

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):	
<input type="checkbox"/> \$100,000 / \$300,000	<input type="checkbox"/> \$250,000 / \$750,000
<input type="checkbox"/> \$500,000 / \$1,500,000	<input type="checkbox"/> \$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																											
	Office Manager _____			Telephone: _____																								
	Street _____	Suite _____		Fax: _____																								
	City _____	State _____	Zip Code _____	County _____																								
	Cellular: _____			Email: _____																								
9.	Residential Address: _____																											
	Street _____			Telephone: _____																								
	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. <i>(List others on Supplemental Page)</i>																												
10.	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 50%;">Name</th> <th style="width: 15%;">City</th> <th style="width: 20%;">Status of Privileges (Active, Temp., Courtesy)</th> <th style="width: 15%;">Practice %</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Name	City	Status of Privileges (Active, Temp., Courtesy)	Practice %																				
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PERSONAL, HOSPITAL AND LICENSE INFORMATION

11.	Are you now, or have you ever been, evaluated, treated or hospitalized for the use of any of the following:	<u>YES</u>	<u>NO</u>
	11.1 Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
	11.2 Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
	11.3 CNS stimulants or depressants	<input type="checkbox"/>	<input type="checkbox"/>
12.	Are you now, or have you ever been, evaluated, treated or hospitalized for any mental or emotional disorders?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have your medical staff privileges ever been revoked, suspended or restricted? (Please explain on supplemental page.)	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you ever received any of the following:		
	18.1 Any hospital disciplinary action due to professional and/or behavioral reasons?	<input type="checkbox"/>	<input type="checkbox"/>
	18.2 Licensing board disciplinary or administrative proceeding due to impropriety or incompetence in a medical practice?	<input type="checkbox"/>	<input type="checkbox"/>
	18.3 Licensing board disciplinary or administrative proceeding due to prescribing, dispensing or distributing pharmaceuticals?	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
	19.2 DEA License	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/> N <input type="checkbox"/>
Fellowship Type:	_____	From	To
City:	_____	State:	_____
Specialty:	_____	Completed?:	Y <input type="checkbox"/> N <input type="checkbox"/>
Explain any gaps in time from date of medical school graduation to completion of training: _____			
		<u>N/A</u>	<u>YES</u>
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?		<input type="checkbox"/>	<input type="checkbox"/>

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?

Have you ever failed to maintain continuous professional liability insurance while rendering professional services? (If YES, please attach explanation.) YES NO

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

25. If currently insured with a claims-made policy, are you requesting Prior Acts Coverage? YES NO

(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? YES NO

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.)	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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.) _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
33.	Does your practice include any of the following? (Check all that apply.)		
<input type="checkbox"/>	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.	
<input type="checkbox"/>	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: <ul style="list-style-type: none"> • Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP); • Pneumatic or mechanical esophageal dilation (not with bougie 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.	
<input type="checkbox"/>	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.	
<input type="checkbox"/>	Radiology (Diagnostic)	Indicate the annual number of readings performed: _____ Type of readings performed: _____	
<input type="checkbox"/>	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:

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

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

- | | | |
|---|--------------------------|--------------------------|
| 37. Do you perform any of the following: | YES | NO |
| 37.1 Chelation Therapy for other than lead poisoning | <input type="checkbox"/> | <input type="checkbox"/> |
| 37.2 Home Deliveries | <input type="checkbox"/> | <input type="checkbox"/> |
| 37.3 Second Trimester Abortions in a non-hospital setting | <input type="checkbox"/> | <input type="checkbox"/> |
| 37.4 Botox Injections (if other than a dermatologist/plastic surgeon) | <input type="checkbox"/> | <input type="checkbox"/> |
| 37.5 Bariatric Surgery (please complete supplemental application) | <input type="checkbox"/> | <input type="checkbox"/> |
| 37.6 Any non-FDA approved procedure/trial. | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Do you attend or supervise deliveries in a non-hospital setting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you changed specialties/procedures in the past five years?
If YES, please detail your prior practice on the Supplemental Page. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Are you an employee of a hospital? If YES, name of hospital: _____
If another carrier covers the hospital employment exposure, see question 42. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.)
Do you have any contracts with a hospital, physician or other professional organization for your services? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. If yes, please provide contract. | <input type="checkbox"/> | <input type="checkbox"/> |

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?		Has Own Coverage (attach certificate)
			Separate Limits	Shared Limits	Vicarious Liability
			<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"/>

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

<p>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.</p> <p>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.</p>			
	<u>YES</u>	<u>NO</u>	
52.	Has any claim or suit for alleged malpractice been brought against you or your professional association, partnership or corporation?	<input type="checkbox"/>	<input type="checkbox"/>
	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?	<input type="checkbox"/>	<input type="checkbox"/>
	a) A request for records from a patient and/or attorney related to an adverse outcome?	<input type="checkbox"/>	<input type="checkbox"/>
	b) A letter from an attorney regarding your medical treatment of a patient?	<input type="checkbox"/>	<input type="checkbox"/>
	c) Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	<input type="checkbox"/>	<input type="checkbox"/>
	d) Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>
	e) Any other circumstances that might indicate the possibility of a claim or suit being brought against you?	<input type="checkbox"/>	<input type="checkbox"/>
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?:	<input type="checkbox"/>	<input type="checkbox"/>
	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?	<u>YES</u>	<u>NO</u>
		<input type="checkbox"/>	<input type="checkbox"/>
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?	<u>YES</u>	<u>NO</u>
		<input type="checkbox"/>	<input type="checkbox"/>
57.	Have any unexpected or potentially problematic results/incidents/reported claims occurred in the following categories?:	<u>YES</u>	<u>NO</u>
	• Death;	<input type="checkbox"/>	<input type="checkbox"/>
	• Loss of Function:	<input type="checkbox"/>	<input type="checkbox"/>
	• An impairment requiring long term/permanent care as a result of treatment rendered:	<input type="checkbox"/>	<input type="checkbox"/>
	• Post-operative coma or neurological deficits	<input type="checkbox"/>	<input type="checkbox"/>
	• All others (please explain): _____	<input type="checkbox"/>	<input type="checkbox"/>

(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): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Carrier Name:	Policy Number:	Date Reported:
9. Present status or disposition of claim including amount of settlement or judgement:		
<input type="checkbox"/> Open <input type="checkbox"/> 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