUIRED:***

**X** ______________________________ ______________________

Signature Date