PHYSICIANS PROFESSIONAL LIABILITY INSURANCE

APPLICATION INSTRUCTIONS

A. Please complete all questions.*
- Accuracy and legibility are important.
- If a question does not pertain to your practice, answer "N/A".
- If you need to provide extra information, please do so on a separate sheet of your letterhead.

B. Sign and date the application on pages 5, 6 and 10.

C. Be sure all required information, such as claims supplement or a copy of the Declarations Page and any Endorsements from your current policy, is attached.

D. To expedite the Underwriting process and provide you with a faster decision on coverage, please attach a copy of your:
- Current Curriculum Vitae
- Current State License(s)
- Letterhead

E. If you fax the information, you must also mail the original and all attachments.

SEND COMPLETED APPLICATIONS TO:

Submitting Broker: _____

Agency: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

Surplus Lines License #: _____ State: _____

* *If you are changing your practice in any way, please fill out the application for the new practice - rather than the practice in which you are presently involved. This includes any change in location, procedures or type of practice. An explanation of the change is required in the Personal Information Section.*

3700 North 24th Street, Suite 200 • Phoenix, Arizona 85016
Phone: (602) 977-3550 • Fax: (602) 956-8848

NAME: _____

First Middle Last Professional Degree (MD/DO)

This is an application for a claims-made insurance policy. It covers claims arising from the performance of medical services after the retroactive date stated on the declarations page of the policy and before the termination date providing that such claim is properly reported to the company prior to the termination date or during any established period of tail coverage. If you have any questions concerning the coverages for which you are applying, please contact your insurance agent. The proper report of an otherwise covered medical incident triggers coverage under this policy.

Policy Information

1. Requested effective date: _____
2. Prior acts coverage: ☐ YES ☐ NO
3. Retroactive date of current policy: _____
   (Attach a copy of of your current declarations page)

4. Limits requested (Limits are shown per claim/aggregate)

☐ $100,000/$300,000 ☐ $500,000/$1.5Million
☐ $200,000/$600,000 ☐ $1Million/$3Million
☐ $250,000/$750,000 ☐ Other_____

☐ LEXINGTON INSURANCE COMPANY
WILMINGTON, DELAWARE
ADMINISTRATIVE OFFICES: 100 SUMMER STREET, BOSTON, MA 02110-2103
(A Capital Stock Insurance Company)

☐ LANDMARK INSURANCE COMPANY
777 South Figueroa Street, Los Angeles, CA 90017
ADMINISTRATIVE OFFICES: 100 SUMMER STREET, BOSTON, MA 02110-2103
(A Capital Stock Insurance Company)

Personal Information

5. Home Address: _____ Street _____ City _____ State _____ Zip

6. Practice Address: _____ Street _____ City _____ State _____ Zip

7. Practice Address County: _____

8. Social Security #: _____/_____/_____

9. Home Phone ( ) _____
   Office Phone ( ) _____
   Fax ( ) _____
   E-Mail _____

10. Date of Birth: _____/_____/_____

11. Additional Locations: ☐ Yes ☐ No
    (If YES, list each separate address, including county, on attachment)

Training, License Information & Practice History

12.	College/Hospital	City/State	Year Completed
Medical School			
Internship			
Residency			
Fellowship			

(Please supply additional training information on attachment sheet or submit *Curriculum Vitae.*)

13. Specialty / Sub-Specialty _____

14. American Board of Medical Specialty Certification

Name of Board: _____ Date: _____

Name of Board: _____ Date: _____

Training, License Information & Practice History (Cont)

15. List all states in which you are licensed to practice. List additional licenses separately.

	State	License #	% of patient visits in each state

16. Has there been any change in your practice in the past five years? ☐ Yes ☐ No
If YES, please describe:_____

17. List all locations where you have practiced in the last 10 years. Attach additional page if necessary.

	Street	City	County/State	From-To

Prior Carrier Information

18. List all malpractice carriers for the last 10 years:

Name of Insurer	Dates Covered (From-To)	Limit of Liability	Number of Pending Claims	Number of Closed Claims	Total

Please attach a copy of the declaration page of your current or most recent policy.

Current Practice Information

19. Type of Practice

a. **Individual Practice**

☐ Sole Proprietor ☐ Employee Name of Employer: _____
☐ Independent Contractor Contracted To: _____
☐ Individual Professional Corporation, if any: _____

b. **Group Practice** (attach page with names of all partners, shareholders and employees)

☐ Partnership Legal Name of Partnership: _____
Number of partners:_____ _____
☐ Multi-Shareholder Corporation Name of Professional Corporation: _____
Number of shareholders: _____ _____
☐ Separate Limits
Are you applying for group coverage? ☐ Yes ☐ No Retroactive Date of Group: _____ ☐ Shared Limits

c. **Professional Association/Office Sharing** Fictitious Name (DBA), if any: _____

Current Practice Information (Cont)

20. Employees

a. Do you employ any physicians or surgeons? ☐ Yes ☐ No
If YES, please provide name, specialty and information on each employee's current malpractice coverage.

b. Do you employ, contract with or supervise any non-physician Health Care Providers? ☐ Yes ☐ No
If YES, please complete the following:

	Name(s)		Name(s)
Acupuncturist		Nurse Anesthetist	
Cardiac Perfusionist		A. Hospital Based	
Cert. Physicians Assistant		B. Non-Hospital Based	
Chiropractor		Optometrist	
Nurse Midwife		Psychologist	
Nurse Practitioner		RN First Assistant	
Other (please describe)			

Note: There is no coverage for any employed physician/surgeon or non-physician health care provider unless a separate application is made, approved and the appropriate premium is paid.

21. Are you applying for coverage for the listed providers? ☐ Yes ☐ No
If yes: Separate Limits: _____
Shared Limits: _____

22. Please list the names and addresses of all hospitals where you have or are applying for staff privileges:

_____

_____

If you do not have privileges at any hospital, please explain why on a separate page.

23. Average number of individual patients that you see per week: _____ Average number of patient visits per week: _____

24. Average number of hours that you work each week: _____

25. If you practice less than 20 hours per week, what is the reason for your part-time practice? _____

_____

26. Number of continuing medical education credits in the past 12 months?_____

27. Number of credits in excess of state license requirement? _____

28. Scope of Practice – Check All That Apply

☐ Angiography ☐ Arteriography ☐ Cardiac catheterization
☐ Percutaneous coronary angioplasty
☐ Bronchoscopy
☐ Chelation therapy (other than heavy metal poisoning)
☐ Jail/correctional facility patients in my practice
☐ No Surgery ☐ Minor Surgery ☐ Major Surgery
If minor surgery, list procedures_____
_____
☐ Cosmetic surgery – list procedures _____
☐ Anti-aging therapy
☐ Limited cosmetic surgery – list procedures _____
☐ Weight treatment, reduction or control.
Percentage of practice: _____
☐ Care of bariatric surgery patients or bariatric surgery
☐ Liposuction – body areas _____

☐ Prenatal care beyond the first trimester
☐ First trimester abortions – number per year _____
☐ Second trimester abortions
☐ Obstetrics - # of deliveries per year: _____
☐ Sex change surgery/phalloplasty/penile implants
☐ Nursing home - In facility care
☐ Medical Director
Name & Type of facility: _____
☐ Clinical Investigation studies not FDA approved
☐ Experimental treatments (Attach description)
☐ Experimental procedures, or procedures considered outside the scope of your specialty (Attach description)
☐ Urgent / Walk-in care
☐ Pain management
List all procedures: _____

CURRENT PRACTICE INFORMATION (CONT)

29. I have my own surgical suite: ☐ Yes ☐ No If yes, do other practitioners use the facility for their own patients? ☐ Yes ☐ No

30. **Specialty Practice Profile**

If your specialty is listed below, please complete the appropriate section.

☐ **General Surgery**

A. Have you ever performed weight reduction surgery in your practice? ☐ Yes ☐ No
B. Peripheral Vascular Surgery ☐ Yes ☐ No
C. Neck Node Dissections ☐ Yes ☐ No

☐ **Obstetrics**

A. Do you use standardized documentation forms that meet or exceed ACOG Guidelines? ☐ Yes ☐ No
B. Do you provide home deliveries or supervise lay midwives? ☐ Yes ☐ No
C. Do you perform deliveries in any hospitals that do not have policies and procedures regarding umbilical cord blood acid-base assessment and placental evaluation that meet ACOG guidelines? ☐ Yes ☐ No
D. What is the total number of VBAC deliveries per year? _____

☐ **Orthopedics**

Spinal Column Surgery ☐ Yes ☐ No

☐ **Podiatry**

A. No Surgery ☐ Yes ☐ No
B. Below Knee Surgery ☐ Yes ☐ No
C. Above Knee Surgery ☐ Yes ☐ No

☐ **Radiology**

A. Number of Mammograms per year _____
B. Do you have any capitated contracts for mammograms? ☐ Yes ☐ No
C. Do you provide Telemedicine services? ☐ Yes ☐ No
If YES, please describe on attachment to application and include all states to which you provide services.

☐ **Urology**

Prosthetic implants? ☐ Yes ☐ No

UNDERWRITING INFORMATION

If the answer to any of the following questions is YES, please attach a detailed explanation (including dates) and provide any pertinent documentation:

31. Have you ever been denied hospital privileges? ☐ Yes ☐ No
32. Has any hospital as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision? ☐ Yes ☐ No
33. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? ☐ Yes ☐ No
34. Has any hospital after granting you any privilege: (a) suspended or revoked that privilege; (b) modified or restricted that privilege; or (c) placed your exercise of that privilege under supervision, observation, or any other type of review? ☐ Yes ☐ No
35. Have you ever
    a. Been convicted of a crime other than a traffic violation? ☐ Yes ☐ No
    b. Been convicted of a crime or a traffic violation involving drugs or alcohol? ☐ Yes ☐ No
    c. Suffered from or been treated for substance abuse, disability, mental illness or serious physical illness/injury? ☐ Yes ☐ No
    d. Had a complaint filed against you with a medical association, foundation, state or federal government authority (i.e., Medicare, licensing board, etc.)? ☐ Yes ☐ No
    e. Had any professional license or permit investigated, suspended, revoked, restricted or placed under probation? ☐ Yes ☐ No
    f. Received a decree of censure from the licensing board (of any state) or been under a boards probation or stipulation? ☐ Yes ☐ No
    g. Entered into any voluntary stipulation, order or similar action with a licensing board (of any state)? ☐ Yes ☐ No
    h. Been denied any professional license or certification by a specialty board? ☐ Yes ☐ No
36. Have you ever had professional liability insurance declined, canceled, issued on special terms or been non-renewed? ☐ Yes ☐ No
37. Have **any** claims or suits ever been made or brought against you? ☐ Yes ☐ No
38. **If you answered YES to question 37, total number of incidents, claims and suits that have ever been submitted to another insurer or similar source of coverage whether payment has been made or not. Involved: Please complete one Supplemental Claim Information form for each claim or suit.** ☐

39. Do you have knowledge of any incident or activity (including a request for patient records) that might give rise to a claim or suit in the future? .....☐ Yes ☐ No

If YES, have all such matters been reported to your current or prior malpractice insurance company? .....☐ Yes ☐ No

Remarks:

I understand that this is an application for insurance, not an insurance binder.

I hereby certify that I have read the above application and that all statements in this application are true, material and complete. I understand that: (1) If the policy is issued, this is done in reliance upon these representations; and (2) any policy obtained by fraud, material misrepresentation or omission is void.

I agree that a facsimile copy of my signature may be relied upon as if it were the original.

Signature of Applicant Date of Signature

Print or Type Name

Please Note: You are required to notify your agent or Schaefer Smith Ankeney Insurance Agency, 3700 N. 24th Street, Suite 200, Phoenix, AZ 85016 immediately of any change in your practice. Failure to do so may jeopardize coverage.

If you have any questions about any part of this application, please call your agent or Schaefer Smith Ankeney Insurance Agency at (602) 977-3550. Office Hours: Monday through Friday, 8:30 a.m. – 5:00 p.m., MST.

Applicant's Authorization

I authorize the release of all relevant information to Schaefer Smith Ankeney Insurance Agency from the following:

- Any medical college or other institution where I have received training;
- Any person(s) with whom I received training, such as a preceptorship, which I am using as a basis for specialty training and requesting coverage;
- Any hospital at which I have applied for privileges, whether those privileges were granted or not;
- Past and present medical associations, societies, specialty boards and the regulatory body granting me a license to practice medicine in any state;
- Any insurance company to which I have applied for professional liability insurance coverage, whether such coverage was granted or not;
- Any employer for whom I performed medical services, whether as an employee or an independent contractor;
- Any Credit Reporting Agency, Equifax, Dunn & Bradstreet or similar organization.

I understand that information requested by Schaefer Smith Ankeney Insurance Agency may include, but not necessarily be limited to:

- Any incident, claim or suit in which I may be or may have been involved.
- Denial, suspension, revocation, or disciplinary recommendation or action connected with my providing medical services.
- Censure, probation or any disciplinary action taken by any medical licensing authority or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities.

I understand that the information will be used in addition to my application in making insurability decisions.

I agree that the persons providing the information, their agents, directors and employees shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I also authorize Schaefer Smith Ankeney Insurance Agency to release any such information, as well as any and all other information which they may have, to any committee of a professional association or society, or any subcommittee or section thereof, formed for the purpose of providing services to Schaefer Smith Ankeney Insurance Agency pursuant to an agreement entered into between them, including consultation and advice with respect to underwriting review, claims review, loss prevention, physician counseling and related services.

I consent to Schaefer Smith Ankeney Insurance Agency obtaining reviews from other physicians/surgeons if necessary or appropriate to evaluate my application.

I understand that this is an application for insurance, not an insurance binder.

I hereby certify that I have read the above application and that all statements made in this application are true, material and complete. I understand that: (1) if the policy is issued, this is done in reliance upon these representations; and (2) any policy obtained by fraud, material misrepresentation or omission is void.

I AGREE THAT A FACSIMILE COPY OF MY SIGNATURE MAY BE RELIED UPON AS IF IT WERE THE ORIGINAL.

Signature of Applicant Date of Signature

Print or Type Name

Supplemental Claim Information

1. Full Name of Applicant: _____

2. Full Name of Claimant: _____ Age _____

3. Indicate whether: ☐ Claim ☐ Suit ☐ Incident

4. Date of Incident: _____ 5. Date Claim was Reported: _____

6. Additional Defendants: _____

7. If Closed:
   Total Loss Paid Including Deductible: $_____ Defense Costs: $_____
   Indicate whether: ☐ Court Judgement or ☐ Out of Court Settlement
   Date Closed: _____

8. If Pending:

	Amount $		Amount $
Claimant's Settlement Demand		Defendants Offer for Settlement	
Insurers Loss Reserve		Deductible Amount	
Is Claim in Suit? ☐ Yes ☐ No		If Yes, Amount asked in Summons	

9. Insurance Carrier: _____

10. Description: (Please provide enough information to allow evaluation. Use reverse side or attachment if additional space is required.)

a. Alleged acts, error or omission upon which Claimant bases claim	
b. Description of case and events:	
c. Description of the type and extent of injury or damage allegedly sustained:	

_____
Signature of Applicant Date of Signature

_____
Print or Type Name

MANDATORY FRAUD WARNINGS BY STATE

NOTICE TO APPLICANTS

WARNING LANGUAGE:

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 ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES

ARKANSAS & LOUISIANA

WARNING LANGUAGE:

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.

COLORADO

WARNING LANGUAGE:

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 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.

DISTRICT OF COLUMBIA

***WARNING LANGUAGE*:**

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.

FLORIDA

WARNING LANGUAGE:

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.

KENTUCKY

WARNING LANGUAGE:

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.

MAINE

WARNING LANGUAGE:

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.

NEW JERSEY

WARNING LANGUAGE:

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NEW MEXICO

WARNING LANGUAGE:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULANT 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.

NEW YORK

WARNING LANGUAGE:

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 EACH SUCH VIOLATION.

OHIO

WARNING LANGUAGE:

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.

OKLAHOMA

WARNING LANGUAGE:

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.

PENNSYLVANIA

WARNING LANGUAGE:

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.

TENNESSEE & VIRGINIA

WARNING LANGUAGE:

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.

SIGNATURE OF APPLICANT **DATE OF SIGNATURE**

PRINT OR TYPE NAME