



# MedChoice

## RISK RETENTION GROUP

### *Physicians & Surgeons Professional Liability Insurance Application*

<b>YOU</b>	<input type="checkbox"/> Copy of current most relevant Medical License and DEA Certificate	<input type="checkbox"/> Copy of current Declarations Page
<b>MUST</b>	<input type="checkbox"/> Copy of letterhead or sample billing statement and all stationary	<input type="checkbox"/> Curriculum Vitae
<b>ATTACH</b>	<input type="checkbox"/> Supplemental claim form for each claim, regardless of outcome	<input type="checkbox"/> Copy of Board Certifications
	<input type="checkbox"/> Financial Statements / P&L balance sheets	<input type="checkbox"/> Copy of Medical Degree
	<input type="checkbox"/> Copy of all advertisements within the last 2 years	<input type="checkbox"/> Copy of Residency Certificates

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/\$5,000,000 Name of Corporation \_\_\_\_\_  
 Shared Limits  Separate 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:

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**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 MedChoice Risk Retention Group, Inc. to release certificates of insurance and claims information to any third party payor, hospital, HMO, PPO, or Managed Care Organization.



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Signature of Applicant

Date





# MedChoice

RISK RETENTION GROUP

**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 have never had any claims/incidents opened, paid, or closed, please check the box 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