

Physicians Indemnity Risk Retention Group, Inc.

Renewal Application for 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.

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
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you received a request for records from a patient and/or attorney related to an adverse outcome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you received a letter from an attorney regarding your medical treatment of a patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you encountered any intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you received any patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Any other circumstances that might indicate the possibility of a claim or suit being brought against you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL PROCEDURES

Please check any of the following procedures you will perform:

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

	YES	NO
1. Do you perform any of the following:		
1.1 Chelation Therapy for other than lead poisoning	<input type="checkbox"/>	<input type="checkbox"/>
1.2 Home Deliveries	<input type="checkbox"/>	<input type="checkbox"/>
1.3 Second Trimester Abortions in a non-hospital setting	<input type="checkbox"/>	<input type="checkbox"/>
1.4 Botox Injections (if other than a dermatologist or plastic surgeon) <i>**Proof of training required if not on file**</i>	<input type="checkbox"/>	<input type="checkbox"/>
1.5 Bariatric Surgery (please complete supplemental application)	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Any non-FDA approved procedure/trial.	<input type="checkbox"/>	<input type="checkbox"/>
1.7 Do you attend or supervise deliveries in a non-hospital setting?	<input type="checkbox"/>	<input type="checkbox"/>
1.8 Do you serve in a hospital emergency room for which you require this policy to provide coverage	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you now, or have you ever been, evaluated, treated or hospitalized for the use of any of the following:		
2.1 Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
2.2 Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
2.3 CNS stimulants or depressants	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you now, or have you ever been, evaluated, treated or hospitalized for any mental or emotional disorders?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your application for medical staff privileges at a hospital, other health care facility or managed care organization, ever been denied or restricted?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have your medical staff privileges ever been revoked, suspended or restricted?	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
8.2 DEA License	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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