



The link between
coverage and caring®

Preferred Professional Insurance Company

Professional Liability Insurance Application Occurrence Basis

IMPORTANT INSTRUCTIONS - PLEASE READ CAREFULLY

1. **PLEASE MAKE SURE ALL QUESTIONS ARE ANSWERED IN FULL.**
Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.
2. **IF YOU HAVE HAD CLAIMS OR SUITS FILED AGAINST YOU OR HAVE REPORTED INCIDENTS TO YOUR CURRENT INSURANCE COMPANY,** please make certain you have completed the claim information report on page 10 for each claim, suit, or incident.
3. **SIGNATURES ARE REQUIRED.** The policy application, the claim information report form, and the authorization form must be signed (Pages 9, 10 and 11).
4. **ENCLOSE COMPLETED APPLICATION IN THE RETURN ENVELOPE PROVIDED.**
5. **PREMIUM BILLING.** Upon acceptance of your application, you will be notified of the premium due. If coverage is to be bound upon acceptance, a deposit of \$500 must be enclosed.

We are aware of the urgent concern of many health care providers regarding their insurance renewal date. **However, applicants must meet the underwriting standards of Preferred Professional Insurance Company before coverage will be provided.** Qualified applicants who meet our underwriting standards can receive an effective date as early as the date after postmark of their application, if so requested.

FOR ASSISTANCE, PROVIDERS MAY CALL OUR HOME OFFICE

800 441-7742

(402) 392-1566

FAX: (402) 392-2673

E-MAIL: ppic@ppicins.com

Preferred Professional Insurance Company

P.O. Box 540658

Omaha, Nebraska 68154-0658



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APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR HEALTH CARE PROVIDERS

OCCURRENCE BASIS

(Please Type or Print)

1. Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Office or Hospital Telephone: () _____ Facsimile Number: () _____

Primary Clinic or Hospital Name and Address: _____

City: _____ County _____ State _____ Zip Code _____

Contact Person: _____ Title: _____

Current Billing Address (if other than above): _____

Home Street Address: _____ Home Telephone: () _____

City _____ State _____ Zip Code _____

2. Medical Specialty: _____ Sub-Specialty: _____

3. Desired Effective Date: _____ (All policies effective 12:01 AM)

Educational Information

4. (a) Medical School: _____
Name of School City State

Year Graduated: _____ Degree: _____

(b) Internship: _____
Name of Hospital City State Dates

(c) Residency: _____
Name of Hospital City State Dates

Name of Hospital City State Dates

(d) Residency Completed: _____ Yes _____ No

Date Completed or Expected Completion Date: _____

(e) Fellowship: _____
Name of Hospital City State Dates

Name of Hospital City State Dates

Fellowship Completed: _____ Yes _____ No

Date Completed or Expected Completion Date: _____

(f) Any other continuing medical education: _____ Yes _____ No

If Yes, give details: _____

(g) If you are a foreign medical school graduate, are you certified by the Education Council for
Medical School Graduates? Yes: _____ No: _____ Certificate Number: _____

Have you passed FLEX or USMLE? _____ Yes _____ No

5. Memberships, Licenses, and Affiliation Dates:

(a) Medical Associations and Societies: _____

(b) Are you Board Certified? _____ Yes _____ No

Name of Specialty Board: _____ Date Certified: _____

(c) Are you Board eligible? _____ Yes _____ No

Date eligibility expires: (Month/Year) _____

(d) List all states where licensed to practice and License Numbers:

_____ License Number: _____

_____ License Number: _____

_____ License Number: _____

6. List all locations (or name of hospitals if hospital-based practice) where you have practiced during the last 10 years (beginning with current practice):

Street City State Dates

(a) _____

(b) _____

(c) _____

(d) _____

7. Do you practice as: (Check One)

Solo Unincorporated Solo Corporation Partner in a Partnership Employed Physician

(a) Please indicate if you are an employed physician.

Employed by: _____

Full Time: _____ Part Time: _____ Number of Hours a Week: _____

If employed, limits of liability are those provided under the policy for your employer.

(b) If a solo physician or a partner in a partnership, give legal name of entity and list all partners associates, or physician employees (include letterhead):

Do you wish corporations, partnerships, or clinics added as additional insureds: ___ Yes ___ No

If Yes, give legal names: _____

8. (a) How many of the following support personnel are employed by you or your group?

- | | |
|----------------------------------|--|
| 1. _____ RN/LPN | 5. _____ Licensed PA |
| 2. _____ Lab/X-Ray Technician | 6. _____ Nurse Practitioner/Perfusionist |
| 3. _____ CRNA | 7. _____ Paramedic |
| 4. _____ Certified Nurse Midwife | 8. _____ Surgical Assistant |

(b) If you employ any personnel in the above categories, please show name(s) and describe their duties, whether or not they have their own professional liability insurance protection, and attach copy(ies) of state license(s) or credentials:

9. (a) List all hospitals and locations at which you are currently a staff member and show admissions (or consultations, procedures) in each hospital by number and percentage of total.

| Hospital/City | Number of Admissions (consultations or procedures) | Percentage |
|---------------|--|------------|
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |
| 4. _____ | | |
| 5. _____ | | |

NOTE: Certificates of insurance are provided to all hospitals at which you indicate privileges are held. If you do not wish to have a certificate sent to a particular hospital, please indicate.

- (b) Briefly describe the extent of your privileges at each hospital:

- (c) Are all of these hospitals JCAHO accredited? _____ Yes _____ No

If No, identify nonaccredited hospitals:

- (d) Please indicate the percentage of your practice that is conducted at your office(s) _____ %

10. (a) Do you normally staff an emergency room? _____ Yes _____ No
- (b) Do you practice in or staff a surgi-center or similar minor emergency clinic? _____ Yes _____ No
- (c) Are you engaged in any moonlighting activities? _____ Yes _____ No
- (d) Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? _____ Yes _____ No
- (e) Do you own or operate a surgi-center, emergency service facility, or similar outpatient facility? _____ Yes _____ No

Please explain any Yes answers:

Information of Practice and Specialty

11. In one or more of the spaces below, indicate only those specialties that describe your practice. If you engage in more than one specialty, please indicate the percentage of time you practice in each specialty.

SURGERY:

- _____ Cardiovascular
 _____ Colon & Rectal
 _____ General
 _____ Hand
 _____ Head and Neck
 _____ Neurosurgery
 _____ Orthopedic

Otorhinolaryngology:

- _____ Not Cosmetic _____ Cosmetic
 _____ Plastic
 _____ Not Cosmetic _____ Cosmetic
 _____ Thoracic
 _____ Traumatic
 _____ Urological
 _____ Vascular (inc. Peripheral)

- | | | |
|-------------------------------|-----------------------------|--|
| _____ Aerospace | _____ Hematology | _____ Pathology |
| _____ Allergy | _____ Hypnosis | _____ Pediatrics |
| _____ Anesthesiology | _____ Infectious Diseases | _____ Pharmacology |
| _____ Cardiovascular Disease | _____ Intensive Care | _____ Physical Medicine & Rehabilitation |
| _____ Dermatology | _____ Internal Medicine | _____ Psychiatry |
| _____ Emergency Medicine | _____ Legal Medicine | _____ Psychoanalysis |
| _____ Endocrinology | _____ Nephrology | _____ Public Health |
| _____ Family/General Practice | _____ Neurology | _____ Pulmonary Diseases |
| _____ With Ob/Gyn | _____ Nuclear Medicine | _____ Radiology, Diagnostic |
| _____ Without Ob/Gyn | _____ Obstetrics/Gynecology | _____ Radiology, Therapeutic |
| _____ Forensic | _____ Occupational Medicine | _____ Rheumatology |
| _____ Gastroenterology | _____ Oncology | _____ Urology |
| _____ Geriatrics | _____ Ophthalmology | |
| _____ Gynecology | _____ Otology | |

Other-Specify: _____

12. Please indicate with an "X" only those descriptions that describe your own particular practice:

NO SURGERY

No minor surgery, no major surgery, and no obstetrical procedures. Incision of boils or superficial abscesses and suturing of skin or superficial fascia are not to be considered surgical procedures.

MINOR SURGERY

Including obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies, adenoidectomies, and Cesarean sections are considered major surgery.

MAJOR SURGERY

Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation done using general anesthesia.

13. Please indicate with an "X" any of the following medical techniques or procedures you presently perform or contemplate performing in the next year:

- | | |
|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> ERCP (Endoscopic Retrograde Cholangio-Pancreatography) |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Gastrointestinal endoscopy |
| <input type="checkbox"/> other than acupuncture anesthesia | <input type="checkbox"/> Hair transplants |
| <input type="checkbox"/> Anesthesia - general | <input type="checkbox"/> Investigational procedures (provide detail) |
| <input type="checkbox"/> Anesthesia - spinal/caudal block/epidural | <input type="checkbox"/> Laparoscopy (peritoneoscopy) |
| <input type="checkbox"/> Angiography - coronary | <input type="checkbox"/> Lasers - used in therapy or surgery |
| <input type="checkbox"/> Angiography - all other | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Angioplasty - coronary | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Catheterization - right heart, including insertion of temporary and/or permanent pacemakers; Swan Ganz | <input type="checkbox"/> Needle biopsy - including lung & pleura |
| <input type="checkbox"/> Catheterization - left heart with coronary arteriography | <input type="checkbox"/> Needle biopsy - Type(s) _____ |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Open fracture |
| <input type="checkbox"/> Chemonucleolysis | <input type="checkbox"/> Pericardiocentesis |
| <input type="checkbox"/> Closed fracture - non aligned | <input type="checkbox"/> Pneumatic or mechanical endoscopic dilation |
| <input type="checkbox"/> Discograms | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Dilation and curettage (D&C) | <input type="checkbox"/> Research |
| <input type="checkbox"/> Elective cardioversion | <input type="checkbox"/> Sterilization |
| <input type="checkbox"/> Electroconvulsive therapy | <input type="checkbox"/> Weight-reduction surgery |
| <input type="checkbox"/> Other (describe): _____ | <input type="checkbox"/> None of the above |

Are there any other procedures that you have been trained for that you have not identified?

Yes No

If Yes, please identify: _____

Insurance Information

14. List prior Professional Liability Carriers for the past five years: (Please attach copy of declarations.)

| Insurer | Policy Number | <u>Type of Policy</u> Claims Made or Occurrence | Limits of Liability | Expiration Month/Day/Year |
|---------|---------------|---|------------------------|------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

15. If prior Professional Liability insurance was on a Claims Made basis, please indicate if you have purchased a “reporting endorsement” (commonly called “tail coverage”) from the insurance company that provided your expiring coverage.

_____ Yes _____ No

16. Amount of insurance desired: *

| | | |
|----------------------|-----------------------|-----------|
| | Each Medical Incident | Aggregate |
| [] | 100,000 | 300,000 |
| [] | 200,000 | 600,000 |
| [] | 500,000 | 1,500,000 |
| [] | 1,000,000 | 3,000,000 |
| [] | 2,000,000 | 4,000,000 |
| (indicate other) [] | _____ | |

* If employed, limits of liability are those provided under the policy for your employer.

17. Has any insurer ever cancelled, refused to renew, declined, or modified coverage (e. g. reduced limits, assigned a deductible, restricted coverage, surcharged rates) for any similar insurance ever issued to you? _____ Yes _____ No

18. Has anyone ever filed a complaint of any kind against you with your medical society or association? _____ Yes _____ No

19. Have your hospital privileges ever been restricted, suspended, or revoked? _____ Yes _____ No

20. Have you voluntarily withdrawn or resigned from any hospital privileges in lieu of disciplinary action? _____ Yes _____ No

21. Have you ever been under punitive or disciplinary observation, preceptorship, or sponsorship in a hospital? _____ Yes _____ No

22. Has any government agency ever investigated, suspended, revoked, or taken any other action against either your narcotics license or your license to practice medicine? _____ Yes _____ No
23. Have you ever been convicted of a felony? _____ Yes _____ No
24. Have you ever been notified of your involvement in a malpractice claim, suit, or “incident” either directly or indirectly? _____ Yes _____ No
****If Yes, explain below or on Page 10.**
25. Are you aware of any incident that could lead to a malpractice claim? _____ Yes _____ No
26. Do you have any personal health problems that might affect your practice of medicine? _____ Yes _____ No
27. Have you ever been treated for alcoholism, narcotics addiction, or mental illness? _____ Yes _____ No

USE THIS SECTION TO EXPAND ON ANY “YES” ANSWERS TO QUESTIONS 17 THROUGH 27.

ELIGIBILITY AND RISK MANAGEMENT PROGRAM:

If accepted, I agree to actively participate in the Risk Management Program established by my member hospital and by Preferred Professional Insurance Company and to use my best efforts to further the objectives of reducing the frequency and severity of claims. If I am unable to actively participate in the program, I will lose my eligibility to be insured by Preferred Professional Insurance Company.

WARRANTY:

It is warranted that the information contained on this application is true and that it shall be the basis upon which the policy of insurance will be issued and shall be deemed incorporated therein, should the Company accept this application. I acknowledge and understand that any material misrepresentation or concealment of information requested by this application may be a basis for denial of a claim or voiding of coverage.

I HAVE READ AND UNDERSTAND THE ABOVE. I HAVE HAD AN OPPORTUNITY TO HAVE ALL OF MY QUESTIONS ANSWERED.

Signature of Applicant*: _____

Date: _____

** Signing this form does not bind the applicant or the Company to complete this insurance, but one copy of this application will be attached to and form a part of the policy, if issued.*

NOTE: The application must be signed on pages 9, 10, and 11.

FRAUD WARNING: ANY PERSON WHO KNOWINGLY INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any representative of Preferred Professional Insurance Company to obtain from any hospital, clinic, place of employment, place of practice, or from any other entity with which I have been associated in any way in providing health care services any information, including full claims history, that the Preferred Professional Insurance Company shall desire in connection with the investigation of my qualifications to become insured. I hereby authorize the release of claims information from any prior or existing medical malpractice insurer to Preferred Professional Insurance Company. I further authorize the keeper of any records of any such entity to release all information including otherwise privileged or confidential information, relating to the aforementioned. A photocopy of this Authorization for Release of Information is valid as the original.

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, any such entity, its authorized representatives, and any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, provided, performed, made, requested or received by any such entity and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information made or given in good faith and relating to the foregoing information.

I hereby state that I have read and fully understand the above statements. I hereby consent to the disclosure of the information that is the subject of this authorization.

DATE

SIGNATURE

NAME OF HEALTH CARE PROVIDER (PRINT)