



APPLICATION FOR PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

- 1. (a) (i) Full name of Applicant:
(ii) Professional Degree:
(b) Principal practice address:
(c) Secondary practice locations:
(d) (i) Phone: (ii) Fax:
(iii) E-Mail Address: (iv) Website Address:
(e) (i) Date of Birth (MM/DD/YYYY): (ii) Place of Birth:
(e) (i) Social Security No.: (ii) Federal Tax ID Number:
2. Are you a U.S. citizen?
If No, what is your status in the U.S. and current citizenship?
3. (a) Type of practice:
(b) Do you want coverage for the entity named Item 3. (a) above?
(c) Attach a copy of your letterhead (if any).
(d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, please list the names of all physicians practicing under the entity name in Item 3. (a) above.
4. Do you practice with any physician not named in Item 3. (d) above?
If Yes, provide the name of each physician and the practice relationship to you.
5. Are you currently in active military service?

6. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. Federal DEA License No. and status: \_\_\_\_\_

8. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

<u>Facility Name</u>	<u>City</u>	<u>State</u>	<u>Percentage of Work</u>	<u>Type of Privileges</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. Are you currently a hospital chief of staff or head of any hospital department? .....  Yes  No  
**If Yes**, describe. \_\_\_\_\_

10. Do you or the entity firm named in Item 3. (a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? .....  Yes  No  
**If Yes**, provide a detailed explanation specifically including the name, location, size, and number of beds. \_\_\_\_\_

11. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .....  Yes  No  
**If Yes**,  
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .....  Yes  No  
(ii) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_

**II. EDUCATION AND TRAINING**

1. (a) Provide your medical or surgical specialty: \_\_\_\_\_  
(b) Do you limit your practice to the specialty stated in item (a) above? .....  Yes  No  
(c) Do you have a subspecialty? .....  Yes  No  
**If Yes**, describe. \_\_\_\_\_

2. Are you American Board certified? .....  Yes  No  
**If Yes**, provide the following: Medical specialty in which you are certified: \_\_\_\_\_  
Date of certification: \_\_\_\_\_ Any recertification date(s): \_\_\_\_\_  
**If No**, do you plan on taking the Board examination? .....  Yes  No

3. Provide the following information:

	<u>Name of Institution</u>	<u>City</u>	<u>State</u>	<u>Date Completed</u>
Medical School	_____	_____	_____	_____
PGY-1/Internship	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Residency – Specialty: _____	_____	_____	_____	_____
Fellowship – Specialty: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? .....  Yes  No  
**If Yes**, provide the following: year of certification: \_\_\_\_\_ describe your medical degree: \_\_\_\_\_

5. Provide a detailed summary of where you have practiced your profession since completing your training: \_\_\_\_\_
6. Are you a member of any professional societies?.....  Yes  No  
**If Yes**, provide information regarding your membership(s). \_\_\_\_\_
7. How many hours of continuing medical education have you take within each of the last two (2) years? \_\_\_\_\_

**III. SCOPE OF PRACTICE**

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia? .....  Yes  No  
**If Yes**, complete 1. (b) below.
- (b) If you perform any of the following procedures, check all that apply. For each procedure performed, please indicate the type of facility(ies) where the procedure is performed:  
**H = Hospital S = Surgi-center OF = Office OT = Other** (describe in comments section, see page #8)

<u>Type of Facility</u>	<u>Type of Facility</u>
<input type="checkbox"/> Abortions - 1st Trimester _____	<input type="checkbox"/> Hysterectomies _____
<input type="checkbox"/> Abortions - 2nd/3rd Trimester _____	<input type="checkbox"/> Laser skin resurfacing _____
<input type="checkbox"/> Acupuncture _____	<input type="checkbox"/> Laser Surgery (describe) _____
<input type="checkbox"/> Adenoidectomy/Tonsillectomy _____	<input type="checkbox"/> Lymphangiography _____
Anesthesia – Non-obstetrical: _____	<input type="checkbox"/> Minimally invasive surgery (describe) _____
<input type="checkbox"/> General _____	_____
<input type="checkbox"/> Spinal _____	<input type="checkbox"/> Moh's micrographic surgery _____
<input type="checkbox"/> Epidural _____	<input type="checkbox"/> Myelography _____
Anesthesia – Obstetrical: _____	<input type="checkbox"/> Needle biopsies (describe) _____
<input type="checkbox"/> General _____	Obstetrics: _____
<input type="checkbox"/> Spinal _____	<input type="checkbox"/> Prenatal care _____
<input type="checkbox"/> Epidural _____	<input type="checkbox"/> Normal deliveries - annual #: _____
<input type="checkbox"/> Anesthesia – Other (describe) _____	<input type="checkbox"/> Caesarean sections - annual #: _____
_____	<input type="checkbox"/> VBAC deliveries – annual #: _____
<input type="checkbox"/> Angiography _____	<input type="checkbox"/> Open Reduction of Fractures _____
<input type="checkbox"/> Angioplasty _____	<input type="checkbox"/> Pain Management (describe) _____
<input type="checkbox"/> Anti-aging procedures – other than use of human growth hormone (describe) _____	_____
<input type="checkbox"/> Arteriography _____	Plastic – Cosmetic Procedures: _____
<input type="checkbox"/> Assisting in Surgery – on own patients or the patients of others _____	<input type="checkbox"/> Blepharoplasty _____
<input type="checkbox"/> Breast Implants _____	<input type="checkbox"/> Collagen injections _____
<input type="checkbox"/> Breast Reductions _____	<input type="checkbox"/> Botox injections _____
<input type="checkbox"/> Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel _____	<input type="checkbox"/> Liposuction under 3500 cc's volume _____
<input type="checkbox"/> Cosmetic implantation or injection of silicone or other material _____	<input type="checkbox"/> Liposuction 3500 cc's or more volume _____
<input type="checkbox"/> Cryosurgery - other than on benign or pre-malignant dermatological lesions _____	<input type="checkbox"/> Phalloplasty or penile implant _____
<input type="checkbox"/> Chelation Therapy _____	<input type="checkbox"/> Rhinoplasty _____
<input type="checkbox"/> Dermabrasion/Chemical Peels _____	<input type="checkbox"/> Silicone implants _____
<input type="checkbox"/> Dilation & Curettage _____	<input type="checkbox"/> Silicone injections _____
<input type="checkbox"/> Discograms _____	<input type="checkbox"/> Other plastic – cosmetic procedures (describe) _____
<input type="checkbox"/> Electroconvulsive Therapy _____	<input type="checkbox"/> Pneumoencephalography _____
<input type="checkbox"/> Endoscopic procedures _____	<input type="checkbox"/> Prolotherapy/proliferative therapy _____
<input type="checkbox"/> Hair Transplants or Suturing of Hairpieces _____	<input type="checkbox"/> Radiation Therapy _____
<input type="checkbox"/> Hyperbaric Medicine _____	<input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae _____
	<input type="checkbox"/> Refractive surgery: LASIK, PRK, AK, PTK, ICR _____
	<input type="checkbox"/> Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy) _____
	<input type="checkbox"/> Trans Myocardial Laser procedures _____

2. (a) Do you perform surgery for obesity? .....  Yes  No  
**If Yes**, complete 2. (b) below.
- (b) If you perform any of the following procedures, check all that apply and provide the number of procedures performed:
- Roux-en-Y:
- Laparoscopic:  
Number performed in past 12 months: \_\_\_\_\_  
Number you expect to perform in next 12 months: \_\_\_\_\_
- Open:  
Number performed in past 12 months: \_\_\_\_\_  
Number you expect to perform in next 12 months: \_\_\_\_\_
- Banding:
- Laparoscopic:  
Number performed in past 12 months: \_\_\_\_\_  
Number you expect to perform in next 12 months: \_\_\_\_\_
- Open:  
Number performed in past 12 months: \_\_\_\_\_  
Number you expect to perform in next 12 months: \_\_\_\_\_
- Gastric Restriction, Other (describe) \_\_\_\_\_:  
Number performed in past 12 months: \_\_\_\_\_  
Number you expect to perform in next 12 months: \_\_\_\_\_
3. Is general anesthesia administered for any of the procedures identified in 1. (b) or 2. above? .....  Yes  No  
**If Yes**, is anesthesia administered by:
- (a) you?.....  Yes  No  
(b) an Anesthesiologist?.....  Yes  No  
(c) a Certified Registered Nurse Anesthetist (CRNA)?.....  Yes  No  
**If Yes**, is the CRNA directed by or responsible to an Anesthesiologist? .....  Yes  No  
**If No**, explain the type of surgery and percentage of your surgeries or average number of such cases per month.
- 
- (d) Are Harvard Standards for the administration of all anesthesia adhered to? .....  Yes  No
4. (a) Do you perform any surgery in your office? .....  Yes  No  
**If Yes**, answer the following:
- (i) Describe each procedure not already identified above in 1. (b) or 2. above: \_\_\_\_\_  
\_\_\_\_\_
- (ii) Is your surgical suite certified or accredited? .....  Yes  No  
**If Yes**, provide the name of the certification/accreditation body: \_\_\_\_\_
- (b) Do you perform any surgery in other non-hospital facilities?.....  Yes  No  
**If Yes**, answer the following:
- (i) Describe each procedure not already identified above in 1. (b) or 2. above: \_\_\_\_\_  
\_\_\_\_\_
- (ii) Name each facility: \_\_\_\_\_  
\_\_\_\_\_
5. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise?.....  Yes  No  
**If Yes**, answer the following:
- (a) Percentage of your patients that are weight control patients: \_\_\_\_\_
- (b) Do you dispense/prescribe any drugs? .....  Yes  No  
**If Yes**, provide the name(s) of the drug(s) dispensed/prescribed. \_\_\_\_\_

(c) Do you use injections for weight control? .....  Yes  No  
**If Yes**, provide the name(s) of the drugs injected. \_\_\_\_\_

6. Do you perform any hospital emergency room care? .....  Yes  No  
**If Yes**, is this solely a requirement for active admitting privileges? .....  Yes  No

**If No**, provide a detailed description including the approximate number of hours per month spent in emergency room care. \_\_\_\_\_

7. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? .....  Yes  No

**If Yes**, provide the following:

(a) Identify all states in which such patients reside: \_\_\_\_\_

(b) What percentage of your total practice is involved in such activities? \_\_\_\_\_

8. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? .....  Yes  No

**If Yes**, identify all states in which such patients reside. \_\_\_\_\_

9. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? .....  Yes  No  
**If Yes**, do you follow FDA-approved protocols? .....  Yes  No

**If Yes**, describe. \_\_\_\_\_

(b) Are you a Principal Investigator for any clinical trial? .....  Yes  No

10. (a) Indicate the number of professional employees in your practice for each of the following: (If none, check here )

____ Physicians, other than you	____ Podiatrists	____ Chiropractors	____ Optometrists
____ Physician's Assistants*	____ Nurses	____ Nurse Practitioners*	____ Nurse Anesthetists*
____ Surgeon's Assistants*	____ Nurse Midwives*	____ Psychologists	
____ Other (describe) _____			

\*Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? .....  Yes  No

**If No**, provide a detailed explanation on a separate page.

11. (a) Estimated number of weekly patient load: \_\_\_\_\_ (b) Estimated number of patients annually: \_\_\_\_\_

12. Average number of hours you practice each week: \_\_\_\_\_

13. What is your approximate gross annual income from your practice? (Check one.)

<input type="checkbox"/> Less than \$50,000	<input type="checkbox"/> \$50,000 to \$99,999	<input type="checkbox"/> \$100,000 to \$149,999
<input type="checkbox"/> \$150,000 to \$249,999	<input type="checkbox"/> \$250,000 to \$499,999	<input type="checkbox"/> \$500,000 or more*

\* If more than \$500,000, please indicate expected annual income \$ \_\_\_\_\_

14. Do you supervise anyone other than your own employees? .....  Yes  No

**If Yes**, indicate by profession the number of individuals you supervise:

____ Physicians	____ Podiatrists	____ Chiropractors	____ Optometrists
____ Physician's Assistants	____ Nurses	____ Nurse Practitioners	____ Nurse Anesthetists
____ Surgeon's Assistants	____ Nurse Midwives	____ Psychologists	
____ Radiology Technicians	____ Laboratory Technicians	____ Other (describe) _____	

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. \_\_\_\_\_

15. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

16. Do you currently participate in any state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? .....  Yes  No

17. Do you anticipate any changes in your practice in the next year? .....  Yes  No  
**If Yes**, attach a detailed explanation.

**IV. AFFILIATIONS**

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3. (a) above? .....  Yes  No  
**If Yes**, provide a detailed explanation including a description of your responsibilities. \_\_\_\_\_

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3. (a) above? .....  Yes  No  
**If Yes**, provide a detailed explanation including a description of your responsibilities. \_\_\_\_\_

**If Yes**, does any contract contain a hold harmless agreement? .....  Yes  No  
**If Yes**, attach a copy of the contract.

3. Are you in the employ of or under contract to any governmental entity? .....  Yes  No  
**If Yes**, provide a detailed explanation including a description of your responsibilities. \_\_\_\_\_

4. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? .....  Yes  No  
**If Yes**, attach a copy of all advertisements.

5. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? .....  Yes  No  
**If Yes**, attach a copy of the advertisement or applicable website address.

6. Are you the Medical Director of a nursing home, clinic, commercial enterprise or any other organization? .....  Yes  No  
**If Yes**, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position. \_\_\_\_\_

7. Do you have any administrative or teaching responsibilities? .....  Yes  No  
**If Yes**, provide the following and attach a copy of any contract or agreement:

(a) Name of entity and location: \_\_\_\_\_  
 Your title \_\_\_\_\_

(b) Does the entity provide you coverage for:  
 (i) Your administrative responsibilities? .....  Yes  No  
 (ii) Your direct patient care? .....  Yes  No

8. Do you work for any locum tenens companies? .....  Yes  No  
**If Yes**, answer the following:  
 (a) Name of each company that places you in locum positions: \_\_\_\_\_  
 (b) Check one, you an  Employee or  Independent Contractor  
 (c) Number of hours each month in which you work in locum positions: \_\_\_\_\_  
 (d) Does each company provide you with Professional Liability Insurance for locum positions?.....  Yes  No  
**If Yes**, attach a copy of your Certificates of Insurance.
9. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location? .....  Yes  No  
**If Yes**, provide details. \_\_\_\_\_
10. Are you engaged in or planning to engage in any "moonlighting" activities? .....  Yes  No  
**If Yes**, do you want coverage for your "moonlighting" activities? .....  Yes  No  
**If Yes**, describe the activities. \_\_\_\_\_

---

**V. CLAIMS AND HISTORY**

---

1. Within the past 10 years, has any claim or suit for malpractice been made against you or any entity proposed for this insurance? .....  Yes  No  
**If Yes**, how many? \_\_\_\_\_ Complete a Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? .....  Yes  No  
**If Yes**, how many? \_\_\_\_\_ Complete a Supplemental Claim form for each one.
3. Are you or any staff or owner of an entity to be covered by this insurance aware of any act, error, omission, fact, circumstance, or records request from any patient, patient's family or patient's attorney which may result in a malpractice claim or suit against any proposed insured? .....  Yes  No  
**If Yes**, how many? \_\_\_\_\_ Complete a Supplemental Claim form for each one.
4. Within the past 10 years, have you been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? .....  Yes  No
5. Within the past 10 years, has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? .....  Yes  No
- 6.....Within the past 10 years, have you been notified to respond to, appeared before or have you been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? .....  Yes  No
7. Within the past 10 years, have you ever been charged with or convicted of an act committed in violation of any law or ordinance? .....  Yes  No
8. Within the past 10 years, have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? .....  Yes  No
9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? .....  Yes  No

**Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.**

**NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY**

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

CoverX Corporation or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.





**BROKER RISK SUMMARY**  
**(Medical Malpractice and Specified Medical)**

ACCOUNT NAME:

Address  
City, State, Zip  
States of Licensure  
New or Renewal for CoverX/First Mercury

DESCRIPTION OF SERVICES:  
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: \_\_\_\_\_  
Limits: \_\_\_\_\_ Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_ Retro Date: \_\_\_\_\_

LOSS EXPERIENCE:  
(10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:  
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: