Physicians Indemnity Risk Retention Group, Inc.

Renewal Application for 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.

APPLICANT INFORMATION

Full Name: _____ Degree: _____

Office: _____ Suite: _____

City: _____ State: ____ Zip Code: _____ County: _____

Contact: _____ Phone: _____ Email: _____

Office Phone: _____ Fax: _____

Insured Cell: _____ Insured Email: _____

COVERAGE REQUESTED

Renewal Date: _____ Specialty: _____

Retroactive Date: _____

Hours per week: _____ Patients per week: _____

Current Limits of Liability (indicated are per medical incident/annual aggregate):

*Contact our office to change your limits of liability

PROFESSIONAL ENTITY COVERAGE

Professional Entity Name: _____ Retro Date: _____

Professional Entity Name: _____ Retro Date _____

PROFESSIONAL EXTENDERS

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.**

Full Name	Retro	Shared Limits	Separate Limits	Vicarious Liability Attach COI
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

CLAIMS INFORMATION		NO	YES	REPORTED
1.	Has any claim or suit for alleged malpractice been brought against you or your professional association, partnership or corporation since your last renewal?	☐	☐	☐
2.	Have you received a request for records from a patient and/or attorney related to an adverse outcome?	☐	☐	☐
3.	Have you received a letter from an attorney regarding your medical treatment of a patient?	☐	☐	☐
4.	Have you encountered any intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	☐	☐	☐
5.	Have you received any patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	☐	☐	☐
6.	Any other circumstances that might indicate the possibility of a claim or suit being brought against you?	☐	☐	☐

MEDICAL PROCEDURES

Please check any of the following procedures you will perform:

- ☐ First Trimester Abortion
- ☐ Second Trimester Abortion
- ☐ 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
- ☐ General/Spinal/Caudal Anesthesia
  - ☐ In a non-hospital setting?
- ☐ 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
- ☐ Perinatology / Neonatology
- ☐ Diagnostic Embolization
- ☐ 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 _____ per year
- ☐ Cesarean Sections _____ per year
- ☐ Home Deliveries _____ per year
- ☐ Hair Transplants
- ☐ Gastrointestinal Endoscopy
- ☐ Biopsy (Endoscopic)
- ☐ Other Medical Techniques

_____

_____

- ☐ None Listed

	YES	NO
1. Do you perform any of the following:		
1.1. Chelation Therapy for other than lead poisoning	☐	☐
1.2 Home Deliveries	☐	☐
1.3 Second Trimester Abortions in a non-hospital setting	☐	☐
1.4 Botox Injections (if other than a dermatologist or plastic surgeon) ***Proof of training required if not on file***	☐	☐
1.5 Bariatric Surgery *(please complete supplemental application)*	☐	☐
1.6 Any non-FDA approved procedure/trial.	☐	☐
1.7 Do you attend or supervise deliveries in a non-hospital setting?	☐	☐
1.8 Do you serve in a hospital emergency room for which you require this policy to provide coverage	☐	☐
2. Are you now, or have you ever been, evaluated, treated or hospitalized for the use of any of the following:		
2.1 Alcohol	☐	☐
2.2 Narcotics	☐	☐
2.3 CNS stimulants or depressants	☐	☐
3. Are you now, or have you ever been, evaluated, treated or hospitalized for any mental or emotional disorders?	☐	☐
4. Have you ever incurred or become 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)	☐	☐
5. 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)?	☐	☐
6. Has your application for medical staff privileges at a hospital, other health care facility or managed care organization, ever been denied or restricted?	☐	☐
7. Have your medical staff privileges ever been revoked, suspended or restricted?	☐	☐
8. Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered or subject to probationary terms (in any jurisdiction)?		
8.1 Medical License	☐	☐
8.2 DEA License	☐	☐
9. Have you been notified to respond to, appear before or have you been investigated or are you currently being investigated by any State Board of Medical Examiner's Board of Medical Quality Assurance, Narcotics Board or other licensing governmental regulatory agency?	☐	☐
10. Do you provide any services to any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison, holding facility or other location, skilled nursing facility or assisted living center?	☐	☐
11. Do you have any contracts with a hospital, physician or other professional organization for your services? **Please provide.**	☐	☐

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.

Significant discrepancies will require clarification on my part before the renewal application process can be completed.

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 not or should have been reported to my present carrier or any former carrier.

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.

Printed Name	Renewal Policy #
Signature	Date of Signature