



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
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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
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Residency:

Hospital	City	State	Dates(from/to)	Type
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Hospital	City	State	Dates(from/to)	Type
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Fellowship or Other Training:

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

Name of 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
		Number
Nurse Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
		Number
Certified Registered Nurse Anesthetist	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
		Number
Certified Nurse Midwife	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
		Number
Optometrists	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
		Number

List all other personnel that you employ:

<input type="checkbox"/> RN's _____	<input type="checkbox"/> Other _____	_____	_____
Number		Type	Number
<input type="checkbox"/> LPN's / LVN's _____	<input type="checkbox"/> Other _____	_____	_____
Number		Type	Number
<input type="checkbox"/> Medical Assistants _____	<input type="checkbox"/> Other _____	_____	_____
Number		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 Practice	Description	City	State	County	%	of
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Name	Description	City	State	County	% of Practice
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C. Previous Practice Locations: (List most recent first and explain any gaps in dates)

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

<u>Insurance Carrier</u>	<u>Policy Period</u>	<u>Limit of Liability</u>	<u>Coverage Type</u>	<u>Retroactive Date</u>	<u>Deductible Amount</u>	<u>Tail Purchased</u>	<u>Policy Premium</u>
1.	From: To:		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence			<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	From: To:		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence			<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	From: To:		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence			<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	From: To:		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence			<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

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: ____/____/____