



Physicians & Surgeons Professional Liability Insurance Application

	<input type="checkbox"/> Copy of current most relevant medical license	<input type="checkbox"/> Copy of current declarations page
YOU	<input type="checkbox"/> Copy of letterhead or sample billing statement	<input type="checkbox"/> Curriculum vitae
MUST	<input type="checkbox"/> Supplemental claim form for each claim, regardless of outcome	<input type="checkbox"/> Copy of board certification
ATTACH	<input type="checkbox"/> Financial Statements / P&L balance sheets	<input type="checkbox"/> Copies of all Stationary
	<input type="checkbox"/> Copies of all advertisements within the last 2 years to include yellow page	

Please type or legibly print your responses in full. Please supplement this application with copies of the documents requested below and with responses to questions requiring more room than contained in this form.

1. Name (First, Middle, Last): _____			<input type="checkbox"/> M.D.	<input type="checkbox"/> D.O.	<input type="checkbox"/> Other _____
2. Social Security Number: _____		3. Date of Birth: _____		Birthplace: _____	
4. Narcotics DEA Number: _____		5. License Number/Date: _____			

6. Mailing Address:

Street: _____	
City/State/Zip: _____	County: _____

Office Telephone: _____	Fax: _____	E-Mail: _____
Business manager/contact person: _____		Telephone: _____

7. Principal office address (if different than mailing address):

Street: _____	Telephone: _____
City/State/Zip: _____	County: _____

Other Practice Locations:

Residence address (if different than mailing address):

Street: _____	County: _____
City/State/Zip: _____	Residence Telephone: _____

8. Requested limits of insurance: \$1,000,000/\$3,000,000 Name of Corporation _____

Shared Limits Seperate Limits

9. Requested effective date (12:01 a.m.): _____ Requested retroactive date (12:01 a.m.): _____

Retroactive date is the date to which coverage is to be extended for acts prior to the effective date.

10. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage for? Yes No

If yes, please list name of employer and insurance company: _____

11. Medical Specialty: _____ Subspecialty (if any): _____

12. Specialty Board Certification(s): _____ Date of certification(s): _____

If not board certified, are you board eligible? Yes No - Anticipated date of taking exam: _____

13. All states where you are licensed:

State	License Number	Active/Inactive

14. All hospitals and surgi-centers at which you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each:

Name	City	State	Type of privileges	% of admissions

15. All medical societies, medical associations, or other related professional societies, to which you belong:

16. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation Date
If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date certified: _____		If no, please explain:	

17. All internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Mo./Yr. Completed
Served internship at:		
Served residency at:		
Served fellowship at:		
Served fellowship at:		

18. All practice locations within the ten years prior to this application, the current or most recent first:

19. Please indicate below your best estimate of the number of the following procedures you expect to perform, or in which you will participate, in the next year, beginning with the date of your requested coverage:

Abortions - first trimester:

- _____ Hospital
- _____ Clinic
- _____ Office

Abortions - after first trimester:

- _____ Hospital
- _____ Clinic
- _____ Office
- _____ Acupuncture
- _____ Adenoidectomies
- _____ "Alternative Medicine" or "complementary medicine" procedures (as viewed by most physicians)

Please describe: _____

Anesthesia - obstetrical:

- _____ General
- _____ Spinal
- _____ Epidural

Anesthesia - non-obstetrical:

- _____ General
- _____ Spinal
- _____ Epidural

Anesthesia (other) - Please describe: _____

- _____ Angiographies
- _____ Angioplasty
- _____ Arteriographies
- _____ Assisting in major surgery - own patients
- _____ Assisting in major surgery - other than own patients
- _____ Breast implants
- _____ Breast reductions

Catheterizations:

- _____ Cardiac
- _____ Arterial

Other - Please describe: _____

- _____ Chelation therapy
- _____ Chemabrasion
- _____ Chemical Peels
- _____ Chemotherapy
- _____ Colonoscopies
- _____ Cosmetic implantation or injection of silicone or other materials - Please describe:

_____ Cryosurgery - Please describe: _____

- _____ D & C's

Deliveries:

- _____ Vaginal
- _____ Cesarean
- _____ Vaginal after Cesarean

- _____ Discograms
- _____ Electromyography
- _____ Endoscopy (other than proctoscopy or sigmoidoscopy) - Please describe: _____

- _____ Eyeliner pigmentation
- _____ Fracture reductions - closed
- _____ Fracture reductions - open
- _____ Hair transplants, or other hair growing or replacement techniques

I DO NONE OF THESE PROCEDURES

Hemorrhoidectomies:

_____ Internal

_____ External

_____ Herniorrhaphies

Laparoscopy:

_____ Diagnostic - Please describe: _____

_____ Surgical - Please describe: _____

_____ Laser Surgery - Please indicate type of surgery: _____

_____ Liposuction

_____ Lumbar punctures

_____ Manipulation therapy

_____ Myelography

_____ Needle aspirations

_____ Needle biopsies

_____ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts - Please indicate type of surgery: _____

_____ Pacemaker insertion

_____ Pain management - Please indicate type: _____

_____ Pre-natal care

_____ Radial keratotomy

_____ Radiation - diagnostic

_____ Radiation - therapeutic

_____ Sclerotherapy (choose one) <1mm >1mm

_____ Shock therapy

_____ Spinal Surgery

_____ Tattoo removal

_____ Thoracentesis

_____ Tonsillectomies

_____ Total joint replacements

_____ Tubal ligations

_____ Vasectomies

_____ Venography

_____ Weight control by means other than diet or exercise - Please describe: _____

_____ Any other procedure you reasonably believe will be of interest to a medical professional

_____ liability insurer - Please describe: _____

I DO NONE OF THESE PROCEDURES

20. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of major surgery:

_____ Abdominal	_____ Ophthalmological
_____ Bariatric	_____ Orthopedic - including spinal surgery
_____ Cardiac	_____ Orthopedic - without spinal surgery
_____ Colon/rectal	_____ Plastic - cosmetic
_____ General	_____ Plastic - reconstructive
_____ Gynecologic	_____ Thoracic
_____ Hand	_____ Traumatic
_____ Head and Neck	_____ Urologic
_____ Neurosurgical	_____ Vascular
_____ Obstetrical	I DO NONE OF THESE PROCEDURES

21. Please describe, and provide dates for, any major changes in your practice in the last seven years, such as changes of speciality, or significant procedures initiated or no longer performed:

In responding to questions 22 through 38, please explain any "yes" response, or provide any required explanation or details on supplementary pages and attach to this application.

22. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. A. Has any state ever refused you're a license to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Has any state ever restricted, suspended or revoked your license to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Have you ever voluntarily surrendered a license to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Has any state agency ever placed you on probation or restricted your practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Have you ever been investigated by any governmental agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. Has any hospital ever denied, restricted, reduced, or suspended your privileges or invoked probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30. Have you ever been refused board certification?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31. Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had renewal refused? To your knowledge is any such action under consideration by any current medical professional liability insurer?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
32. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33. Are you an employee of, or do you do contract work for, any government agency? If so, provide name _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34. Are you a sports team physician for any college, university or professional team?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
35. Do you participate in any pharmaceutical testing programs? If yes, is it (are they) FDA approved?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
36. Please indicate the number of people you employ by the following categories:		
_____ Lab or X-ray technicians	_____ Nurse practitioners	
_____ Medical Assistants	_____ Physicians or surgeons	
_____ Nurses	_____ Physician assistants	
_____ Nurse anesthetists	_____ Surgical assistants	
_____ Nurse midwives	_____ Other (please specify):	

37. Do you treat or review treatment for jail or prison inmates? (If coverage is to be provided by another carrier, please provide evidence of that other coverage.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
38. Do you admit patients for other physicians?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
39. Do you engage in any "moonlighting" activity, apart from your practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
40. Do you work in an emergency room? If yes, how many hours on average per week? _____ For what institution? _____ If coverage is to be provided by another carrier, please provide evidence of other coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
41. Do you use a collection agency? If yes, does the collection agency have authority to file collection suit at its discretion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
42. Do you work with a blood bank?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
43. If you are NOT a radiologist: Do you take and/or interpret your own X-rays or other imaging procedures? If yes, estimated number per year _____ Does a radiologist over-read your X-rays? If a non-radiologist is over-reading your X-rays, who? _____ What specialty? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
44. Do you perform surgery in your office? If yes, please list the specific procedures: _____ Is general anesthesia administered for these office procedures? If yes, by whom? _____ With what training? _____	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
45. Do you perform invasive pain management procedures? If yes, please list the procedures you perform and indicate if each is done in a hospital or office: Do you provide fluoroscopic guided procedures ? Do you use sedation? Do you place permanent pumps or stimulators? _____	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
46. Average number of patients per week:	# of patients _____	
47. Average weekly number of hours practiced per week: (a) Is your office staff certified in CPR?	hours per week _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
48. If you are practicing part time, please provide the date on which you began practicing in that capacity:		
49. Do you practice as a Hospitalist: If yes please complete all applicable below	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a) Individual (solo practice)? Please provide the name and Federal ID of the solo professional corporation or service corporation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Employee? Name of Employer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Independent contractor? Name of hiring party to contract:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Partner/shareholder? Name of corporation/partnership: Federal ID of the solo professional corporation or service corporation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
50. If you practice as a partner in a partnership or shareholder in a multi-shareholder professional corporation, is corporation coverage desired?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If coverage is desired, a corporate/organization application may be required. **Note:** This coverage is not available unless all partners, shareholders and employed physicians/surgeons are insured by the company.

51. Beginning with your most recent, or current, insurer please list all professional liability insurers for the past ten years. Please explain any gaps in the continuity of your professional liability coverage.

Name of Insurer	Coverage Type (Occurrence or Claims-made)	Policy Number	Policy Period

52. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer?
 Yes No
 (Please provide a copy of the Declarations page of your current coverage and any reporting period extension "tail").

53. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged?
 Yes No
 If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage?
 Yes No

54. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim?
 Yes No
 If yes, has this incident (these incidents) been reported to a prior insurer?
 Yes No

55. Have you had a request for medical records of a patient which has been reported to your current carrier?
 Yes No

56. Have you served as an expert witness or have you been deposed as an expert in any case of medical malpractice?
 If so, please supply copies of your deposition or testimony if available.
 Yes No

Please provide complete details for each incident on a separate page and attach to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition or current status must be included.

APPLICANT'S REPRESENTATION AND AUTHORIZATION

A) I understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of the carrier intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned. The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I authorize the release of any underwriting and/or claim information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents. I authorize Nevada Docs Medical Risk Retention Group to release certificates of insurance and claim information to any third party payor, HMO, PPO hospital or Managed Care Organization.



Signature of Applicant

Date

B) I have received and reviewed to my satisfaction the Information Circular with all of its attachments dated _____ for the Nevada Docs Medical Risk Retention Group, Inc.



Signature of Applicant

Date

C) I understand that: **This policy is issued by your risk retention group. Your 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. Therefore, these funds will not pay your claims or protect your assets if your risk retention group, the insurer, becomes insolvent and is unable to make payments as promised.**



Signature of Applicant

Date

D) I understand that to obtain and maintain insurance coverage under this program, I must belong to the Nevada Docs Association and that a copy of this application will serve as my application for membership in that organization. I understand that my dues of \$600 in the association must be maintained per the bylaws and that I must maintain my membership in good standing to continue to benefit from the association's programs. The nonrefundable application fee of \$50 will be applied to my first year's membership.



Signature of Applicant

Date

RETROACTIVE COVERAGE FORM

(This form must be completed, signed and dated; attach a separate sheet where necessary)

1. Name of Applicant: _____
First Middle Last
2. I am applying for: Retroactive coverage on my professional liability policy - Effective: _____
(Retroactive Date)
3. Limits of liability requested: \$1,000,000/\$3,000,000
4. Did you practice as part of a partnership or corporation during the prior acts period? Yes No
If yes, name(s) of corporation/partnership: _____
5. Have you reported any incidents (potential claims) to a prior carrier during the prior acts period? Yes No N/A
If yes, date of incident: _____ Name of carrier: _____
If yes, please describe: _____
6. Was the nature of your practice different during any of the prior acts period than it is now? Yes No N/A
If yes, please describe: _____
7. Did you practice in another state during the prior acts period? Yes No N/A
Please list states: _____
8. Did you function as a Medical Director for any facility? Yes No
If yes, name of the facility _____ and the length of time you have been there.
Medical Director from _____ to _____
Do you admit patients to the above facility? Yes No
9. Are you a hospitalist? Yes No If yes state the name of the facility. _____
10. Do you treat or admit patients at a nursing home? Yes No If yes how many patients per month? _____
11. Have you reported all outcomes that have resulted in a death, permanent damage/disability or bad outcome to your current carrier? Yes No N/A If yes, please list date(s) reported. _____

I understand that, if granted prior acts coverage by the carrier, such coverage will apply only to liability arising out of occurrence which happened prior to the effective date and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

- 1. any claim which has been reported to another insurance carrier prior to the effective date.**
- 2. any claim known to the insured at the effective date which has not been reported to a prior carrier.**
- 3. any claim which may arise out of an incident which has been reported to another insurance carrier prior to the effective date.**
- 4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.**

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge, and that I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I further authorize the release of any underwriting or claim information from all prior and current insurers, professional societies or association, or hospitals to the carrier.

FRAUD WARNING

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement or a claim or any false, incomplete or misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.



Signature of Applicant

Date

No coverage will be bound until after the Company has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment in advance of review of the application is not an expression of the Company's intent to provide coverage. If coverage is refused by the Company, any advance payment will be returned.



IMPORTANT: This form must be completed, signed, and dated. If the applicant's claim history is clean, simply mark, "N/A" on form, sign, and date. Thank you

SUPPLEMENTAL CLAIM INFORMATION FORM

Please provide the information below for each additional claim or suit to report.

If you do not have any claims/incidents open or paid, please check the box at left and sign the bottom

1. Physician's name (please print): _____

2. Patient's name: _____ Age: _____ Sex: _____

3. Date of first consultation: _____

4. Physical condition and diagnosis at the above date: _____

5. Nature of treatment given and dates of same: _____

6. Date of incident or occurrence from which claim resulted: _____

7. Date of claim: _____

8. Allegations made against you: _____

9. Was this claim reported to your insurance carrier? Yes No

If yes, list name of carrier and policy number:

10. Present status or disposition of claim including **amount of settlement or judgment**:

11. Subsequent condition or health of patient:

12. Names of other doctors, and hospitals, if any, involved in the claim or suit:

13. To whom may we refer for further information about the claim?

Signature of Applicant

Date