Professional SOLUTIONS INSURANCE COMPANY

Physicians and Surgeons Professional Liability Claims Made Application

A. AGENCY INFORMATION

Agency Name: _____ Agency License Number: _____

Soliciting Producer: _____
Last Name First Middle Initial

Address: _____
Street City State Zip

Office Phone: _____ Email Address: _____
Your email address will never be sold. It will be used to send you important messages.

B. APPLICANT INFORMATION

Name: _____
Last First Middle Initial

☐ Male ☐ Female Social Security No.: _____ Date of Birth: _____
MO/DAY/YR

Contact Person/Insured's Representative: _____
Last First Middle Initial

Office Phone: _____ Office Fax: _____

Email Address: _____ Website Address: _____
Your email address will never be sold. It will be used to send you important messages.

Primary Office Address: _____ _____ % of Practice
Street City State Zip County (all locations must total 100%)

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

If yes: _____ _____ % of Practice
Street City State Zip County (all locations must total 100%)

Mailing Address: ☐ Primary Office Address
☐ Other: _____
Street City State Zip

Billing Address: ☐ Primary Office Address
☐ Mailing Address
☐ Other: _____
Street City State Zip

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

C. COVERAGE INFORMATION

1. Effective dates desired: From: _____ To: _____
MO/DAY/YR MO/DAY/YR

2. Select requested coverage:

☐ Claims Made Coverage ***with*** Prior Acts **OR** ☐ Claims Made Coverage ***without*** Prior Acts: *(select one below)*

Desired Retroactive Date:

_____
MO/DAY/YR

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.

☐ Prior coverage written on an Occurrence basis

☐ An extended reporting endorsement **has** been purchased

☐ An extended reporting endorsement **has not** been purchased

*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. Please indicate limits of liability requested for coverage or a quote: *(not all limits may be available in all states)*

☐ $100,000/$300,000 ☐ $250,000/$750,000 ☐ $500,000/$1,500,000 *(MI only)* ☐ $1,000,000/$3,000,000

☐ $200,000/$600,000 *(only limit available in KS)* ☐ $500,000/$1,000,000 ☐ $1,000,000/$1,500,000 *(MI only)* ☐ $2,000,000/$4,000,000

C. COVERAGE INFORMATION *(continued)*

4. Requested deductible for coverage or a quote: ☐ None ☐ $5,000/$15,000 ☐ $10,000/$30,000 ☐ $15,000/$45,000

5. Will you be performing activities that will be covered by another professional liability policy? ☐ Yes ☐ No
   If yes, please attach a copy of your declarations page, 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
   If yes, please indicate the state operating the fund: _____
   Are you a resident of the compensation fund state? ☐ Yes ☐ No

PLEASE ATTACH A COPY OF YOUR DECLARATIONS PAGE FOR YOUR CURRENT OR PREVIOUS PRIMARY INSURER

D. EDUCATION

1. School of Graduation: _____ Degree: _____ Year: _____
   _____
   City State Country

2. Internship: _____
   Name of facility City State

3. Residency: _____
   Name of facility City State

4. When was your residency or fellowship completed? _____ *Mo/Yr*

5. Are you a foreign medical graduate? ☐ Yes ☐ No
   If yes, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ 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 on taking your boards? Date: _____ *MO/YR*

7. Have you participated in any continuing medical education within the last three years? ☐ Yes ☐ No
   If yes, how many Category 1 credit hours? _____

8. Have you completed any Risk Management/Loss Prevention courses in the past 12 months? ☐ Yes ☐ No
   If yes, please attach a copy of any Certificates of Completion

9. Are you a member of any professional organizations? ☐ Yes ☐ No
   If yes, please list: _____
   _____

PLEASE ATTACH A CURRENT COPY OF YOUR CURRICULUM VITAE (CV)

E. PRACTICE LOCATION(S)

1. Please provide the requested information for practice locations in each separate state.

   State: _____ License No.: _____ Activities in this state _____ %
   State: _____ License No.: _____ Activities in this state _____ %
   State: _____ License No.: _____ Activities in this state _____ %

   (Activities must add up to 100%)

2. Do you perform surgical procedures at a surgicenter, 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, are you board certified in emergency medicine? ☐ Yes ☐ No
   How many hours in emergency medicine per month? _____ Hours

E. PRACTICE LOCATION(S) *(continued)*

6. Do you have medical staff or courtesy privileges at any healthcare facilities? ☐ Yes ☐ No

If yes, provide the following information:

Facility Name	City	State	County	Activities at this location
				%
				%

F. PRACTICE INFORMATION

1. Employment Status: ☐ Employee ☐ Independent Contractor ☐ Solo Unincorporated/Sole Proprietor ☐ Shareholder/Partner ☐ Other: _____

If Employee or Independent Contractor, complete this section:

Name of Employer: _____ *Name of Contractee:* _____

2. Entity Type: ☐ Solo Incorporated – No employee or contracted physicians ☐ Partnership/LLC ☐ Multi-Shareholder Corporation ☐ 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. Does your entity include a surgicenter, laboratory or other freestanding facility? ☐ Yes ☐ No

If yes, please explain: _____

FOR PARTNERSHIP/LLC, MULTI-SHAREHOLDER CORPORATION OR OTHER, PLEASE ATTACH A COPY OF DECLARATIONS PAGE

G. MEDICAL PERSONNEL

1. Do you employ any physicians, surgeons, or certified nurse midwives? ☐ Yes ☐ No

If yes, please complete the following:

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

2. Do you employ any mid-level providers? (PA, NP, CRNA, etc.) ☐ Yes ☐ No

If yes, please complete the following:

Name	Job Title or Specialty	License No./State of Certification	School/Training/Courses including year of completion	Coverage Desired?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If coverage is desired, please complete and submit: ***Mid-Level Employee Roster Addendum (PSIC-MDAPP-06)***

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

If yes, please complete the following:

Job Title/Specialty: _____ Number of Employees: _____

Job Title/Specialty: _____ Number of Employees: _____

PLEASE ATTACH A LOSS HISTORY FOR THE PAST 5 YEARS FOR EACH EMPLOYED MID-LEVEL PROVIDER, IF AVAILABLE. IF NOT AVAILABLE, PLEASE LIST ANY CLAIMS FOR EACH EMPLOYEE ON A SEPARATE SHEET.

H. PRACTICE ACTIVITIES

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

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

If yes, please list: _____ *% of practice:* _____

H. PRACTICE ACTIVITIES *(continued)*

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: _____ hours
Average hours per month assisting on patients of others: _____ hours

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

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

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

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

Elective Abortions _____
Acupuncture _____
Anesthesia:
- Spinal _____
- Caudal _____
- General _____
- Local _____
- Other _____

Angiography _____
Angioplasty _____
Appendectomy _____
Arteriography _____
Arthroscopy _____
Biopsies:
- Breast _____
- Core Needle _____
- Endoscopic/Punch _____
- Excisional _____

Blepharoplasty _____
Breast Implants:
- Cosmetic _____
- Reconstructive _____

Bronchoscopy _____
Cardiac Catheterization _____
Chelation Therapy (other than heavy metal poisoning) _____
Chemonucleolysis _____
Cholecystectomy _____
Cholecystectomy, Laparoscopic _____
Circumcision (other than newborns) _____
Colonoscopy < 65 cm _____
Colonoscopy > 65 cm _____
Colposcopy _____
Cryosurgery (other than external lesions) _____
Cosmetic/Dermatological Surgery:
- Botox injections _____
- Chemical peels _____
- Chemabrasion _____
- Collagen Injections _____
- Cryosurgery (superficial only) _____
- Dermabrasion _____
- Eye liner Pigmentation _____
- Fat Transfer _____
- Hair Transplants _____
- Laser Hair Removal _____
- Laser Skin Resurfacing _____
- Lipodissolve _____
- Mesotherapy _____
- Microdermabrasion _____
- Silicone Injections _____
- Tumescent Liposuction _____
- Other _____ _____

D&C _____
Dermatopathology _____
Echocardiography _____
Electrocardiography _____
Emergency Medicine _____
Endoscopic Laser Therapy _____
Endoscopy (other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy) _____
ERCP/EGD/ERC _____
Exchange Transfusions In Newborns _____
Fertility Treatment _____
Fluoroscopy _____
Fracture Reductions:
- Open _____
- Closed _____

Gastroscopy _____
Hemorrhoidectomy _____
Hernia Repair _____
Hip Nailings _____
Hospitalist Activities _____
Hyperbaric Medicine _____
Hysterectomy _____
Hysteroscopy _____
Intensive Care Activities _____
Intensive Care for Newborns within a Tertiary Care Unit _____
Laminectomy _____
Laparoscopy _____
Laser Surgery _____
Liposuction < 3,500 cc _____
Liposuction > 3,500 cc _____
Lithotripsy _____
Lumbar Fusion _____
Mammography _____
Maternal Fetal Medicine Activities _____
Myelography _____
Myomectomy _____
Neonatology _____
Norplant Insertion/Extraction _____
Osteopathic Manipulative Medicine _____
Pain Management:
- Medication Only _____
- Facet Blocks _____
- Selective Nerve Root Blocks _____
- Rhizotomy _____
- Spinal Injections _____
- Dorsal Root Gangliotomies _____
- Thoracic Sympathectomies _____
- Spinal Cord Stimulators _____
- Implantation/Removal of Drug Infused Pumes _____
- Sphenopalatine Lesioning _____
- Trigeminal Lesioning _____
- Cordotomies _____
- Other _____ _____

Pedicle Screws for Spinal Surgery _____
Percutaneous Vertebroplasty _____
Permanent Pacemaker _____
Polypectomy _____
Prenatal Care _____
Prolotherapy _____
Radiation/X-ray Therapy _____
Radiopaque Dye _____
Roux-en-y _____
Sclerotherapy _____
Scoliosis Surgery _____
Shock Therapy _____
Sigmoidoscopy >60 cm _____
Thyroidectomy _____
Tonsillectomy/Adenoidectomy ___
Transgender Surgery and/or Hormonal Gender Conversion _____
Trigger Point Injections _____
Tubal Ligation _____
Urgent Care Activities _____
Vasectomy _____
Weight Control:
- Bariatric Bypass _____
- Gastric Bubble _____
- Gastric Stapling _____
- Other _____ _____

Medications Prescribed (please list)

_____
_____
_____
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_____
_____

H. PRACTICE ACTIVITIES *(continued)*

6. Are you an Obstetrician or Family Practitioner who provides obstetrical care? ☐Yes ☐No
   If yes, indicate the number of each per year:
   Normal Vaginal Deliveries _____ C-Sections _____ C-Sections (Assist) _____ VBACs _____
   ☐Own Patients **OR** ☐Others
7. Do you perform any procedures or practice activities not routinely performed by other physicians in your specialty or subspecialty? ☐Yes ☐No
   *If yes, please explain:*_____
8. Have there been any changes in your specialty or practice activities within the past 5 years? ☐Yes ☐No
   (For example, any activities added or discontinued.) *If yes, please explain:* _____
   _____
9. Are you entering private practice for the first time? ☐Yes ☐No
10. Do you practice less than 21 hours per week in direct patient care? ☐Yes ☐No
    *If yes, please complete and submit **Physicians and Surgeons Part Time Credit Application (PSIC-MDAPP-07)**.*
11. Do you use Locum Tenens Physicians? ☐Yes ☐No
    If yes, indicate number of days per year: _____ days

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

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 provide clinical or administrative services to any nursing home, skilled nursing facility, assisted living center, hospice or similar facility? ☐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
4. 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? _____ %
5. 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
6. Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ☐Yes ☐No
   If yes, please attach copies of any protocols and informed consent documents.
7. Do you engage in telemedicine activity in a state other than your primary office location? (Includes, but is not limited to, the prescribing of drugs or providing diagnosis via the Internet.) ☐Yes ☐No
8. Are you employed full-time by the federal government or are you serving in the military? ☐Yes ☐No

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

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

ATTACH AN ENTIRE LOSS HISTORY INCLUDING: POLICY NUMBER, CLAIM NUMBER, REPORT DATES, DESCRIPTION OF LOSS AND SETTLEMENT AMOUNT

J. HISTORY *(continued)*

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 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 surrendered? ☐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. Other than minor traffic violations, have you ever been indicted and/or convicted of a crime? ☐Yes ☐No
13. Has any government health program ever suspended, restricted or put you on probation? ☐Yes ☐No

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

K. LOSS INFORMATION

1. Have you been involved, directly or indirectly, in a **claim**, **potential claim**, or suit arising out of the rendering or failing to render professional services within the last 10 years?* ☐Yes ☐No

   If yes, please indicate the number of each below:

   Number of pending suits: _____ Number of closed claims: _____ Number of **potential claims**: _____

2. Have all **claims**, **potential claims**, suits and circumstances that might reasonably be expected to lead to a **claim** or suit been reported to your current or prior professional liability insurer?* ☐Yes ☐No

   If no, please explain:

* *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 or any professional corporation or partnership.*

*For the purpose of this section the word **potential claim** is defined as any circumstance that has been brought to your attention by a patient or patient's representative, in a manner that would indicate the possibility of a legal action against you or any professional corporation/partnership. (This may include, but is not limited to: a letter from an attorney or a patient requesting medical records or expressing dissatisfaction regarding your medical treatment, a patient or family member's dissatisfaction with the outcome of a procedure, treatment, or diagnosis, or any other circumstance that might reasonably lead to a claim or suit.)*

FOR EACH PENDING SUIT, CLOSED CLAIM AND POTENTIAL CLAIM, PLEASE COMPLETE AND ATTACH A CLAIM INFORMATION FORM

L. OPTIONAL COVERAGES

1. Coverage for a separate limit of liability for your partnership/corporation is available. Please consult your agent to see if it is necessary. If so, it requires a separate application and an additional charge above your professional liability premium.

   Do you want coverage for a separate limit of liability for your partnership/corporation? ☐Yes ☐No

   *If yes, please complete and submit **Corporate and Partnership Professional Liability Application (PSIC-MDAPP-02)**.*

M. REQUIRED DOCUMENTS

Please remember to attach a copy of the following with the application:

- Your current Declarations Page
- A current curriculum vitae (CV) for each physician
- If losses were noted in Section K, provide loss runs from all carriers for the previous 5 years or since the start of the practice, whichever is greater
- A list of all past claims. Please complete Claim Information Forms as necessary
- Each physician's medical license and board certification

N. SIGNATURE REQUIRED

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

THE ABOVE STATEMENTS ARE, TO THE BEST OF MY KNOWLEDGE, THE TRUTH, AND I HAVE NOT KNOWINGLY SUPPRESSED, WITHHELD OR MISSTATED ANY MATERIAL FACT IN COMPLETING THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE.

The undersigned represents and acknowledges that all information provided including the application, its supplements, attachments and answers to any questions our underwriter asks will be relied upon by the Company in determining whether to insure and 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 Professional Solutions 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 Professional Solutions.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to Professional Solutions Insurance Company, 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 Professional Solutions 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 Professional Solutions 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 agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: 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.

X _____ **X** _____

SIGNATURE OF APPLICANT DATE

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 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.

O. DETAILS…

Section/Question	Comments

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE

