Application for
Claims-Made
PROFESSIONAL LIABILITY INSURANCE

Checklist:

Please include copies of the following along with your application:

_____ 1. C.V.

_____ 2. Medical and DEA Licenses

_____ 3. Board Certification

_____ 4. Declarations Page from expiring insurance policy (including expiring premium)

_____ 5. Practice Letterhead (if requesting company coverage)

_____ 6. ECFMG or Fifth Pathway certificate, if applicable

_____ 7. Signed Loss History Request Form

_____ 8. Hospital Contracts

RETURN APPLICATION TO:

Physicians Indemnity

Telephone (813) 513-3041
Fax (888) 608-6327
info@pirrg.com

Re: Request for Insurance Company Loss History
Policy: _____

Dear Claims Verification Department:

I authorize _____ to release information relating to claims and
(current insurance carrier)
suits against me. Please provide a current loss run and claims history for the period of time during which I was insured by your company. I understand the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant.

Please fax this information directly to (888) 608-6327 as soon as possible.

Thank you in advance for your assistance with this urgent request.

Sincerely,

_____
Signature

_____
Print Name

Application for Claims-Made
PROFESSIONAL LIABILITY INSURANCE

Application for Individual Medical professional liability insurance. A claims-made policy covers claims arising from the performance of professional services after the retroactive date shown on the policy and first brought against you while the policy is in effect. Please type or print in blue or black ink. All questions must be answered completely. If a question does not apply to you or your practice, please indicate by writing "no", "none", or "N/A" (non-applicable).

COVERAGE REQUESTED

1. Effective date of coverage requested _____
Month / Day / Year

2. Retroactive date requested (If applying for Prior Acts Coverage): _____
Month / Day / Year

3. Specialty for which this coverage would apply _____

Sub-Specialty (if applicable) _____

4. Limits of Liability requested (limits indicated are per medical incident/annual aggregate):

☐ $100,000 / $300,000 ☐ $250,000 / $750,000 ☐ $500,000 / $1,500,000 ☐ $1,000,000 / $3,000,000

APPLICANT INFORMATION

5. _____
Last Name First Name Middle Initial Degree

6. Date of Birth: _____ Gender: _____ Social Security #: _____

7. Medical License: State: _____ License #: _____ Active ☐ Inactive ☐

State: _____ License #: _____ Active ☐ Inactive ☐

8. Office Locations

_____ Telephone: _____
Office Manager

_____ Fax: _____
Street Suite

_____ Cellular: _____
City State Zip Code County

Email: _____

9. Residential Address:

_____ Telephone: _____
Street Apt #

_____ Fax : _____
City State Zip Code County

List all hospitals, nursing homes or outpatient facilities where you are or will be on staff, have privileges or render professional medical services, including managed care organizations. *(List others on Supplemental Page)*

10.

Name	City	Status of Privileges (Active, Temp., Courtesy)	Practice %

PERSONAL, HOSPITAL AND LICENSE INFORMATION

		YES	NO
11.	Are you now, or have you ever been, evaluated, treated or hospitalized for the use of any of the following:		
	11.1 Alcohol	☐	☐
	11.2 Narcotics	☐	☐
	11.3 CNS stimulants or depressants	☐	☐
12.	Are you now, or have you ever been, evaluated, treated or hospitalized for any mental or emotional disorders?	☐	☐
13.	Have you ever incurred or became aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? (e.g. alcoholism, convulsive disorders) If YES, did you submit your treating physician statement to the hospital for review?	☐	☐
14.	Have you ever been charged with, convicted or found guilty (even if adjudication withheld) of violating any federal, state law or municipal ordinance (other than traffic offenses or minor offenses involving a fine of $100.00 or less)? (Please explain on supplemental page.)	☐	☐
15.	Has your application for medical staff privileges at a hospital, other health care facility or managed care organization, ever been denied or restricted? (Please explain on supplemental page.)	☐	☐
16.	Have your medical staff privileges ever been revoked, suspended or restricted? (Please explain on supplemental page.)	☐	☐
17.	Has your membership in a medical society or professional organization ever been denied, suspended, revoked, or subjected to disciplinary proceedings due to professional or ethical conduct?	☐	☐
18.	Have you ever received any of the following:		
	18.1 Any hospital disciplinary action due to professional and/or behavioral reasons?	☐	☐
	18.2 Licensing board disciplinary or administrative proceeding due to impropriety or incompetence in a medical practice?	☐	☐
	18.3 Licensing board disciplinary or administrative proceeding due to prescribing, dispensing or distributing pharmaceuticals?	☐	☐
19.	Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered or subject to probationary terms (in any jurisdiction)?		
	19.1 Medical License	☐	☐
	19.2 DEA License	☐	☐

NOTE: If any of the questions are answered YES, a detailed explanation, in writing, MUST accompany application. Questions 11 through 13 require a letter from the attending physician or institution outlining the diagnosis, dates of treatment and current status. Questions 14 through 19 require a copy of all legal documents (e.g. Complaint, Stipulation, Final Order, Resolution).

MEDICAL EDUCATION

20. Medical School: _____ From _____ To _____

City: _____ State: _____

Internship: _____ From _____ To _____

City: _____ State: _____

Residency: _____ From _____ To _____

City: _____ State: _____

Specialty: _____ Completed?: Y ☐ N ☐

Fellowship Type: _____ From _____ To _____

City: _____ State: _____

Specialty: _____ Completed?: Y ☐ N ☐

Explain any gaps in time from date of medical school graduation to completion of training: _____

	N/A	YES	NO
If foreign medical school graduate: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG) or have you completed the Fifth Pathway Program?	☐	☐	☐

SPECIALTY BOARD CERTIFICATIONS

		YES	NO
21.	Indicate if you are certified by the **American Board of Medical Specialties** or **Advisory Board for Osteopathic Specialists:**	☐	☐
	If Yes, name of Board: _____ Date Certified: _____		
	Sub-Specialty (if applicable): _____ Expiration Date: _____		
22.	If you are NOT certified:		
	Are you board eligible?	☐	☐
	If YES: Date of eligibility: _____ Anticipated exam date: _____		
	Have you been an applicant or candidate for over five years? If YES, please explain:	☐	☐
	_____		
	_____		
	Have you ever failed the written exam? If YES, please indicate the number of times: ____	☐	☐
	Have you ever failed the oral exam? If YES, please indicate the number of times: ____	☐	☐
	Have you ever been denied certification by a specialty board? If YES, please explain:	☐	☐
	_____		

PROFESSIONAL LIABILITY INSURANCE COVERAGE

23. List all professional liability insurance carried during the last ten years (use additional page if necessary):

Name of Carrier	Policy Number	Policy Effective	Policy Expiration	Specialty Covered	Policy Limits	"Tail" Purchased?

	YES	NO
Have you ever failed to maintain continuous professional liability insurance while rendering professional services? (If YES, please attach explanation.)	☐	☐
Have you ever had professional liability insurance refused, cancelled or non-renewed?	☐	☐

PRIOR ACTS COVERAGE

24. Type of current medical professional liability insurance: ☐ Claims-made ☐ Occurrence

		YES	NO
25.	If currently insured with a claims-made policy, are you requesting Prior Acts Coverage? (A copy of the current carrier's Declarations page or certificate of insurance **MUST** be submitted.)	☐	☐
a.	If YES, are the limits of liability you are requesting higher than the limits of liability you currently carry?	☐	☐
b.	If YES, please advise on your current carrier's claims trigger: ☐ Incident ☐ Formal Complaint ☐ Unknown		
c.	If NOT REQUESTING PRIOR ACTS coverage and you are currently insured with a claims-made policy, are you purchasing an Extended Reporting Endorsement ("tail") from your current carrier?	☐	☐
d.	If NOT REQUESTING PRIOR ACTS AND NOT PURCHASING "TAIL", please review the following statement: "I understand that unless I obtain Prior Acts Coverage or Purchase Tail, I will have **NO** coverage for any claims which may arise in the future as a result of any act or omission which occurred prior to the effective date of this policy."		
	Initial here **if you are NOT** requesting Prior Acts Coverage : **X** _____		

		YES	NO
26.	Are you a Medical Director of a nursing home, health care facility or any other business enterprise providing medical services?	☐	☐
	If YES, do you render patient care in your capacity as Medical Director to all patients at the facility?	☐	☐
	If you do not render patient care to all patients at the facility, please provide evidence of your coverage for the medical directorship exposure.		

SPECIALTY BOARD CERTIFICATIONS

		YES	NO
21.	Indicate if you are certified by the **American Board of Medical Specialties** or **Advisory Board for Osteopathic Specialists:**	☐	☐
	If Yes, name of Board: _____ Date Certified: _____		
	Sub-Specialty (if applicable): _____ Expiration Date: _____		
22.	If you are NOT certified:		
	Are you board eligible?	☐	☐
	If YES: Date of eligibility: _____ Anticipated exam date: _____		
	Have you been an applicant or candidate for over five years? If YES, please explain:	☐	☐
	_____		
	_____		
	Have you ever failed the written exam? If YES, please indicate the number of times: ____	☐	☐
	Have you ever failed the oral exam? If YES, please indicate the number of times: ____	☐	☐
	Have you ever been denied certification by a specialty board? If YES, please explain:	☐	☐
	_____		

PROFESSIONAL LIABILITY INSURANCE COVERAGE

23. List all professional liability insurance carried during the last ten years (use additional page if necessary):

Name of Carrier	Policy Number	Policy Effective	Policy Expiration	Specialty Covered	Policy Limits	"Tail" Purchased?

	YES	NO
Have you ever failed to maintain continuous professional liability insurance while rendering professional services? (If YES, please attach explanation.)	☐	☐
Have you ever had professional liability insurance refused, cancelled or non-renewed?	☐	☐

PRIOR ACTS COVERAGE

24. Type of current medical professional liability insurance: ☐ Claims-made ☐ Occurrence

		YES	NO
25.	If currently insured with a claims-made policy, are you requesting Prior Acts Coverage? (A copy of the current carrier's Declarations page or certificate of insurance **MUST** be submitted.)	☐	☐
a.	If YES, are the limits of liability you are requesting higher than the limits of liability you currently carry?	☐	☐
b.	If YES, please advise on your current carrier's claims trigger: ☐ Incident ☐ Formal Complaint ☐ Unknown		
c.	If NOT REQUESTING PRIOR ACTS coverage and you are currently insured with a claims-made policy, are you purchasing an Extended Reporting Endorsement ("tail") from your current carrier?	☐	☐
d.	If NOT REQUESTING PRIOR ACTS AND NOT PURCHASING "TAIL", please review the following statement: "I understand that unless I obtain Prior Acts Coverage or Purchase Tail, I will have **NO** coverage for any claims which may arise in the future as a result of any act or omission which occurred prior to the effective date of this policy."		
	Initial here **if you are NOT** requesting Prior Acts Coverage : **X** _____		

		YES	NO
26.	Are you a Medical Director of a nursing home, health care facility or any other business enterprise providing medical services?	☐	☐
	If YES, do you render patient care in your capacity as Medical Director to all patients at the facility?	☐	☐
	If you do not render patient care to all patients at the facility, please provide evidence of your coverage for the medical directorship exposure.		

CLASSIFICATION INFORMATION

		YES	NO
27.	Has there been a change in your specialty or rating classification during the time period stated above? If YES, please explain. (Use additional page if necessary.)	☐	☐
28.	Hours worked per week: _____ Average # of Patients seen per week: _____		
29.	Do you evaluate medical procedures, devices, drugs, drug regimens, therapy or clinical research or perform any procedure in your medical practice that is in an experimental stage or not FDA approved?	☐	☐
30.	Where (locations) have you practiced for the past 10 years or since your retroactive date, whichever is greater? *(Use additional page if necessary.)*		

_____

_____

_____

Explain any gaps in time between the locations indicated above: _____

_____

31.	Have you had more than 5 practice locations?	☐	☐
32.	As of the requested retroactive date for coverage, have you or will you practice Telemedicine, E*Commerce Medicine or practice medicine outside the state in which you have applied for coverage? If YES, please explain below. (Use additional page if necessary.)	☐	☐

_____

_____

33. Does your practice include any of the following? (Check all that apply.)

☐ **No Surgery**

No surgery, with the exception of: suture of minor lacerations; incision of sebaceous boils and cysts; needle aspiration of cysts (limited to subcutaneous tissue); incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.

☐ **Minor Surgery**

Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures:

- Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP);
- Pneumatic or mechanical esophageal dilation (not with bougle or olive);
- Angiography, Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists that completed a cardiovascular subspecialty training);
- Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue;
- Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae.

No general Anesthesia.

☐ **Major Surgery**

Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes all operations using general anesthesia.

☐ **Radiology (Diagnostic)**

Indicate the annual number of readings performed:_____
Type of readings performed: _____

☐ **Elective Plastic Surgery**

Non-Plastic Surgeons, please indicated the following:
Types of procedures performed: _____
Annual number performed: _____
Training received to perform procedures:
_____

34. Indicate the percentage of your surgical practice devoted to the following surgical activities:

___% Plastic(Reconstruction only)	___% Thoracic	___% Orthopedic (Including back)
___% Plastic(Cosmetic Enhancement)	___% Cardiac	___% Orthopedic (Not including back)
___% Hand	___% Vascular	___% Other _____
___% Traumatic	___% Obstetrics	_____

CLASSIFICATION INFORMATION *(con't.)*

35. Please check any of the following procedures you will perform:

- ☐ Abortions
  - ☐ First Trimester ☐ Second Trimester
- Suction - max wks gestation _____
- D&C - max wks gestation _____
- ☐ Acupuncture
  - ☐ Therapeutic/Local Anesthesia
  - ☐ General Anesthetic
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arthroscopy
- ☐ Arteriography
- ☐ Assisting in major surgery
  - ☐ Own patients only
  - ☐ Own and other than own patients
- ☐ Blepharopigmentation
- ☐ Blepharoplasty – Brow Lifts
  - Cosmetic____% of practice
  - Reconstruction____% of practice
- ☐ Breast Implants
  - Cosmetic____% of practice
  - Reconstruction____% of practice
- ☐ Bronchoscopy
- ☐ Cataract Surgery
- ☐ Cryosurgery (other than external lesions)
- ☐ ERCP
- ☐ D & C
- ☐ Phenol Facial Peels
- ☐ Diagnostic Embolization
- ☐ General/Spinal/Caudal Anesthesia
  - ☐ In a non-hospital setting?
- ☐ Hair Transplants
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser Surgery (☐ Endoscopic)
- ☐ Liposuction
- ☐ Lymphangiography
- ☐ Lithotripsy
- ☐ Major Gynecological Surgery
- ☐ Myelography
- ☐ Needle Biopsy
- ☐ Nerve blocks
  - ☐ Lumbar Epidural Steroid
  - ☐ Paraspinal ☐ Sciatic
  - ☐ Facet ☐ Paravertebral
  - ☐ Peripheral ☐ Myofascial
  - ☐ Occipital ☐ Trigger point
- ☐ Phlebography
- ☐ Pnuemoencephalography
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye
  - ☐ Non-Ionic Only
- ☐ Shock Therapy
- ☐ Sigmoidoscopy
  - ☐ < 60 cm
  - ☐ > 60 cm
- ☐ Colonoscopy
- ☐ Gastrointestinal Endoscopy
- ☐ Biopsy (Endoscopic)
- ☐ Perinatology / Neonatology
  - # of Deliveries: _____
- ☐ Pacemakers under General Anesthesia
- ☐ Silicone Injections
- ☐ Skin Flap/Grafts
  - Cosmetic_____% of practice
  - Reconstruction_____% of practice
- ☐ Swan-Ganz Catheterization
- ☐ Left Heart Catheterization
- ☐ Right Heart Catheterization (other than CVP lines)
- ☐ Tubal Ligations
- ☐ Vasectomies
- ☐ Weight Control Therapy/Surgery
  - ☐ __ % practice
  - ☐ Medication-Weight Control
  - ☐ Gastric Bubble / Stapling
  - ☐ Other Weight procedures
- ☐ Prenatal Practice
  - ☐ See patients during 1st & 2nd trimester
  - ☐ See patients to Term, no delivery
  - ☐ See patients to Term, delivery
- ☐ Normal Obstetrical Deliveries
  - How many per year?_____
- ☐ Cesarean Sections
  - How many per year?_____
- ☐ Home Deliveries
  - How many per year?_____
- ☐ None Listed
- ☐ Other Medical Techniques

_____
_____
_____
_____

36. If elective abortions performed, list hospitals, clinics or other facilities where they are performed:

_____
_____

		YES	NO
37.	Do you perform any of the following:		
	37.1 Chelation Therapy for other than lead poisoning	☐	☐
	37.2 Home Deliveries	☐	☐
	37.3 Second Trimester Abortions in a non-hospital setting	☐	☐
	37.4 Botox Injections (if other than a dermatologist/plastic surgeon)	☐	☐
	37.5 Bariatric Surgery *(please complete supplemental application)*	☐	☐
	37.6 Any non-FDA approved procedure/trial.	☐	☐
38.	Do you attend or supervise deliveries in a non-hospital setting?	☐	☐
39.	Have you changed specialties/procedures in the past five years? *If YES, please detail your prior practice on the Supplemental Page.*	☐	☐
40.	Do you serve in a hospital emergency room for which you require this policy to provide coverage? If YES, number of hours per month: _____ If another carrier covers the ER exposure, see question 42.	☐	☐
41.	Are you an employee of a hospital? If YES, name of hospital: _____ If another carrier covers the hospital employment exposure, see question 42.	☐	☐
42.	Will you be performing activities which will be covered by another professional liability policy? If YES, please provide description of activities and certificate of coverage.	☐	☐
43.	Do you perform any procedure(s) for which you have not been approved to perform at any of the hospitals where you have privileges? If YES, please explain. (Use additional page if necessary.)	☐	☐
44.	Do you have any contracts with a hospital, physician or other professional organization for your services? **If yes, please provide contract.**	☐	☐

ENTITY COVERAGE

45. Do you desire coverage for your Professional Entity (Company Coverage)? ☐ Yes ☐ No

46. What type of coverage do you desire for your Professional Entity?

_____ Separate Limits (for an additional 30% of the total physician premium)
(This option is not available for Solo Practitioners)

_____ Shared Limits (no additional premium) - Typical

Note: Entity coverage will only be provided for physicians/physician extenders that are currently employed by the entity and insured with PIRRG. Entity coverage for physicians/physician extenders that have left the group prior to it joining PIRRG will need to be underwritten separately.

47. Legal Name of Group to be insured: _____

Type: ____ Solo Practitioner ____ Partnership ____ Medical Corporation ____ Professional Association ____ Other (*explain*): _____

48. Please list all the physician members of your Professional Association, Partnership, Corporation or Entity.

Physician Name	Shareholder	Partner	Employee
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐
6.	☐	☐	☐

49. Do you own or operate any medical business whether related or not to your practice? If YES, please describe the nature of the business enterprise and your affiliation (e.g., owner, employee, independent contractor etc.). *Use additional page if necessary.* YES ☐ NO ☐

ANCILLARY COVERAGE

50. Please provide the names and license numbers for the highly trained Healthcare Personnel (as described below) that your practice employs. Coverage can be provided for these employees through our program; either on a Shared Limits basis (one set of limits shared between the employer and ancillary) for no additional premium or on a Separate Limits basis for an additional premium. For those Healthcare Personnel who carry their own coverage, please indicate so below and vicarious liability coverage will be provided to you for claims resulting from the providing or failure to provide professional services by such personnel for whose acts you are legally responsible. All other ancillaries (ex. Dosimetrists, RNs, LPNs & Medical Assistants) will be automatically covered on a Shared Limit basis under the physician's/entity's limit. **Please note that ARNPs must also have a minimum of $250,000 / $750,000 coverage. Shared limits coverage of $250,000/$750,000 between a physician and ARNP is not suggested as both parties may fall below the state minimum. See F.S. 458.320 and Chapter 64B8-12.**

Name:	**License #:**	**Type:** (PA, ARNP, CNM, CRNA)	**Coverage Requested through PIRRG?** Separate Limits	Shared Limits	**Has Own Coverage** *(attach certificate)* Vicarious Liability
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

ANCILLARY CLAIM INFORMATION

51. Regarding the ancillaries named above requesting either shared or separate limits through our program, has any claim or suit for alleged malpractice been brought against any of them? ☐ Yes ☐ No

If YES, please have the attached Claim Information Form completed by the ancillary for EACH CLAIM.

CLAIM INFORMATION

A "Suit" means a civil proceeding alleging damages for a medical incident, and includes a proceeding in a court, an arbitration proceeding, and any compulsory mediation or court ordered proceeding. A "Claim" means any other request for compensation or relief made on the allegation of damages for a medical incident. A "medical incident" means any act, error or omission in the providing of professional services as a healthcare provider.

A "Potential Claim or Suit" includes, without limitation, instances where you have received an oral or written communication from an individual or his legal representative demanding explanations or satisfaction or threatening legal action. It also includes a request by a patient or the patient's legal representative for copies of medical records under circumstances reasonably indicative of a possible claim or suit.

		YES	NO
52.	Has any claim or suit for alleged malpractice been brought against you or your professional association, partnership or corporation? If YES, please indicate how many claims or suits: _____	☐	☐
53.	Other than stated in question #48 above, are you aware of any potential claim or suit, or any of the following circumstances that might indicate the possibility of a claim or suit being brought against you, even if you believe the claim or suit would be without merit?	☐	☐
	a) A request for records from a patient and/or attorney related to an adverse outcome?	☐	☐
	b) A letter from an attorney regarding your medical treatment of a patient?	☐	☐
	c) Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	☐	☐
	d) Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	☐	☐
	e) Any other circumstances that might indicate the possibility of a claim or suit being brought against you?	☐	☐
54.	Other than stated in question #48 above, have all circumstances that might indicate the possibility of a claim or suit being made against you (even if you believe the possible claim or suit would be without merit) been reported to your current or prior Professional Liability carrier?: If YES, please indicate the number of potential claims: _____ **Please attach documentation of all such reports.** If YES, please explain: _____	☐	☐
55.	If you are NOT AN OBSTETRICIAN, have you ever been involved in an obstetrical case regardless of whether the case is open or closed or whether a payment was made or not made?	☐	☐
56.	Have you ever been involved in a case where it has been proven that alteration of medical records has occurred, regardless of whether the case is closed or if a payment was made or not made?	☐	☐
57.	Have any unexpected or potentially problematic results/incidents/reported claims occurred in the following categories?:		
	• Death;	☐	☐
	• Loss of Function:	☐	☐
	• An impairment requiring long term/permanent care as a result of treatment rendered:	☐	☐
	• Post-operative coma or neurological deficits	☐	☐
	• All others (please explain): _____	☐	☐

(A Separate Incident/Claim Information Form MUST be completed for each incident, potential claim, claim or suit.) Please make copies of this blank form as needed.
Note: if there are none to report, please indicate "n/a" and sign the blank form.

INCIDENT/CLAIM INFORMATION FORM (Past or Pending)

If you answered YES to any item in Questions 51-56, you must complete this form with respect to any incident, potential claim, claim or suit against you. Photocopy this form if you have more than one incident, potential claim, claim or suit to report. (Attach all supplemental information necessary.)

1. Physician Name / Healthcare Ancillary Name:

2.	Patient/Claimant name:	Age	Gender
3.	Physical condition and diagnosis at time of incident:	Date of first consultation:	
4.	Date of incident or occurrence from which claim resulted:	Date claim was filed:	
5.	Description of treatment rendered:	Alleged Date of Loss:	

6. Allegations made against you (state injury or damages alleged):

7. Subsequent condition or health of patient:

8. Was this claim reported to your insurance carrier (if YES, list name of carrier and policy number): ☐ Yes ☐ No

Carrier Name: Policy Number: Date Reported:

9. Present status or disposition of claim including amount of settlement or judgement:

☐ Open ☐ Closed Amount Paid on Your Behalf: $ _____

Date Closed ___/___/___ Total Amount Paid on Claim (inc other defendants): $ _____

I hereby authorize release to Aon Risk Services and its agents for information from my insurance carriers, their adjusting firms, and attorney concerning past or present claim matters in which I am involved.

X _____ _____

Signature of Applicant Date of Signature

(A photostatic copy of this authorization shall be considered as effective and as valid as the original. Each incident/claim information form must have physician's original signature.)

PLEASE READ AND SIGN

I certify that any and all answers given above represent full and true disclosure of the facts sought by Physicians Indemnity. I understand and agree that any misrepresentation, omission, or misstatement of fact in this application that is material to the risk shall be grounds for rescission of all coverage granted pursuant to this application.

I understand that the information given is confidential and will be used only for medical professional liability evaluation.

I understand that any and all answers to the above questions are subject to verification, and that all required documentation must be furnished, that significant discrepancies will require clarification on my part before the application can be considered.

I understand that acceptance of the application for individual coverage does not necessarily mean that my request for Prior Acts Coverage will be accepted.

I hereby certify that following careful review of my professional activities, including patient records, I have reported to my present insurance carrier all claims, suits, or potential claims or suits, as defined in the application, in which I am involved or in which I may become involved, arising out of events that took place during the period of my coverage with my present carrier. I understand that I will not have coverage for claims or suits, or potential claims or suits, which were or should have been reported to my present carrier or any former carrier.

I understand that disapproval of my application in no way represents a reflection upon me personally or upon my qualifications as a practitioner of medicine. I further understand and agree that if my application is not approved, the reason(s) for its disapproval will be kept in strict confidence. I hereby agree to release from liability for slander, libel, defamation of character, or any and all other causes of action, Physicians Indemnity and Aon Risk Services, Inc. and all of its directors, agents, officers, employees, designees, committees, or committee members.

I AGREE TO IMMEDIATELY NOTIFY PHYSICIANS INDEMNITY IN WRITING, IF THERE IS ANY CHANGE IN ANY ANSWER GIVEN IN MY APPLICATION INCLUDING ANY CHANGE IN MY PROFESSIONAL STATUS AND I UNDERSTAND AND AGREE THAT SUCH CHANGES ARE MATERIAL TO THE RISKS COVERED BY THE CARRIER I AM APPLYING FOR.

Notice to **Florida** Applicants: Any person who knowingly and with intent to injure, defraud, or deceive an insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

The policy for which you are applying is issued by a risk retention group. The risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

PRINT OR TYPE NAME OF APPLICANT

X

Signature of Applicant **Date of Signature**