Advanced Providers' Insurance

APPLICATION FOR PHYSICIANS PROFESSIONAL LIABILITY INSURANCE

This is a Claims-Made Policy with Defense inside the Limit
Read Your Policy Carefully

A. Complete Application:			
Please attach the following to complete your application: ☐ Your CV, including your medical education and training ☐ Your medical license ☐ Drug Enforcement Agency License ☐ **Your advertising materials (unless provided in Corporate Entity Application)* ☐ **Copy of current declarations page* ☐ **Current loss runs from previous carriers (5 years)* ****If Possible***			
B. Personal Data:			
Name		☐ MD ☐ DO	
Mailing Address			
City	County	State	Zip
Practice Address (if different)			
City	County	State	Zip
Medical License No.	Licensed State	DEA License No.	
Date of Birth	Place of Birth	☐ Male ☐ Female	
Office Phone No.	Fax No.		
E-mail Address	Social Security Number:		
Office or business manager contact name:			

C. Policy Information:

1. Date you desire coverage to begin:
2. Date you first began practice:
3. Beginning with your most recent or current insurer, please list **ALL** current and prior medical professional liability insurers for the previous five (5) years. Please explain any gaps in the continuity of your professional liability coverage in the Remarks section:

Coverage Period From Mo./Yr. To Mo. Yr.	Insurance Carrier	Policy # Type of Policy (Claim-made or Occurrence)	Retroactive Date

4. If your expiring policy is on a claims-made basis, an extended reporting period endorsement "tail" is generally available as an option to your expiring claims-made policy.
   a. Are you exercising these options? ☐Yes ☐No
   b. If no, do you want us to provide coverage for prior acts (claims or incidents which may have occurred, but, as yet, no indication of a claim has been made to you)? ☐Yes ☐No
   c. Indicate the date you would like coverage provided back to (retroactive date):
   d. Indicate reason for termination of latest policy:

Prior acts coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier. There is a shared aggregate of $750,000 or 70% of all premiums written which ever is greater. Limits available:
☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000

D. Practice Information:

5. Your practice specialty:	Subspecialty:

6. Is there any aspect of your medical practice for which you do not want coverage under this policy?	☐Yes ☐No
If yes, please describe below: (include location address if applicable)	

7. Indicate the practice situation that best describes you :

☐ "Solo" Physician	☐ Licensed Resident
☐ Employee	☐ Independent Contractor (please describe nature and scope of the contract or submit the contract)
☐ Member of Group Practice	☐ Other

8. List all hospitals where you currently have staff privileges (include courtesy staff and percentage of your hospital practice):

Hospital	City	State	% of practice

If you do not have admitting privileges, please describe your mechanism for handling your patients who may require immediate in-patient care. We may also require a copy of a letter or contract that you have which provides evidence of a relationship with a physician that will admit your patients:

9. Indicate all the locations you practice at:

☐ Office ☐ Urgent Care Clinic ☐ Surgicenter ☐ Emergency Department ☐ Any other office locations not listed on this application

☐ Nursing Home ☐ Assisted Living Facility ☐ Patient's Home

10. Do you do any moonlighting outside the practice described herein?	☐Yes ☐No
If yes, please provide details.	
11. Are you a medical director of any nursing home, home health care agency, health care facility or business enterprise providing medical services? If so, indicate name:	☐Yes ☐No
12. Are centralized records maintained in a secure environment and are computer files backed-up?	☐Yes ☐No

13. What is your average weekly patient load?	14. What is your total weekly hours of practice time including on call, charting, teaching, phone consultations, etc.):

15. Are you American Board Certified in your Specialty? ☐Yes ☐No Sub-Specialty?	☐Yes ☐No
If yes, name of board and year of certification:	
If no, please explain status:	
16. Have you practiced continuously for the past ten (10) years?	☐Yes ☐No
If no, please explain on page 4 (remarks section) .	
17. Have your practice procedures, specialty, location(s), etc., changed in the past ten (10) years?	☐Yes ☐No
If yes, please describe, and provide dates for any major changes, such as changes in specialty or significant procedures initiated or no longer performed:	

18. Check the box that best describes your practice:

☐ **No surgery** – permits incision of boils and wound debridement (up to Stage III only), or suturing of skin or superficial fascia.

☐ **Minor surgery**–Includes "No Surgery plus wound debridement up to Stage IV only or suturing of skin or superficial fascia.

☐ **Major surgery** – includes any procedure not listed in "No Surgery or Minor Surgery" above including anesthesia, such as; tonsillectomies, adenoidectomies, cesarean sections, and assisting in major surgery on patients **other than your own**. **NOTE: There will be no coverage for any Major surgery.**	
19. List the average number of house call patients you visit each month:	
20. List the average number of narcotic prescriptions you write each month:	
Weight Control:	
21. Does your practice involve weight reduction or control, other than prescribing exercise? (percentage of patients exclusively for weight reduction or control _____%)	☐Yes ☐No
If yes, please describe:	
Wound Care:	
22. Are you providing wound care (decubitus ulcers) ?	☐Yes ☐No
If so, what stages 1-5 are you treating? (please circle) 1 2 3 4 5	
What additional training do you have for providing wound care for stages 4 & 5 if you are not a surgeon? Please describe:	
National Protocols call for a wound care specialist to treat stages 4 & 5 decubitus ulcers. What arrangements do you have for referrals to a wound care specialist? Please explain:	
Please identify the name of the referral physician and provide contact information: Name: ________________ Phone: ________________ Fax: ________________ Address: ________________ ________________	
E. Claims Information	
23. Have you ever practiced without insurance or allowed a claims-made policy to lapse without the purchase of Extended Reporting Period Endorsement (tail) or Prior Acts (nose coverage)? If yes, please provide details on page 4 (remarks section).	☐Yes ☐No
24. Have you ever had professional liability insurance refused, declined, non-renewed, cancelled or accepted on special terms?	☐Yes ☐No
If you marked yes to any of the above, please explain on the sheet provided.	
25. Have you ever:	
a. Been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, non-renew or revoke your privileges?	☐Yes ☐No
b. Had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?	☐Yes ☐No
c. Been notified to respond to, appear before or investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct?	☐Yes ☐No
d. Been charged with or convicted of a felony or misdemeanor other than minor traffic violations?	☐Yes ☐No
e. Been evaluated, treated or hospitalized for any of the following:	
Alcohol	☐Yes ☐No
Narcotics	☐Yes ☐No
Central nervous system stimulants or depressants	☐Yes ☐No
Mental or emotional disorders	☐Yes ☐No
f. Had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine?	☐Yes ☐No
If yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.	☐Yes ☐No
g. Had Medicare/Medicaid fraud charges filed against you?	☐Yes ☐No

h. Been suspended from Medicare/Medicaid?	☐Yes ☐No
If you answered yes to any of the above questions, please provide full details on the sheet provided.	
26. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last seven (7) years, or are you presently involved in malpractice litigation?	☐Yes ☐No
If yes, submit a separate form for each case in the last seven (7) years (see page 5 claim supplemental).	
27. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?	☐Yes ☐No
a. A request for records from a patient and/or attorney related to an adverse outcome?	☐Yes ☐No
b. A letter from a patient and/or attorney regarding your medical treatment of a patient?	☐Yes ☐No
c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities including those in relation to the use of Fen-Phen (Redux)?	☐Yes ☐No
28. Are you aware of a patient dissatisfaction with the outcome of a procedure, treatment or diagnosis?	☐Yes ☐No
29. Have all circumstances that might reasonably lead to an incident, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐Yes ☐No

Remarks and/or Additional Information:

Question # Remarks

Supplemental Claims Form

Note: This form is to be completed if you have been involved directly or indirectly in a claim, potential claim, notice of intent, suit or incident arising out of the rendering of or failure to render professional services.

Name of Patient or Claimant:

Date of Injury:	Date Reported to Insurance Carrier:

Name of previous Insurance Carrier:

Location of Incident: (City) (State)

Other Persons or Defendants Named:

If Claim is Brought, what is the Disposition of Case:	☐ Pending	☐ Trial Verdict	☐ Settled	☐ Dismissed

Amount of Reserve if Case is Pending:

Amount of Payment from Trial Verdict or Settlement:

Description of Injury and/or Alleged Malpractice:

Comments:

I understand that information submitted herein becomes a part of my Professional Liability Application and is subject to the same representations and conditions.

Signature of Applicant

Date

Print Name

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OF A MATERIAL NATURE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO IMPRISIONMENT, FINES AND DENIAL OF INSURANCE.

APPLICANT'S REPRESENTATIONS AND AUTHORIZATION

I agree that the statements made by me herein are my representations.

The execution and submission of this Application shall not bind the Company or its agents to the issuance of insurance, nor shall it bind the Applicant to the acceptance of a policy. However, in the event a policy is issued by the Company and accepted by the Applicant, all of the undertakings in the Application shall be binding upon the Applicant. A copy of this application will be attached to the policy and incorporated therein by reference.

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, to Company. This information includes, but is not limited to, 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, Physician Recovery Network, National Practitioners Database, Motor Vehicle Driving Records, Bexar Credentials Verification, Inc. 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 in the evaluation of information so received from whatever source.

______________________________ ______________________________

Signature of Applicant Date

You may qualify for one of the following discounts. Please check all that apply:

- ☐ Practicing in a group practice with more than 4 full time physicians who are also applying for coverage.
- ☐ Completed 5.0 or more hours of continuing medical education (CME) in a risk management education program within the last year.
- ☐ Claims free for a period of at least 5 years.

Please fax or email your completed application and requested attachments to:

Fax: 586-585-1352
info@apirrg.com

Or mail to:

Advanced Providers' Insurance Risk Retention Group, Inc.
24150 Little Mack
St. Clair Shores, MI 48080
844-819-0846