



APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Name _____ Applicable Med. License No. _____

Office Address _____ NPI No. _____

Office Phone No. _____

Cell Phone No. _____

Mailing Address (if different from above) _____ Email Address _____

Website Address _____

Type of Practice (Check as many as apply)

- Checkboxes for Solo, Member of a group practice, Full-time faculty, Resident/fellow member, Practice under contract, Employed by, I employ the following physician(s), Temporarily substituting for (physician's name)

States in which you are licensed to practice _____

If you now practice in more than one state, give the percentage of your practice in each _____

Date you began practice at your present professional location _____

Previous locations of practice, including dates (please attach CV) _____

Date of Birth _____ Place of Birth _____

Date coverage desired _____

Payment plan desired [] Advanced Payment Plan (5% discount) [] Semi-annual [] Quarterly [] 10 Monthly

Limits requested for Professional Liability Insurance (\$ each medical incident/\$ annual aggregate)

- Grid of checkboxes for insurance limits: 1 million/3 million, 2 million/4 million, 2 million/6 million (VIRGINIA ONLY), 3 million/5 million, 4 million/6 million, 5 million/7 million, 6 million/8 million, 7 million/9 million, 8 million/10 million, 9 million/11 million, 10 million/12 million

Name of most recent insurance carrier _____

Termination date of current or last policy _____ Retroactive date of last policy _____

FOR OFFICE USE ONLY

Institution and Location

Dates (From/To)

Medical School _____

Internship _____

Residencies/Fellowships

Institution and Location

Specialty

Dates (From/To)

1. _____

2. _____

3. _____

If you graduated from a foreign medical school, are you ECFMG certified? Yes No

What is your current specialty? _____ Percentage of practice _____

Specialties in which you are Board eligible _____

Specialty Board Certifications which you hold _____

List all hospitals where you have privileges. Indicate whether you wish us to send verification of insurance to each.

<u>Hospital</u>	<u>City/State</u>	<u>Types of Privileges</u>	<u>Send Verification (yes/no)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe the professional activities for which you are requesting coverage

How many hours per month do such activities involve? _____

Do you or will you render any medical professional services via telecommunications technology (telemedicine or internet medicine) that involves patients who reside in states other than your indicated state of practice? Yes No

Do you serve as a Medical Director? Yes No

If "yes", please list the name of the facility(ies) _____

Do you have other medical professional liability coverage for this exposure? Yes No

With whom? _____



Please carefully review the following list and check any procedures that apply or will apply to your practice

- | | | |
|---|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Cosmetic/dermatological procedures | <input type="checkbox"/> Orthopedics — hand surgery only |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Orthopedics — fracture reduction |
| <input type="checkbox"/> Amniocentesis | <input type="checkbox"/> Chemical peel | <input type="checkbox"/> Open |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Chemabrasion | <input type="checkbox"/> Closed |
| <input type="checkbox"/> General | <input type="checkbox"/> Collagen injection | <input type="checkbox"/> Orthopedics — spine surgery |
| <input type="checkbox"/> Spinal (including caudal) | <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> With instrumentation |
| <input type="checkbox"/> Regional | <input type="checkbox"/> Fat transfer | <input type="checkbox"/> Without instrumentation |
| <input type="checkbox"/> Conscious sedation | <input type="checkbox"/> Hair transplant | <input type="checkbox"/> Pacemaker insertion |
| <input type="checkbox"/> Local only | <input type="checkbox"/> Laser skin resurfacing | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Lipodissolve/mesotherapy | <input type="checkbox"/> Medication only |
| <input type="checkbox"/> Angioplasty (with or without stints) | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Selective nerve block |
| <input type="checkbox"/> Coronary | <input type="checkbox"/> Silicon injection | <input type="checkbox"/> Facet joint injection |
| <input type="checkbox"/> Peripheral | <input type="checkbox"/> Other | <input type="checkbox"/> Rhizotomy |
| <input type="checkbox"/> Appendectomy | _____ | <input type="checkbox"/> Lumbar epidural |
| <input type="checkbox"/> Assist in major surgery | <input type="checkbox"/> Electroconvulsive/shock therapy | <input type="checkbox"/> Cervical epidural |
| <input type="checkbox"/> On own patients only | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Spinal cord stimulator |
| <input type="checkbox"/> On patients of others | <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Trigger point injection |
| <input type="checkbox"/> Bariatric surgery | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Penile implants |
| <input type="checkbox"/> Only at MBSAQIP accredited center | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Percutaneous vertebroplasty |
| <input type="checkbox"/> Biopsy — endoscopic | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Prenatal care past 1 st trimester |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> EGD | <input type="checkbox"/> Pulmonary artery catheterization (Swan-Ganz) |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> ERC | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Therapeutic | <input type="checkbox"/> ERCP | <input type="checkbox"/> Tonsillectomy/adenoidectomy |
| <input type="checkbox"/> Chelation therapy (for other than heavy metal poisoning) | <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Tubal ligations |
| <input type="checkbox"/> Cholangiography | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Tumor ablation therapy |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Sigmoidoscopy | List types |
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Thoracoscopy | _____ |
| <input type="checkbox"/> Breast implant | <input type="checkbox"/> Esophageal dilation | <input type="checkbox"/> Vascular surgery |
| <input type="checkbox"/> Facial cosmetic surgery | <input type="checkbox"/> Interventional cardiology | <input type="checkbox"/> Vein procedures |
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Interventional radiology | <input type="checkbox"/> Endovenous laser ablation |
| <input type="checkbox"/> Other cosmetic procedures | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Sclerotherapy |
| Please list: | <input type="checkbox"/> Lumbar puncture | <input type="checkbox"/> Surface laser for spider veins |
| _____ | <input type="checkbox"/> Myelography | <input type="checkbox"/> Vena cava filter placement |
| _____ | <input type="checkbox"/> Obstetrics | |
| | <input type="checkbox"/> Non-surgical | <input type="checkbox"/> Surgical |

1. If **none** of the above procedures apply to your practice, please initial here _____

2. Do you perform procedures that are outside the customary scope of practice within your specialty? Yes No

IF "YES", PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER AND INCLUDE DOCUMENTATION OF TRAINING FOR SUCH PROCEDURES.

ANSWER EACH QUESTION. FOR ALL YES ANSWERS, ATTACH COMPLETE DETAILS ON A SEPARATE SHEET

YES NO

1. Has your LICENSE to practice in any state ever been denied, suspended, revoked, voluntarily surrendered, restricted, or subject to probationary terms?
2. Has your DEA Certificate for prescribing or dispensing narcotics ever been denied, suspended, revoked, voluntarily surrendered, restricted, or subject to probationary terms?
3. Has your MEMBERSHIP in any medical society or professional organization ever been denied, suspended, revoked, or voluntarily surrendered?
4. Have you ever been the subject of any DISCIPLINARY proceedings or reprimand by any medical board, administrative agency, medical society, or licensing board?
5. Has your application for hospital staff PRIVILEGES ever been denied or restricted?
6. Have your hospital PRIVILEGES ever been modified, revoked, non-renewed, subject to probationary or disciplinary action, or voluntarily surrendered while under review?
7. Have PRECEPTOR(S) or assisting physician(s) ever been assigned to any aspect of your practice by a hospital other than during your Residency or Fellowship Program?
8. Have you ever had specialty BOARD CERTIFICATION refused, suspended, or revoked?
9. Have you ever been convicted of, or plead nolo contendere, to a VIOLATION of any law or ordinance other than a traffic offense?
10. Has any hospital, medical society, administrative agency, or professional organization ever requested or required you to be EVALUATED for any medical condition, alcohol and/or drug abuse/dependency, anger or behavior problems, or alleged sexual boundary questions?
11. Have you ever had or do you currently have an ILLNESS OR DISABILITY that impaired, impairs or could impair your ability to practice your medical specialty including, but not limited to, alcoholism, drug addiction, compulsive disorders, tremors, multiple sclerosis, or rheumatoid arthritis?
If "yes", the details required on a separate sheet must include the name and address of your treating physician.
12. Has any CLAIM OR LAWSUIT for any alleged malpractice ever been brought against you?
If "yes", how many? _____ PLEASE ATTACH A COMPLETED CLAIMS ADDENDUM FORM FOR EACH "YES" ANSWER.
13. Has any CLAIM OR LAWSUIT for alleged malpractice ever resulted in a court judgment against you or a settlement by you or by an insurance company, self-insured plan, other form of indemnification, or other form of protection on your behalf?
14. Are you aware of any INQUIRY by an attorney representing any patient (other than worker's compensation or accident claims) about medical care you provided?
 If "yes", has the inquiry (or inquiries) been reported to and accepted by another medical professional liability insurer?
15. Are you aware of any patient or family member of a patient who has expressed DISSATISFACTION with medical care you provided?
 If "yes", has the inquiry (or inquiries) been reported to and accepted by another medical professional liability insurer?
16. Has your medical professional liability INSURANCE ever been cancelled, non-renewed, or issued on special terms or has your application for such medical professional liability insurance ever been declined?

INDICATE THE NUMBER OF YOUR EXTENDER EMPLOYEES

Number at
Primary Location

Number at
Remote Location

<input type="checkbox"/> None		
<input type="checkbox"/> Anesthesiologists Assistant - Certified	_____	_____
<input type="checkbox"/> Clinical Nurse Specialist	_____	_____
<input type="checkbox"/> Nurse Anesthetist (CRNA)	_____	_____
<input type="checkbox"/> Nurse Midwife (no deliveries)	_____	_____
<input type="checkbox"/> Nurse Midwife (with deliveries)	_____	_____
<input type="checkbox"/> Physician assistant	_____	_____
<input type="checkbox"/> Nurse Practitioner	_____	_____
<input type="checkbox"/> Optometrist	_____	_____
<input type="checkbox"/> Perfusionist	_____	_____
<input type="checkbox"/> Physician Assistant	_____	_____
<input type="checkbox"/> Psychologist	_____	_____
<input type="checkbox"/> Radiology Practitioner Assistant	_____	_____
<input type="checkbox"/> Registered Radiology Assistant	_____	_____
<input type="checkbox"/> Surgical Assistant	_____	_____

Are you a medical director or do you have a collaborative agreement to any of the above? Yes No

PLEASE CHECK ONLY ONE

I am applying for Extender Employee Professional Liability Coverage for my extender employees (provides a single separate limit of coverage for each extender employee and requires additional premium). A separate application will be required for each extender employee.

I am NOT applying for insurance for my extender employees.

I REPRESENT that the statements made and the answers provided herein are complete, true, and correct, and are for the purpose of inducing State Volunteer Mutual Insurance Company ("the Company") to issue the policy for which the application is hereby made.

I UNDERSTAND that the entire policy shall be void if, whether before or after a loss or claim, I am found to have willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

I UNDERSTAND that the medical professional liability insurance for which I am applying covers only those medical incidents which arise from professional services or peer review services rendered on or after the retroactive date, and then only if such medical incidents are first reported to the Company during the policy period. I UNDERSTAND that upon termination of a policy, extended reporting (tail) coverage is available for additional premium, except in the event the policy is canceled for non-payment of the premium.

I AUTHORIZE all hospitals, past or present medical associates, licensing boards, past or present professional liability insurers, and all other persons or organizations to release information concerning me and my medical practice history to the Company for the purpose of evaluating my liability risk. I AUTHORIZE the Company to use a copy of this authorization in place of the original. I UNDERSTAND that any such information will be used by the Company solely for underwriting purposes.

REGULATORY NOTICE: I ACKNOWLEDGE that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company, and that penalties include imprisonment, fines and denial of insurance coverage.

I further ACKNOWLEDGE that execution of this application by me does not bind the Company to issue an insurance policy, but that this application shall be the basis of the contract should a policy be issued.

Signature of Applicant

Date

Print or type name as it appears above





CLAIMS DETAIL ADDENDUM

Applicant's Name (please print) _____

Please supply the following information for each "yes" response to questions #12-15 on the application for Medical Professional Liability Insurance:

Total number of claims, suits, incidents or inquiries: _____

Please print or type answers to each of the following questions in detail. If more than one case exists, please photocopy this sheet for each case. FULL DISCLOSURE OF THE INFORMATION REQUESTED BELOW IS NECESSARY.

Patient/Plaintiff's Name _____ Insurance carrier involved _____

Date of occurrence _____ Date reported _____ Date closed (if applicable) _____

What is the status of the case? (check one)

- Pending Settled Out of Court Found for Plaintiff Dropped Dismissed Found for Defendant

If damages were paid, either by settlement or court award, what was the amount? _____

Paid on your behalf \$ _____ Paid by all parties \$ _____

What is/was your status? (check one) Primary Defendant Codefendant Other

In the space below (attach additional page(s) if needed), provide detailed information of the following for each case

- A) Provide a brief description of the incident/claim/suit. B) What were you alleged to have done incorrectly or failed to have done correctly? C) Provide any other details you feel are pertinent to the case. D) Identify any other parties who are named in the claim or suit.

Applicant's Signature _____ Date _____

Print or type name as it appears above _____



SUPPLEMENTAL APPLICATION FOR PRIOR ACTS COVERAGE FOR MEDICAL PROFESSIONAL LIABILITY COVERAGE

If you are desiring to change your professional liability coverage from another claims-made type carrier to SVMIC, you should either arrange to purchase tail coverage from that carrier or make application to SVMIC for prior acts coverage. Without one or the other of these coverages, medical incidents that occurred prior to the initial effective date of SVMIC's policy (if approved), may not be covered under either policy.

In addition to applying for prior acts coverage with SVMIC, it is important that you maintain your option to purchase tail coverage from your current or previous carrier until you have received an official approval letter or declarations page from SVMIC indicating prior acts coverage has been provided. Please note that most insurance carriers require that you notify them of your desire to purchase tail coverage within a limited period of time — usually 30 days from the termination of your policy. Prior Acts Coverage is not granted automatically and requires separate approval from SVMIC.

Applicant's Name (please print) _____

Option 1. _____ I am requesting Prior Acts Coverage from SVMIC.

What is the Prior Acts date requested? _____

This generally should be the date stated as the "Retroactive Date" under your current policy. Please attach a copy of the policy document showing your current retroactive date and limits of liability.

During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g. different states, procedures, coverage, etc.) [] Yes [] No

IF "YES", DESCRIBE SUCH CHANGES, INCLUDING ALL APPLICABLE DATES, ON A SEPARATE SHEET

Option 2. _____ I am not requesting Prior Acts Coverage from SVMIC.

By making this selection, it is assumed that you either do not need or desire this coverage, or that you have made arrangements with your current carrier to purchase tail coverage.

This Supplemental Application is being submitted with SVMIC's Application for Medical Professional Liability Insurance ("Application"), and I certify that I have specifically referred to questions #12, #13, #14, #15 on page 5 of such Application and have fully disclosed any requested claims, suits, incidents or inquires and the details thereof.

(In order for this application to be considered, ONE of the above Options must be marked indicating your request.)

Signature of Applicant _____ Date _____

Print or type name as it appears above _____