

# BERNARD WARSCHAW INSURANCE SALES

12121 Wilshire Boulevard, Suite 601  
Los Angeles, CA 90025

## PHYSICIAN'S PROFESSIONAL LIABILITY POLICY APPLICATION

### NEW POLICY

- Instructions: 1. All questions must be answered  
2. Please type or print clearly

**NOTICE**  
**This is an application for a**  
**CLAIMS-MADE POLICY**

1. (a) Applicant's Full Name: \_\_\_\_\_ Degree/Title: \_\_\_\_\_  
Other Name Used: \_\_\_\_\_ Birth Date: \_\_\_\_\_
- (b) Home Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Number Street City County State Zip
- (c) Principal Office: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Number Street City County State Zip
- (d) Other Office Address(es): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
(if any) Number Street City County State Zip
2. (a) Specify States where you are licensed:  
\_\_\_\_\_  
(License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field) (License #) (State of Licensure) (Field)
- (b) Specify States where you advertise and/or market your services: \_\_\_\_\_  
\_\_\_\_\_
- (c) Social Security Number: \_\_\_\_\_
- (d) Federal DEA Number: \_\_\_\_\_
3. If my application is approved, make coverage effective on \_\_\_\_\_, if possible, otherwise on any other date set by the Company.
4. (a) Type of Practice (check the box(es) that apply):  
1.  Individual 3.  Partnership 5.  Other (Describe)  
2.  Individual Corporation 4.  Member of Multi-person Corporation or association
- (b) List Federal Taxpayer Identification Number(s) and name(s) of corporate entity(ies):  
\_\_\_\_\_  
Entity Name Federal Taxpayer Identification Number  
\_\_\_\_\_  
Entity Name Federal Taxpayer Identification Number
- (c) Please list name(s) of ALL other partners, stockholders, associates, independent contractors and employed physicians (Indicate status of each).  
1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_
5. (a) Degree from (school): \_\_\_\_\_ Dates: \_\_\_\_\_  
City, State, Country mm/dd/yy mm/dd/yy
- (b) Internship: \_\_\_\_\_ Dates: \_\_\_\_\_  
Hospital City, State, Country mm/dd/yy mm/dd/yy
- (c) Residency: \_\_\_\_\_ Dates: \_\_\_\_\_  
Hospital City, State, Country mm/dd/yy mm/dd/yy
- (d) Type of Residency: \_\_\_\_\_
- (e) Residency: \_\_\_\_\_ Dates: \_\_\_\_\_  
Hospital City, State, Country mm/dd/yy mm/dd/yy
- (f) Type of Residency: \_\_\_\_\_
- (g) Fellowship or Additional Training: \_\_\_\_\_ Dates: \_\_\_\_\_  
City, State, Country mm/dd/yy mm/dd/yy
6. (a) Medical Specialty: \_\_\_\_\_ (b) Sub-Specialty: \_\_\_\_\_

7. (a) Are you Board Certified in your Specialty?  NO  YES Date Certified: \_\_\_\_\_  
 (b) Are you Board Certified in your Sub-Specialty?  NO  YES Date Certified: \_\_\_\_\_  
 (c) Name(s) of Specialty Board(s): \_\_\_\_\_  
 \_\_\_\_\_  
 (d) If you hold the foreign equivalent of Board Certification, please explain: \_\_\_\_\_  
 \_\_\_\_\_

8. **If the answer to any of the following is YES, please give full details (including dates) on a separate sheet of paper:** **NO** **YES**
- (a) Have you ever been convicted of, or under indictment for, a felony?
- (b) Have you ever had professional liability insurance declined, canceled, issued on special terms or non-renewed?
- (c) Have you ever been investigated by a State Board of Medical Examiners, Board of Medical Quality Assurance, Narcotics Board or other licensing or governmental regulatory agency?
- (d) Has your membership in any professional society or association ever been refused, censured, suspended or revoked?
- (e) Have you ever had privileges at any hospital or other institution reduced, revoked, restricted or suspended?
- (f) Have you now or ever had any chronic physical defect?
- (g) Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?
- (h) Have you ever been involved in a drug diversion or rehabilitation program?
- (i) Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/ Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau?
- (j) Have you ever been suspended by any governmental health program (e.g. Medicare or Medicaid)?
- (k) Are you aware of any facts or circumstances that may give rise to a claim or suit? (If yes, please complete a Claims Information Form for each case, attached to this Application).
- (l) Have you ever been involved in a malpractice claim or suit, either directly or indirectly, or are you presently involved in malpractice litigation? (If yes, please complete a Claims Information Form for each case.)

### PROCEDURES PERFORMED

9. **Do you perform abortions?** **NO** **YES** (a) Number performed monthly on your patients \_\_\_\_\_  
  (b) Number performed monthly on other patients \_\_\_\_\_  
 (c) List hospitals, clinics, or other facilities where you perform abortions:  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_

10. **Do you administer anesthesia?** **NO** **YES** If yes, circle (a) Spinal (c) General (e) Intravenous (g) Other  
  types used (b) Caudal (d) Local (f) Intravenous Analgesia  
 If yes, location: 1.  Hospital 2.  Surgicenter 3.  Non-hospital facility

11. **Do you practice weight reduction or control?** **NO** **YES** Percent of patients exclusively weight control \_\_\_\_\_ %
12. **Do you practice cosmetic plastic surgery?** **NO** **YES** Percent of patients cosmetic surgery \_\_\_\_\_ %

- |                        |  |                          |                          |                             |                          |                          |
|------------------------|--|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| If yes, do you perform | (a) Rhinoplasty?                                 | <input type="checkbox"/> | <input type="checkbox"/> | (d) Silicone implants?      | <input type="checkbox"/> | <input type="checkbox"/> |
|                        | (b) Hair transplants or suturing of hair pieces? | <input type="checkbox"/> | <input type="checkbox"/> | (e) Liposuction?            | <input type="checkbox"/> | <input type="checkbox"/> |
|                        | (c) Silicone injections?                         | <input type="checkbox"/> | <input type="checkbox"/> | (f) Blepharoplasty?         | <input type="checkbox"/> | <input type="checkbox"/> |
|                        |  |                          |                          | (g) Other cosmetic surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
|                        |  |                          |                          | (h) Phalloplasty?           | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, explain \_\_\_\_\_

- |  |                          |                          |   |                          |                          |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 13. <b>Do you possess or use radioactive materials?</b><br>If yes, please describe materials used: | NO                       | YES                      |   | NO                       | YES                      |
|  | <input type="checkbox"/> | <input type="checkbox"/> | Diagnostic purposes?<br>Therapeutic purposes? | <input type="checkbox"/> | <input type="checkbox"/> |
- 
- |  |                          |                          |  |  |  |
|--|--------------------------|--------------------------|--|--|--|
| 14. <b>Do you perform surgery for obesity (intestinal bypass)?</b> | NO                       | YES                      |  |  |  |
|  | <input type="checkbox"/> | <input type="checkbox"/> |  |  |  |
- |  |                          |                          |   |                          |                          |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 15. <b>(a) Do you perform surgery in your office?</b><br><b>(b) Do you perform surgery in any other non-hospital facility?</b> | NO                       | YES                      |   | NO                       | YES                      |
|  | <input type="checkbox"/> | <input type="checkbox"/> | (c) Is general anesthesia administered<br>1. By you?<br>2. By others? | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, list and describe facilities where surgery is performed: \_\_\_\_\_
- 
- (d) List the surgical procedures you perform in your office or other non-hospital facility: \_\_\_\_\_
- 

### Supplemental Questions

16. In order to properly classify your practice, please answer "YES" or "NO" as to whether you perform or desire to perform the following procedures:

- |  |                          |                          |   |                          |                          |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| <b>A. MEDICINE:</b><br>Arterial Catheterization<br>Liver Biopsy<br>CCU Care other than admitting privileges<br>Elective Cardioversion<br>Peritoneal Dialysis | NO                       | YES                      |   | NO                       | YES                      |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <b>F. ANESTHESIOLOGY:</b><br>Local<br>Digital Block<br>Peripheral Nerve Block<br>Obstetrical Anesthesia<br>IV Anesthesia<br>Spinal Anesthesia<br>Pain Block | <input type="checkbox"/> | <input type="checkbox"/> |
- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <b>B. PEDIATRICS:</b><br>Circumcisions<br>Treating critically ill infants and children<br>Umbilical Catheterization & Monitoring<br>Exchange Transfusions<br>Neonatology (treating critically ill neonates) | NO                       | YES                      |  | NO                       | YES                      |
|   | <input type="checkbox"/> | <input type="checkbox"/> | <b>G. SURGERY:</b><br>Minor Office Surgery<br>Aspiration of Cyst of Breast<br>Repair of Laceration not involving nerve or tendon<br>Assisting in Any Surgical Procedures<br>Hernioplasties<br>Appendectomies<br>Hemorrhoidectomies<br>Breast Biopsies<br>Vein Stripping<br>Anal Fissure<br>Adenoidectomy<br>Tonsillectomy<br>Nasal Polypectomy<br>Cholecystectomies<br>Mastectomies<br>Scalene Node Biopsy<br>Anal Fistulectomies<br>Surgical Weight Reduction | <input type="checkbox"/> | <input type="checkbox"/> |
- |  |                          |                          |  |                          |                          |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <b>C. OBSTETRICS:</b><br>Normal deliveries<br>Episiotomy<br>Managing Toxemia<br>Low forceps<br>Cesarean Sections<br>Mid forceps<br>Amniocentesis - Third trimester only<br>Breech Delivery | NO                       | YES                      |  | NO                       | YES                      |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <b>H. ORTHOPEDICS:</b><br>Injection of Bursa<br>Repair of Extensor Tendon<br>Repair of Flexor Tendon<br>Any Operative Orthopedics<br>Open Reduction of Fractures | <input type="checkbox"/> | <input type="checkbox"/> |
- |   |                          |                          |  |                          |                          |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <b>D. GYNECOLOGY:</b><br>Office Gynecology<br>Endometrial Biopsy<br>Cervical Biopsy<br>Cervical Cautery<br>Culdocentesis<br>Dilatation & Curettage<br>Cold Conization Cervix<br>Tubal Ligation<br>Salpingectomy<br>Oophorectomy<br>A&P repair<br>Hysterectomy<br>Vaginal<br>Abdominal<br>Ectopic Pregnancy<br>Laparoscopy | NO                       | YES                      |  | NO                       | YES                      |
|   | <input type="checkbox"/> | <input type="checkbox"/> | <b>I. EYE:</b><br>Refractions<br>Treatment of Eye Infection<br>Removal of Eyelid Lesions<br>Radial Keratotomy (RK)<br>Photorefractive Keratotomy (PRK)<br>Hexagonal Keratotomy (HK)<br>Excimer Laser Keratotomy<br>Automated Lamellar Keratotomy (ALK)<br>Intraocular Lens Implant | <input type="checkbox"/> | <input type="checkbox"/> |
- |  |                          |                          |  |  |  |
|--|--------------------------|--------------------------|--|--|--|
| <b>E. UROLOGY:</b><br>Biopsy of Penile Lesions<br>Aspiration of Hydrocele<br>Circumcisions<br>Orchidectomy<br>Treatment of Torsion of the Testicle | NO                       | YES                      |  |  |  |
|  | <input type="checkbox"/> | <input type="checkbox"/> |  |  |  |

17. Do you perform any of the following procedures, which are defined as surgery?

	As Surgeon		As Assistant	
	NO	YES	NO	YES
(a) Any surgical procedures involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Orthopedic surgery (other than orthopedic operations on the interphalangeal joints)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Any amputations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Plating, pinning or open reduction of fractures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Mastectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Plastic or cosmetic surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Reconstructive vascular surgery, thromboembolectomy and thrombectomy of the arteries or veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Ophthalmic surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Mastoidectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Operations within the middle or inner ear?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Prostatectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Submucous nasal resections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Thyroidectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Neurological surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Any surgical procedures on malignant lesions except for diagnostic purposes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(p) Any cutting into or on the kidney, ureter or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(q) Myringotomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(r) Adenoidectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(s) Tonsillectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(t) Herniorrhaphy (inguinal or femoral only)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(u) Vasectomies and other procedures involving cutting into the scrotal sac?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(v) Hemorrhoidectomies and other procedures limited to the anal ring?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(w) The care and treatment of pregnancy (including labor, delivery and abortion but excluding cesarean section)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(x) Therapeutic abortion (1st trimester only)? _____ # per month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(y) Therapeutic abortion (after 12 weeks)? _____ # per month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(z) Injection treatment of varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(aa) Orthopedic operations of the interphalangeal joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(bb) Abdominal surgery limited to appendectomies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(cc) Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	As Surgeon		As Assistant	
	NO	YES	NO	YES

18. Indicate below any other procedures that you perform which are commonly considered to be surgery:

_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Do you perform laparoscopic cholecystectomies?  
If yes, describe training below. (Attach separate sheet if necessary.)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

20. Do you perform the following procedures? (check either NO or YES)

	<b>NO</b>	<b>YES</b>		<b>NO</b>	<b>YES</b>
(a) Venography	<input type="checkbox"/>	<input type="checkbox"/>	(r) Paracentesis	<input type="checkbox"/>	<input type="checkbox"/>
(b) Amniocentesis	<input type="checkbox"/>	<input type="checkbox"/>	(s) Polypectomy by endoscopy	<input type="checkbox"/>	<input type="checkbox"/>
(c) Arteriography (explain type)	<input type="checkbox"/>	<input type="checkbox"/>	(t) Dialysis Procedures	<input type="checkbox"/>	<input type="checkbox"/>
(d) Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	(u) Thoracentesis	<input type="checkbox"/>	<input type="checkbox"/>
(e) By-pass Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	(v) Gastric Bubble Insertion	<input type="checkbox"/>	<input type="checkbox"/>
(f) Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	(w) Catheterization-arterial or cardiac	<input type="checkbox"/>	<input type="checkbox"/>
(g) Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	(x) Convulsive shock therapy	<input type="checkbox"/>	<input type="checkbox"/>
(h) Cryosurgery	<input type="checkbox"/>	<input type="checkbox"/>	(y) Lymphangiography	<input type="checkbox"/>	<input type="checkbox"/>
(i) Dermabrasion	<input type="checkbox"/>	<input type="checkbox"/>	(z) Chelation therapy (explain)	<input type="checkbox"/>	<input type="checkbox"/>
(j) Endoscopy (explain type)	<input type="checkbox"/>	<input type="checkbox"/>	(aa) Arthroscopy or arthrography	<input type="checkbox"/>	<input type="checkbox"/>
(k) Hypnosis	<input type="checkbox"/>	<input type="checkbox"/>	(bb) Peripheral nerve surgery	<input type="checkbox"/>	<input type="checkbox"/>
(l) Insertion of IUD	<input type="checkbox"/>	<input type="checkbox"/>	(cc) FDA approved experiments (explain)	<input type="checkbox"/>	<input type="checkbox"/>
(m) Laser therapy (explain)	<input type="checkbox"/>	<input type="checkbox"/>	(dd) Sex change (explain)	<input type="checkbox"/>	<input type="checkbox"/>
(n) Myelography	<input type="checkbox"/>	<input type="checkbox"/>	(ee) Chymo-Papain Injections	<input type="checkbox"/>	<input type="checkbox"/>
(o) Needle Biopsy (explain type)	<input type="checkbox"/>	<input type="checkbox"/>	(ff) IVP	<input type="checkbox"/>	<input type="checkbox"/>
(p) Organ transplants (explain type)	<input type="checkbox"/>	<input type="checkbox"/>	(gg) Home or non-hospital deliveries (explain)	<input type="checkbox"/>	<input type="checkbox"/>
(q) Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	(hh) Norplant Contraceptive	<input type="checkbox"/>	<input type="checkbox"/>

EXPLANATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	<b>NO</b>	<b>YES</b>
(a) Surgical treatment of cysts, superficial abscesses, minor traumatic wounds and superficial biopsies?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Biopsy procedures of lesions of the skin, and the mucous membranes of the mouth, nose, throat, vagina, uterine cervix and rectum?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Biopsy excision of lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>

## SPECIALISTS

**22. ANESTHESIOLOGISTS:**

- |  | NO                       | YES                      |                             |
|--|--------------------------|--------------------------|-----------------------------|
| (a) Do you practice medicine or surgery other than anesthesia?   | <input type="checkbox"/> | <input type="checkbox"/> | Percent of Patient's _____% |
| (b) Describe other medicine or surgery performed: _____<br>_____ |                          |                          |                             |

- |   | NO                       | YES                      |                              |
|---|--------------------------|--------------------------|------------------------------|
| (c) Do you employ <input type="checkbox"/> or have you assumed supervisory duties over <input type="checkbox"/> : |                          |                          |                              |
|   | <input type="checkbox"/> | <input type="checkbox"/> | 1. Any nurse anesthetists    |
|   | <input type="checkbox"/> | <input type="checkbox"/> | 2. Any inhalation therapists |

If yes, explain \_\_\_\_\_

**23. DERMATOLOGISTS:**

- |   | NO                       | YES                      |
|---|--------------------------|--------------------------|
| (a) Do you perform superficial X-ray therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you perform cosmetic surgery?          | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, explain \_\_\_\_\_

**24. OBSTETRICIANS AND GYNECOLOGISTS:**

- |  | NO                       | YES                      |
|--|--------------------------|--------------------------|
| (a) Do you limit your practice to gynecology only?         | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you employ or contract with, or cover for midwives? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Do you do home or non-hospital deliveries?             | <input type="checkbox"/> | <input type="checkbox"/> |

**25. OPHTHALMOLOGISTS:**

- |  | NO                       | YES                      |
|--|--------------------------|--------------------------|
| (a) Do you practice Otorhinolaryngology? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you perform cosmetic surgery?     | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, explain \_\_\_\_\_

**26. OTOLARYNGOLOGISTS:**

- |   | NO                       | YES                      |
|---|--------------------------|--------------------------|
| (a) Do you practice ophthalmic surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you perform cosmetic surgery?    | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, explain \_\_\_\_\_

**27. PEDIATRICS-NEONATOLOGY:**

- |   |  |  |         |
|---|--|--|---------|
| (a) Percentage of your practice derived from neonatology?<br>(i.e., the treatment of critically ill neonates) |  |  | _____ % |
|---|--|--|---------|

**28. CRITICAL CARE, EMERGENCY ROOM, OCCUPATIONAL MEDICINE OR INDUSTRIAL MEDICINE:**

- |  | NO                       | YES                      |
|--|--------------------------|--------------------------|
| (a) Are you a critical care specialist?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Are you an emergency room specialist?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Are you an occupational medicine specialist (evaluation only)?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Are you an industrial medicine specialist (diagnosis & treatment)?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Are you providing or subject to providing care in an outside facility?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) If yes, give facility's full name, location and department in which you serve:<br>_____<br>_____ |                          |                          |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| (g) Is insurance coverage provided for your work by this facility? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| (h) Is your work at this facility: |                          |                          |
| 1. On your own patients only?      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Required for staff privileges?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Other? _____                    |                          |                          |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| (i) 4. Percentage of gross income obtained from this care _____%. |                          |                          |
| Is there a written contract or agreement to provide this service? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, submit copy of written contract.                          |                          |                          |

**SPECIALISTS (continued)**

**29. GENERAL SURGEONS, THORACIC SURGEONS, VASCULAR SURGEONS:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>NO</b>                | <b>YES</b>               |
| (a) Do you perform organ transplants?<br>If yes, what types? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/>  |                          |                          |
| (b) Do you perform any surgery that is categorized as:               | <b>NO</b>                | <b>YES</b>               |
| 1. Orthopedic Surgery?<br><b>If yes, please complete section 31.</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Neurosurgery?<br><b>If yes, please complete section 31.</b>       | <input type="checkbox"/> | <input type="checkbox"/> |

**30. UROLOGISTS:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>NO</b>                | <b>YES</b>               |
| (a) Do you perform prosthetic implants?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you perform organ transplants?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Do you perform sex changes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Do you perform Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection) | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____  |                          |                          |
| <hr/>  |                          |                          |

**31. ORTHOPEDIC OR NEUROLOGICAL SURGERY:**

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>NO</b>                | <b>YES</b>               |
| (a) Do you assume primary care in major spinal trauma?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Do you perform insertion of Pedicle Screws?<br>Number performed annually? _____    | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Do you perform lumbar laminectomies?<br>Number performed annually? _____           | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Do you perform cervical laminectomies?<br>Number performed annually? _____         | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Do you perform spinal fusions?<br>Number performed annually? _____                 | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Do you perform anterior cervical discectomies?<br>Number performed annually? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Do you perform joint implants?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Do you perform scoliosis surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Do you perform neuro implant surgery for pain?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Do you perform stereotactic neurosurgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe special training or experience in spinal surgery: _____                       |                          |                          |
| <hr/>  |                          |                          |

**PRACTICE**

**32. List all locations where you have practiced in the last 10 years:**

	Street	City	County	State	During Years
(a)	_____	_____	_____	_____	_____
(b)	_____	_____	_____	_____	_____
(c)	_____	_____	_____	_____	_____
(d)	_____	_____	_____	_____	_____

**PRACTICE (continued)**

33. What is your average weekly patient load? \_\_\_\_\_

34. Do you or your professional entity employ or contract for the service of any health care personnel in the following categories?  
Give the number of each:

	Number Employed	Number Contracted
(a) Nurses	_____	_____
(b) Technicians	_____	_____
(c) Psychologists	_____	_____
(d) Physical Therapists	_____	_____
(e) Physician's Assistants*	_____	_____
(f) Nurse Practitioners*	_____	_____
(g) CRNA's*	_____	_____
(h) Nurse Midwives*	_____	_____
(i) Other: _____	_____	_____

\*If yes, submit written explanation of practice and procedures performed, along with certificate of course completion and license number.

35. List hospitals at which you are currently a staff member and show percentage of work in each hospital:

- (a) \_\_\_\_\_
- (b) \_\_\_\_\_
- (c) \_\_\_\_\_
- (d) \_\_\_\_\_
- (e) \_\_\_\_\_

36. Are you associated in any capacity with, or do you own, any of the following:

- |   | <b>NO</b>                | <b>YES</b>               |
|---|--------------------------|--------------------------|
| (a) Any health care facility having bed and board accommodations?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Any clinic, foundation, blood bank or laboratory?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Any health maintenance organization (HMO), preferred provided organization (PPO), individual physicians' association (IPA), and/or any pre-paid health plan, etc.?<br>If yes, | <input type="checkbox"/> | <input type="checkbox"/> |

1. Give full legal names and location of facility as well as any department in which you serve:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is insurance coverage provided for this work by the above facility?  NO  YES

3. Are you: (a)  Owner (whole or part) (b)  Executive Officer (e.g. Board Member)  
 (c)  Physician with teaching responsibilities (d)  Administrator (e)  Director of Ancillary Services Department  
 (f)  Committee Member (g)  Other, (describe) \_\_\_\_\_

4. How are you compensated for your services? (a)  Salary (b)  Percentage  
 (c)  Fee for Service (d)  Honorary or non-paid

5. Indicate which type of contractual agreement: (a)  Oral (b)  Written

6. How many days do you work per week? \_\_\_\_\_ Hours per day? \_\_\_\_\_

37. **REMARKS** (Please indicate question number(s) referred to in the following remarks):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRACTICE (continued)**

38. List additional medical specialty training:

	TYPE	DATES

39. List malpractice coverage for the past 10 years:

NAME OF INSURER	DATES COVERED FROM - TO	LIMITS OF LIABILITY	Number of Pending Claims	Number of Closed Claims	Total Number of Claims
A					
B					
C					
D					

**(PLEASE ATTACH A COPY OF YOUR MOST RECENT POLICY.)**

**NOTE: PLEASE FILL OUT A CLAIM INFORMATION FORM FOR EACH SUIT, CLAIM, LETTER OF INTENT AND INCIDENT, OPEN OR CLOSED, AND SUBMIT ANY ADDITIONAL INFORMATION RELATIVE TO THESE CLAIMS.**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>NO</b>                | <b>YES</b>               |
| (1) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) If answer to (1) is NO, do you wish to obtain Prior Acts Coverage from us? NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.  | <input type="checkbox"/> | <input type="checkbox"/> |
| (3) If answer to (2) is YES, please attach a copy of your present insurance policy and complete the following:  |                          |                          |
| (a) Applicant is/is not ( <b>circle one</b> ) as of this date aware of any CLAIMS or INCIDENTS against him/her that have not been reported to his/her present or prior insurer(s). Please Initial: _____  |                          |                          |
| (b) Applicant is/is not ( <b>circle one</b> ) as of this date aware of any conduct, circumstances or incidents which occurred during the periods of coverage above that could reasonably be expected to result in a CLAIM or SUIT, which have not been reported to his/her present or prior insurer(s). Please Initial: _____ |                          |                          |
| (c) Has your practice (e.g. specialty, procedures) changed in the last five years?<br>If YES, please explain:   | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim, suit or incident based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued.**

I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not withheld any information which is calculated to influence the judgement of the Company in considering this application for professional liability insurance.

The Company policy does not provide defense or indemnity coverage for any claims, civil lawsuits, arbitration, legal or administrative proceedings, incidents, accidents, or events in which damages or liability is assumed or imposed, or sought to be imposed, upon an insured under a written or oral agreement, specifically including a "hold harmless" indemnification or similar agreement, where the damages or liability assumed by, imposed or sought to be imposed are greater than that which would exist in the absence of such an agreement.

This application form, duly completed, together with any supplementary information, **must** be signed and dated in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, preceptorship, residency program, insurance company, underwriter and insurance agent to furnish any information concerning me or my medical practice which the company, or its representative may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction, together with the agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# CLAIMS INFORMATION FORM

**CLAIM INFORMATION - Please type or print clearly**

- 1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_
- 4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): \_\_\_\_\_  
\_\_\_\_\_
- 5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_
- 9. Insurance Carrier(s): \_\_\_\_\_
- 10. Other Defendants: \_\_\_\_\_
- 11. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed  
Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)
- 12. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 13. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 14. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 15. Defense Counsel: \_\_\_\_\_
- 16. Plaintiff's Counsel: \_\_\_\_\_

**I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CLAIMS INFORMATION FORM**  
**(If more than one claim, please make copies)**

**CLAIM INFORMATION - Please type or print clearly**

1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_

4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): \_\_\_\_\_  
\_\_\_\_\_

5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_

9. Insurance Carrier(s): \_\_\_\_\_

10. Other Defendants: \_\_\_\_\_

11. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed

Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)

12. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Defense Counsel: \_\_\_\_\_

16. Plaintiff's Counsel: \_\_\_\_\_

**I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**NO KNOWN CLAIMS DECLARATION**

I declare that I am not aware of, nor do I have any knowledge of, any claim or incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to Professional Underwriters Liability Insurance Company.

I have reported all claims, and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

1. Any incident or claim for which I have received notice of a claim.
2. Any incident or claim for which a legal action has been filed against my employees or me.
3. Any incident or claim upon which any companies previously insuring me have previously established a claim file.
4. Any incident or claim arising out of any fact, circumstance, or situation indicating the possibility of a claim which was known to me as of the effective date of insurance for which I am applying.

Signed: \_\_\_\_\_  
Applicant's Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name

State of: \_\_\_\_\_ County of: \_\_\_\_\_