Professional SOLUTIONS

Physicians and Surgeons Professional Liability Application

Section A - INSTRUCTIONS

To ensure a timely review of your request for coverage, please complete all of the questions below and attach a copy of the following with your completed application:

- Your current Declarations Page
- A current curriculum vitae (CV)
- Loss runs from all carriers for the previous 10 years or since the start of the practice, whichever is greater, if losses are noted in Section K.
- A list of claims in the past 10 years and complete PSIC Claim Information Form as necessary for each
- Additional Supplements as indicated throughout the application

We will contact you to obtain any missing information; however, this may result in a delay in processing your application. Please provide as complete information as possible. If any question does not apply, please select No.

Section B - GENERAL INFORMATION

Name: _____
First Middle Initial Last

Social Security No. (last 4 digits): _____ Date of Birth: _____

Residence Address: _____
(Required for KS residents) Street Address City State Zip

Name of Practice: _____

Office Phone: _____ Fax: _____ Cell Phone: _____

Email: _____ Secondary Email: _____
Your email addresses will never be sold. They will be used to send you important messages.

Website: _____

Primary Practice Address: _____ ☐Office ☐Hospital ☐Residence
(Not a P.O. Box) Street Address

_____ ___ % of Practice
City State Zip County (Required) (All locations must total 100%)

Do you have additional Practice Location(s)*? ..... ○ Yes ○ No

If Yes:_____ ☐Office ☐Hospital ☐Residence
Street Address

_____ ___ % of Practice
City State Zip County (Required) (All locations must total 100%)

Contact Person/Insured's Representative: _____ Cell Phone: _____
First Last

Where would you like to receive mail/billing? ..... ○ Residence ○Primary Practice Location ○ Other

If other, please provide: _____
Street Address City State County Zip

***IF MORE ROOM IS NEEDED FOR PRACTICE LOCATIONS, PLEASE USE THE LAST PAGE OF THIS APPLICATION.**

Section C – COVERAGE INFORMATION

1. Desired effective date: _____ (policy issued annually)

2. Choose Type of Coverage:

- ○ (a) Claims Made Coverage without Prior Acts (see below)
- ○ (b) Claims Made Coverage with Prior Acts
  If selected, please indicate your desired **Retroactive Date**: _____
  The Retroactive Date is the date first continuously insured under a Claims Made policy. Please contact your agent should you have any questions pertaining to Claims Made coverage or the need for Prior Acts coverage.
- ○ (c) Claims Made Coverage with Pre-Paid Tail (OK and MI only) (see below)
- ○ (d) Occurrence
  I realize that if I switch from a Claims Made to an Occurrence policy, my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's Claims Made policy. I understand the policy I am purchasing will not provide prior acts coverage. Occurrence coverage is subject to underwriting approval.

If you chose coverage type (a) or (c) above, please select one of the following:

- ○ Prior coverage written on an Occurrence basis
- ○ Prior coverage written on a Pre-Paid Tail basis
- ○ An extended reporting endorsement has been purchased (read the following and check the box):
  I realize that my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's Claims Made policy. I understand the policy I am purchasing will not provide Prior Acts coverage. By checking this box, **I verify the above**: ☐

3. Choose Limits of Coverage (exception states are in bold below):

○ $100,000/$300,000	○ $200,000/$600,000	○ $250,000/$750,000
○ $500,000/$1 Million	○ $1 Million/$3 Million	○ $2 Million/$4 Million

<u>Additional</u> limits available in Michigan:	○ $500,000/$1.5 Million	○ $1 Million/$1.5 Million
The <u>only</u> limits available in Kansas:	○ $500,000/$1.5 Million	

4. Requested deductible:

○ None	○ $5,000/$15,000
○ $10,000/$30,000	○ $15,000/$45,000

5. Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? ..... ○ Yes ○ No
If Yes, please include proof of coverage, a description of these activities and the practice name and location.

6. Will you be participating in a state-operated patient's compensation fund? ..... ○ Yes ○ No
Are you a resident of the compensation fund state? ..... ○ Yes ○ No
If Yes, please indicate the state operating the fund: _____

Section D – EDUCATION

☐ **Curriculum Vitae (CV) attached. If checked, Section D can be bypassed.**

1. School of Graduation: _____ Degree: _____ Year: ____

_____
City State Zip

2. Internship: _____
Name of facility

_____ Date Completed: _____
City State MO/YR

3. Residency: _____
Name of facility

_____ Date Completed: _____
City State MO/YR

4. Have you taken additional training? ..... ○ Yes ○ No

If Yes, please describe the training: _____
When was the training completed? _____
MO/YR

5. Are you a foreign medical graduate? ..... ○ Yes ○ No

6. Are you certified by any approved specialty board(s)? ..... ○ Yes ○ No
If Yes, list each specialty below and attach each certification:

Specialty: _____ Date Certified: _____
MO/YR

Specialty: _____ Date Certified: _____
MO/YR

If No, are you board eligible? ..... ○ Yes ○ No **If Yes, when do you plan to take your boards?** _____
MO/YR

7. Have you ever failed a board exam? ..... ○ Yes ○ No

If Yes, how many times? ____ **Please provide an explanation:** _____

_____

8. Are you a member of any professional organizations? ..... ○ Yes ○ No

If Yes, please list: _____

_____

Section E – PRACTICE LOCATION(S)

1. Please list all states in which you currently hold or have held a license: (All locations must total 100%)

State: _____ License No.: _____ ___ % of Practice

Status of License: ○ Active ○ Inactive ○ Temporary ○ Pending

State: _____ License No.: _____ ___ % of Practice

Status of License: ○ Active ○ Inactive ○ Temporary ○ Pending

State: _____ License No.: _____ ___ % of Practice

Status of License: ○ Active ○ Inactive ○ Temporary ○ Pending

2. Do you perform surgical procedures at a surgical center, office based suite, or similar facility? ..... ○ Yes ○ No

3. Do you have a full ACLS Resuscitation cart in your office? ..... ○ Yes ○ No

4. Do you use an electronic health recordkeeping system? ..... ○ Yes ○ No

5. Do you staff an emergency room? ..... ○ Yes ○ No

If Yes, is this to maintain hospital privileges? ..... ○ Yes ○ No
How many hours in emergency medicine per month? ____ Hours

6. Please advise how hospital admissions are handled if you do not have hospital privileges: _____

_____

_____

Section F – PRACTICE INFORMATION

1. Employment Status:

O Employee O Independent Contractor O Solo Unincorporated/ Sole Proprietor

O Shareholder/Partner O Other: _____

If Employee or Independent Contractor, complete this section:

Name of Employer: _____

Name of Contractee: _____

2. Entity Type:

O Solo Incorporated – No employee or contracted physicians O Partnership/LLC

O Multi-Shareholder Corporation O Other: _____

Name of Partnership or Solo/Multi-Shareholder Corporation: _____

If Partnership, Multi-Shareholder Corporation or Other, complete this section:

Name of partner(s) or other members: _____

3. Do you desire coverage for this entity? ..... O Yes O No

If Yes, do you desire shared or separate limits of liability? ..... O Shared O Separate

Please complete and submit the Corporate and Partnership Professional Liability Application (PSIC-MDAPP-02).

4. Does your entity include a surgicenter, laboratory or other freestanding facility? ..... O Yes O No

If Yes, explain: _____

_____

5. What percentage of your revenue is from the following sources?

___**%** Government Programs (Medicaid, Medicare, Health Exchanges) ___**%** Indemnity/Private Insurance Plans

___**%** Other - Please explain: _____

Section G – MEDICAL PERSONNEL

1. Do you as an individual employ any physicians or surgeons? ..... O Yes O No

If Yes, please complete the following:

Name	Specialty	Surgery Performed (check one)	Independent Contractor?
		O None O Minor O Major	O Yes O No
		O None O Minor O Major	O Yes O No
		O None O Minor O Major	O Yes O No

2. Do you employ or contract with any mid-level providers (PA, NP, CRNA, CNM, CNS, etc.)? ..... O Yes O No

If Yes, please complete the following:

Name	Designation/Specialty	Supervision	Independent Contractor?	Coverage Desired?	FT/PT
		O Direct O Indirect*	O Yes O No	O Yes** O No	O FT O PT
		O Direct O Indirect*	O Yes O No	O Yes** O No	O FT O PT
		O Direct O Indirect*	O Yes O No	O Yes** O No	O FT O PT

*If indirect supervision, please submit a copy of protocols and physician supervision agreement.

**__If coverage is desired__, please complete and submit the Midlevel Provider Supplemental Questionnaire.

If coverage is not needed, please provide proof of coverage for providers.

3. Do you employ any ancillary healthcare providers? (RN, LPN, Medical Assistant, etc.) ..... O Yes O No

Section H – PRACTICE ACTIVITIES

1. Primary medical specialty: _____ Percent of practice: ___%

2. Do you have a secondary medical specialty? ..... ○ Yes ○ No

   If Yes, please list: _____ Percent of practice: ___%

3. Select one of the following as applicable:

   ○ **No Surgery** – This does include incision of boils and superficial abscesses, suturing of skin or superficial fascia, as well as the removal of superficial growths.

   ○ **Minor Surgery** – Activities not considered major surgery, but which surgically penetrate the body cavity and/or surgically penetrate beneath the epidermis. (Catheterizations, tonsillectomies and vasectomies are considered minor surgery.)

   ○ **Major Surgery** – Includes operations in or upon any body cavity such as the cranium, thorax, abdomen or pelvis. Also includes other operations that present a distinct hazard to life, due to the condition of the patient, length of the operation or the circumstances involved. Also includes removal of tumors, open bone fractures and operations done under general anesthesia.

   ○ **Assisting in Major Surgery** – ..... Average hours per month assisting on own patients: ____

   Average hours per month assisting on patients of others: ____

4. Are you a Surgeon? ..... ○ Yes ○ No

If Yes, please provide the percentage of time devoted to the following surgical activities per year:

Abdominal		Hand		Otorhinolaryngology (incl. plastic)	
Bariatrics*		Head and Neck		Otorhinolaryngology (no plastic)	
Bariatrics (Assist)		Neurology		Plastic	
Cardiac		Ophthalmology		Thoracic	
Colon and rectal		Organ Transplant		Traumatic	
General		Orthopedic (incl. spinal)		Urology	
Gynecology		Orthopedic (no spinal)		Vascular	

***If performing Bariatrics, please complete and submit the Bariatrics Supplemental Application (NFL 9630-182206)**

5. Identify the medical activities/procedures that you perform by indicating the number per month:

Acupuncture		Dermatopathology		Norplant Insertion/Extraction	
Addiction Medicine		Echocardiography		Obstetrics	
Anesthesia:		Electrocardiography		Vaginal deliveries	
Spinal		Endoscopic Laser Therapy		C-sections	
Caudal		Endoscopy (other than Proctoscopy,		C-sections (assist)	
General		Sigmoidoscopy, Colposcopy and		○ Own Patient or ○ Others	
Local		Cystoscopy)		VBACs	
Angiography		ERCP/EGD/ERC		○ Own Patient or ○ Others	
Angioplasty		Exchange Transfusions in Newborns		Osteopathic Manipulative	
Appendectomy		Facet Blocks		Medicine	
Arteriography		Fertility Treatment		Pedicle Screws for	
Arthroscopy		Fluoroscopy		Spinal Surgery	
Bariatric Bypass		Fracture Reductions:		Percutaneous Vertebroplasty	
Biopsies:		Open		Permanent Pacemaker	
Breast		Closed		Polypectomy	
Core Needle		Functional Medicine		Prenatal Care	
Endoscopic/Punch		Gastric Bubble		Prolotherapy	
Excisional		Gastric Stapling		Radiation/X-ray Therapy	
Blepharoplasty		Gastroscopy		Radiopaque Dye	
Botox injections		Hair Transplants		Rhizotomy	
Breast Implants:		Hemorrhoidectomy		Roux-en-y	
Cosmetic		Hernia Repair		Sclerotherapy	
Reconstructive		Hip Nailings		Scoliosis Surgery	

Bronchoscopy		Hospitalist Activities		Select Nerve Root Blocks	
Cardiac Catheterization		Hyperbaric Medicine		Sigmoidoscopy >60 cm	
Chelation Therapy		Hysterectomy		Silicone Injections	
(other than heavy		Hysteroscopy		Sphenopalatine Lesioning	
metal poisoning)		Implantation/Removal of		Spinal Cord Stimulators	
Chemabrasion		Drug Infusion Pumps		Spinal Injections	
Chemical peels		Intensive Care Activities		Thoracic:	
Chemonucleolysis		Intensive Care for Newborns		Sympathectomies	
Cholecystectomy		within a Tertiary Care Unit		Trigeminal Lesioning	
Cholecystectomy,		Laminectomy		Trigger Point Injections	
Laparoscopic		Laparoscopy		Thyroidectomy	
Circumcision		Laser Hair Removal		Tonsillectomy/Adenoidectomy	
(other than newborns)		Laser Skin Resurfacing		Transgender Surgery and/or	
Collagen Injections		Laser Surgery		Hormonal Gender	
Colonoscopy		Lipodissolve		Conversion	
Colposcopy		Liposuction < 3,500 cc		Tubal Ligation	
Cordotomies		Liposuction > 3,500 cc		Tumescent Liposuction	
Cryosurgery (other than		Lithotripsy		Vasectomy	
external lesions)		Lumbar Fusion			
Cryosurgery		Mammography		Medications prescribed	
(superficial only)		Maternal Fetal Medicine Activities		(please list):	
Dermabrasion		Medical Marijuana			
Dorsal Root Gangliotomies		Mesotherapy			
Elective Abortions		Microdermabrasion			
Eye liner Pigmentation		Myelography		Other:	
Fat Transfer		Myomectomy			
D&C		Neonatology			

6. Do you perform any procedures or practice activities not routinely performed by other physicians in your specialty or subspecialty? ..... ○ Yes ○ No
   If Yes, explain: _____

7. Have there been any changes in your specialty or practice activities within the past 5 years? ..... ○ Yes ○ No
   If Yes, explain: _____
   _____

8. Are you entering practice for the first time? ..... ○ Yes ○ No

9. How many hours per week do you work? ____ Number of patients seen per week: ____
   If you work less than 21 hours weekly, please advise the number of years you have done so: ____

IF MORE SPACE IS NEEDED FOR EXPLANATIONS, PLEASE USE THE LAST PAGE OF THIS APPLICATION

Section I – ANCILLARY PRACTICE ACTIVITIES

1. Do you hold a full-time teaching appointment with regular clinical supervision responsibilities? ..... ○ Yes ○ No
   If Yes, what percentage of your activities is devoted to clinical supervision? _____%

2. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison, or inmates? ..... ○ Yes ○ No
   If Yes, what percentage of your practice is devoted to these activities? _____%

3. Do you practice Home Health Care? ..... ○ Yes ○ No
   If Yes, please complete and submit the Home Health Care Supplemental Application (NFL 9712).

4. Do you or your employees provide clinical or administrative services to any nursing home, skilled nursing facility, assisted living center, hospice or similar facility, including any mobile healthcare facilities? ○ Yes ○ No
   If Yes, what percentage of your practice is devoted to these activities? _____%
   If Yes, do you treat patients other than your own? ..... ○ Yes ○ No

5. Do you provide professional services or review treatment of any professional athletes? ..... ○ Yes ○ No
If Yes, what percentage of your practice is devoted to these activities? _____%

6. Do you have any medical director responsibilities? ..... ○ Yes ○ No
If Yes, please provide the following information related to your medical director activities:

Facility Name: _____ Location: _____
Does the above facility provide you with coverage for your administrative responsibilities? ..... ○ Yes ○ No

7. Do you participate in any medical research or clinical trials that are not FDA or IRB approved? ..... ○ Yes ○ No
If Yes, please attach copies of any protocols and informed consent documents.

8. Do you engage in telemedicine/telehealth activities? ..... ○ Yes ○ No
If Yes, please complete and submit the Telemedicine/Telehealth Supplemental Application (NFL 9734).

9. Do you engage in retainer medicine, such as concierge, direct primary care, etc.? ..... ○ Yes ○ No
If Yes, please complete and submit the Retainer Practices Supplemental Application (NFL 9707).

10. Are you employed full-time by the federal government or are you serving in the military? ..... ○ Yes ○ No

11. Are you engaged in any "moonlighting" activities? ..... ○ Yes ○ No
If Yes, please indicate the number of hours per month: _____

12. Do you render patients unconscious for treatment in your office or other non-hospital facility? ..... ○ Yes ○ No

13. Do you perform utilization review services for a fee for others? ..... ○ Yes ○ No

14. Do you engage in Pain Management activities? ..... ○ Yes ○ No
If Yes, please complete and submit the Pain Management Supplemental Application (NFL 9656).

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS ON THE LAST PAGE.

Section J – HISTORY

1. Please provide information on each professional liability insurer you have had for the last 10 years.
Please provide this information in chronological order.

Dates	Insurer	Practicing Specialty	Limits of Liability	Coverage Type	Tail Coverage Purchased?	Any Claims?
				○ Occurrence ○ Claims Made	○ Yes ○ No	○ Yes ○ No
				○ Occurrence ○ Claims Made	○ Yes ○ No	○ Yes ○ No
				○ Occurrence ○ Claims Made	○ Yes ○ No	○ Yes ○ No

2. Are you now, or have you ever, practiced without professional liability insurance? ..... ○ Yes ○ No

3. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? *Missouri residents, skip this question* ..... ○ Yes ○ No

4. Has your medical license ever been investigated, denied, restricted, suspended, voluntarily surrendered or revoked in any state? ..... ○ Yes ○ No

5. Regarding your DEA certification, has it ever been restricted/put on probation, suspended or voluntarily suspended? ..... ○ Yes ○ No

6. Have any complaints or actions been brought against you by any hospital?
(This includes restriction, suspension, revocation of privileges or probation) ..... ○ Yes ○ No

7. Have you ever been the subject of or are you aware of any future involvement in an investigation by a regulatory or peer review board? ..... ○ Yes ○ No

8. Have any complaints or claims been brought against you for sexual misconduct? ..... ○ Yes ○ No

9. Have you ever been accused of or been found to have altered health care records? ..... ○ Yes ○ No

10. Have you ever had a chronic physical limitation or mental/emotional illness or disorder which impairs or adversely impacts your practice of medicine? ..... ○ Yes ○ No

11. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics, or any other substance abuse? ..... ○ Yes ○ No

12. Have you ever been charged, indicted or convicted; received a deferred prosecution or a deferred judgment and sentence; entered a guilty plea or a plea of nolo contendere; or been placed on adult diversion for any violation of any law? ..... ○ Yes ○ No

Note: You must answer "Yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

13. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? ..... ○ Yes ○ No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS ON THE LAST PAGE.

Section K – PAST CLAIM/INCIDENT INFORMATION

For the purposes of this section, the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.

1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services? ..... ○ Yes ○ No

   If Yes, please indicate the number of each: Pending suits: _____ Closed claims: _____

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
   - Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient? ..... ○ Yes ○ No
   - A letter from an attorney regarding your treatment of a patient? ..... ○ Yes ○ No
   - A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis? ..... ○ Yes ○ No
   - Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? ..... ○ Yes ○ No

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier?* ..... ○ N/A ○ Yes ○ No

   If Yes, please attach a current loss run for each carrier, as appropriate.

   If No, please explain why these circumstances were not reported: _____

   _____

** For the purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN SECTION K, PROVIDE DETAILS ON A PSIC CLAIM INFORMATION FORM.

Section L – SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or argument related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the Company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

Residents of Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Residents of Ohio: Any person who, with the 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.

Residents of Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing false, incomplete or misleading information is guilty of a felony.

Residents of all other states: 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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

X _____ Date _____

Signature

X _____ Date _____

Agent Signature

Section J - DETAILS	
Section/Question	**Comments**
IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE	

Professional SOLUTIONS

Mail to:
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Clive, Iowa 50325-8258
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Questions:
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