SPG SPECIALTY PROGRAM GROUP

Reset Fields

PHYSICIANS AND SURGEONS MEDICAL PROFESSIONAL LIABILITY APPLICATION

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE AND REPORTED COVERAGE

Please type or print all answers in ink. All questions require a response. If space is insufficient, please attach additional pages.

I. General Information

A. Full name (include professional designation) _____

B. Residence Address_____
(Street Address) (City) (State) (County) (Zip Code)

Residence Phone #_____SSN _____ Date of Birth_____

C. Principal Practice Address_____
(Street Address)

_____
(City) (State) (Zip Code) (County) (Post Office Box)

Additional Practice Locations_____% of practice_____

_____% of practice_____

Phone Number _____Fax Number _____

E-mail Address _____Web Site_____

D. Are you a current U.S. citizen □ **Yes** □ **No** If "No", what is your current status in the U.S., and where is your current citizenship? _____

E. Are you in current military service? □ **Yes** □ **No** If "Yes", in what capacity?

_____

F. Type of Practice:

□ Unincorporated Solo Practice
□ Incorporated Solo Practitioner
□ Professional Corporation
□ Professional Association
□ Limited Liability Company
□ Partnership
□ Other (Please explain) _____

Entity Name and Address _____

Do you require coverage for this entity? □ **Yes** □ **No** If "Yes", please provide the names of all physicians practicing under this entity:

Do you do any business under a d/b/a (doing business as)? □ **Yes** □ **No** If "Yes", please provide name: _____

G. Does your practice have:

A Blog?	□ **Yes**	□ **No**
An EHR (Electronic HealthCare Records) system?	□ **Yes**	□ **No**
Implemented procedures to comply with the HIPAA privacy rules?	□ **Yes**	□ **No**

H. Do you or any organization authorized by you engage in any advertising or solicitation of patients? □ **Yes** □ **No** If "Yes", please attach copies of all advertising material including website address(es).

II. Medical Training

A. Medical Specialty_____% of practice_____

B. Sub Specialty_____% of practice_____

Training	Hospital/School	City & State	Completed?	Dates From/To
Medical School			□ **Yes** □ **No**	
Internship/1st Year Residency			□ **Yes** □ **No**	
Residency			□ **Yes** □ **No**	
Additional Residency			□ **Yes** □ **No**	
Fellowship			□ **Yes** □ **No**	

C. Are you a Foreign Medical School Graduate? □ **Yes** □ **No**
If "Yes", please provide the date of ECFMG certification _____

D. Are you currently certified by the American Board of Medical Specialties? □ **Yes** □ **No**
If "Yes", please provide Name of Board _____
Expiration date of Certification/Recertification _____
If "No", do you plan to take the Board examination? □ **Yes** □ **No**

E. Are you a member of any medical association? □ **Yes** □ **No** If "Yes", please list memberships: _____

F. How many hours of continuing medical education have you taken in each of the past two years?
_____

III. License Information

A. Please provide **Federal DEA License # and status** _____

B. Please provide the following information for all of the states in which you have practiced:

State	License #	Effective Date	Expiration Date	Active?
				□ **Yes** □ **No**
				□ **Yes** □ **No**

IV. Hospital Privileges

A. Provide the following information for all hospitals and surgical centers where you are currently on staff:

Name	City	State	Type of Privileges

V. Office Staffing

A. Do you employ, contract with or supervise any physician(s) or surgeon(s)? □ **Yes** □ **No**
If "Yes", please provide the name(s), medical specialties and copies of certificates of insurance for each.

B. Do you employ, contract with or supervise any non-physician healthcare extenders? □ **Yes** □ **No**
If "Yes", please provide the following information: *(Attach separate sheet, if necessary)*

Name	Title	Employee (Y or N)	Separate Insurance* (Y or N)

Please provide a current certificate of insurance for each healthcare extender with separate coverage.

VI. Practice Characteristics

A. Please provide average weekly patient encounters including those patients seen by healthcare extenders you employ or supervise _____

B. Please provide average weekly practice hours _____

C. Do you practice Concierge Medicine? □ **Yes** □ **No**

D. Does your practice include telemedicine including but not limited to the use of telecommunications technology as a medium for rendering professional services, opinions or advice? □ **Yes** □ **No**

If "Yes", please provide the following information:

Identify all states involved in the telemedicine practice: _____

Provide % of practice devoted to these activities: _____

Are telemedicine services limited to radiology and/or pathology? □ **Yes** □ **No**

E. Are you in the employ or under contract to any entity (including governmental), other than the primary entity listed in **General Information**? □ **Yes** □ **No**

If "Yes", please provide details including your responsibilities:

If under any contracts, do they contain hold harmless agreements? □ **Yes** □ **No**

F. Are you Medical Director of a nursing home, commercial enterprise or other organization?

□ **Yes** □ **No** If "Yes", please describe your duties: _____

G. Do any of the following apply to your practice:

Administrative or teaching responsibilities	□ **Yes**	□ **No**
Locum tenens practice	□ **Yes**	□ **No**
Moonlighting activities	□ **Yes**	□ **No**
Provide services for any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison or holding facility	□ **Yes**	□ **No**

If "Yes", to any of the above, please provide details:

H. Do you treat or consult in any sovereign nation other than the United States including American or Alaskan Native lands? □ **Yes** □ **No**

If "Yes", please explain:

I. Do you participate in an Accountable Care Organization? □ **Yes** □ **No**

If "Yes", please provide name:

VII. Practice Information

A. Does your practice include the following:

□	**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.
□	**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: Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography, pneumatic or mechanical esophageal dilation,(not with bougie or olive), angiography, arteriography, catheterization—arterial, cardiac or diagnostic (applies only to internists who have completed cardio-vascular 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 procedures performed on a patient while under general anesthesia.
□	**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 also includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography, and radiation therapy. Also included is removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.

B. Do you own or operate a Laboratory? □ **Yes** □ **No**

If services are provided for other than your own patients, please describe: _____

_____

C. Do you now, or have you ever performed experimental or investigational procedures or prescribed/ dispensed experimental drugs? □ **Yes** □ **No**

If "Yes", please describe:

D. Do you work in an Emergency Room for other than fulfilling your requirement for hospital privileges? □ **Yes** □ **No**

If "Yes", please explain:

E. Are you a sports team physician or healthcare provider? □ **Yes** □ **No**

If "Yes", please check the following: □ High School □ College □ Professional □ Other

If "Other" please provide details: _____

F. If you, or any healthcare extender that you employ or supervise, perform any of the following procedures, check all that apply. For each procedure indicate where the procedure is performed:

H= Hospital, O = Office, S = Surgi-center

	Location
☐ Abortions – 1st Trimester	____
☐ Abortions – 2nd/3rd Trimester	____
☐ Acupuncture	____
☐ Adenoidectomy/Tonsillectomy	____
☐ Amputations	____
☐ Anal Fissures	____
Anesthesia – Non-obstetrical:	
☐ General	____
☐ Spinal	____
☐ Epidural	____
Anesthesia – Obstetrical	
☐ General	____
☐ Spinal	____
☐ Epidural	____
☐ Anesthesia – Other (describe) _____	____
☐ Angiography	____
☐ Angioplasty	____
☐ Anti-aging procedures – other than use of human growth hormone (describe) _____	____
☐ Arteriography	____
☐ Assisting in Surgery – on own patients or the patients of others	____
☐ Bariatric Surgery	____
☐ Breast Implants	____
☐ Breast Reductions	____
☐ Catheterization – other than umbilical cord, urethral or arterial line in a peripheral vessel	____
☐ Chelation Therapy – other than heavy metal poisoning	____
☐ Cholecystectomies	____
☐ Cleft Lip or Palate Surgery	____
☐ Clinical Trials	____
☐ Colonoscopies	____
☐ Complex Flaps and Grafts	____
☐ Conization of Cervix	____
☐ Cosmetic implantation or injection of silicone or other material	____
☐ Cryosurgery – other than on benign or pre-malignant dermatological lesions	____
☐ Culdocentesis	____
☐ Dermabrasion/Chemical Peels	____
☐ Dilation & Curettage	____
☐ Discograms	____
☐ Electroconvulsive Therapy	____
☐ Erectile Dysfunction Therapy	____
☐ Endoscopic procedures	____
☐ Hair Transplants or Suturing of Hairpieces	____
☐ Hemorrhoidectomies	____
☐ Hernioplasty	____
☐ Herbal Medicine	____
☐ Homeopathy	____

	Location
☐ Hyperbaric Medicine	____
☐ Hysterectomies	____
☐ Joint Replacement Surgery	____
☐ Laparoscopies	____
☐ Laser skin resurfacing	____
☐ Laser Surgery (describe)_____	____
☐ Lymphangiography	____
☐ Mesotherapy	____
☐ Minimally invasive surgery (describe) _____	____
☐ Moh's micrographic surgery	____
☐ Myelography	____
☐ Needle biopsies (describe)_____	____
Obstetrics:	
☐ Prenatal Care	____
☐ Normal deliveries – annual no._____	____
☐ Caesarean sections – annual no._____	____
☐ VBAC deliveries – annual no._____	____
☐ Home or non-hospital deliveries	____
☐ Open Reduction of Fractures (Plating and Pinning)	____
☐ Orchidectomy	____
☐ Organ Transplants	____
☐ Pain Management (describe) _____	____
☐ Pericardiocentesis	____
Plastic – Cosmetic Procedures:	
☐ Blepharoplasty	____
☐ Collagen injections	____
☐ Botox injections	____
☐ Liposuction under 3500 cc's volume	____
☐ Liposuction 3500 cc's or more volume	____
☐ Phalloplasty or penile implant	____
☐ Rhinoplasty	____
☐ Silicone implants	____
☐ Silicone injections	____
☐ Other plastic – cosmetic procedures (describe)_____	____
☐ Pneumoencephalography	____
☐ Prolotherapy/proliferative therapy	____
☐ Radiation Therapy	____
☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	____
☐ Refractive surgery: LASIK, PRK, AK, PTK, ICR	____
☐ Robotic Surgery	____
☐ Sex reassignment/sex change surgery	____
☐ Spinal surgery (incl. chemonucleolysis or percutaneous, lumbar discectomy)	____
☐ Thrombectomy of Arteries and Veins	____
☐ Trans Myocardial Laser procedures	____
☐ Tubal Ligation	____
☐ Vertebroplasty	____

VIII. Coverage Information

A. Coverage Desired:
- a. ___Claims Made coverage without Prior Acts (RDI)
- b. ___Claims Made coverage with Prior Acts coverage

B. If claims made coverage without Prior acts coverage was selected as the desired coverage, and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:
- a. ___An extended reporting endorsement (tail coverage) has been or will be purchased.
- b. ___An extended reporting endorsement has not and will not be purchased.

C. Requested Coverage Period
- a. From (Date) _____/_____/_____(Year)
- b. To (Date) _____/_____/_____(Year)

D. The Retroactive date shown on your current claims made policy is:
- a. _____/_____/_____(Year)

E. Limits of Liability being requested:

___100/300
___200/600
___500/1500
___1M/3M
___Other (specify) _____

F. Please provide the following information regarding the past 5 years of professional liability coverage:

Policy Period	Insurer	Policy Limits	Deductible	Policy Type	Premium	* Total # of Claims
				□ CM □ Occ		
				□ CM □ Occ		
				□ CM □ Occ		
				□ CM □ Occ		
				□ CM □ Occ		

**** Total # of claims by carrier regardless of payment, no payment, dismissed or open.***

E. Have you ever practiced without professional liability insurance? □ **Yes** □ **No**
If "Yes", please indicate dates: From_____ To _____

F. Have you ever had insurance company decline, cancel, rescind or non-renew any Professional Liability policy? (Response not required in State of Missouri.) □ **Yes** □ **No**
If "Yes", please provide explanation:

G. Please complete the following:

1. Have you had or been involved now or ever in a professional liability claim or suit? If "Yes", please complete the **Supplemental Claim Information** form for each. □ **Yes** □ **No**

2. Have you had any losses or claims that have not been reported to a prior insurance carrier or any other source from which payment could be made? □ **Yes** □ **No**

3. Are you aware of any specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim that has not been reported to a prior insurance carrier? □ **Yes** □ **No**

4. Have you had any requests for medical records by a patient or his/her attorney which might result in a claim? □ **Yes** □ **No**

5. Do you have any information relating to service(s) on a Board which may result in a claim? □ **Yes** □ **No**

6. Have you had any prior professional liability carrier refuse coverage for, or decline to accept a report of a specific act, omission or circumstance involving a particular and specific professional service(s) that may result in a claim, threat of a claim, letter of intent, adverse result notice or attorney contact? □ **Yes** □ **No**

7. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend non-renew or revoke your privileges? □ **Yes** □ **No**

8. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? □ **Yes** □ **No**

9. Have you ever been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? □ **Yes** □ **No**

10. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? □ **Yes** □ **No**

11. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse? If "Yes", complete the **Substance Abuse Supplement.** □ **Yes** □ **No**

12. Have you ever been evaluated, treated or hospitalized for mental or emotional disorders? □ **Yes** □ **No**

13. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation would limit your ability to safely practice in your medical specialty? □ **Yes** □ **No**

If "Yes" to any of the above, please provide details:

IX. Notice to the Applicant – Please Read Carefully

If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy.

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom, shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company

and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is assigned and the effective date of the policy, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

The policy for which application is made applies only to "Claims" first made during the "Policy Period".

Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy.

Unless amended by endorsement, "Claim Expenses" shall be applied against the "Deductible".

X. Fraud Statements

Applicable in AL, AR, DC, LA, MD, NM, RI and WV
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies to NY Only.

Applicable in ME, TN, VA and WA
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

XI. Warranty

I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy, I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

_____	_____
Name of Applicant	Title
_____	_____
Signature of Applicant	Date

Signing this form does not bind the Applicant or the Company to complete the Insurance.

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.