

PROFESSIONAL LIABILITY INSURANCE COMPANY OF AMERICA
Physician Professional Liability Insurance Application

I. GENERAL INFORMATION

A. LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ DEGREE _____
 DATE OF BIRTH (M/D/Y) _____ SOCIAL SECURITY NUMBER _____

B. OFFICE LOCATIONS WHERE YOU PRACTICE (List Principal Location First)

1. SUITE _____ NUMBER & STREET _____ CITY _____ STATE _____ ZIP CODE _____ COUNTY _____ %OF PRACTICE _____
 2. SUITE _____ NUMBER & STREET _____ CITY _____ STATE _____ ZIP CODE _____ COUNTY _____ %OF PRACTICE _____
 3. SUITE _____ NUMBER & STREET _____ CITY _____ STATE _____ ZIP CODE _____ COUNTY _____ %OF PRACTICE _____

C. HOSPITALS WHERE YOU PRACTICE. LIST PRINCIPAL LOCATIONS FIRST

1. HOSPITAL _____ CITY _____ STATE _____ COUNTRY _____ TYPE OF PRIVILEGES _____ % OF PRACTICE _____
 2. HOSPITAL _____ CITY _____ STATE _____ COUNTRY _____ TYPE OF PRIVILEGES _____ % OF PRACTICE _____
 3. HOSPITAL _____ CITY _____ STATE _____ COUNTRY _____ TYPE OF PRIVILEGES _____ % OF PRACTICE _____
 4. HOSPITAL _____ CITY _____ STATE _____ COUNTRY _____ TYPE OF PRIVILEGES _____ % OF PRACTICE _____

D. HOME ADDRESS

SUITE _____ NUMBER & STREET _____ CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

E. PREFERRED MAILING ADDRESS: OFFICE# _____ HOME _____ OTHER(BELOW) _____
 FROM B ABOVE

OTHER ADDRESS: _____

() _____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
 BUSINESS PHONE _____ BUSINESS FAX _____ E-MAIL ADDRESS _____

II. EDUCATIONAL BACKGROUND**A. MEDICAL SCHOOL**

NAME OF SCHOOL _____ CITY _____ STATE _____ COUNTRY _____ DEGREE _____ MM/DD/YY _____ COMPLETED _____

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM? YES NO

B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS.

IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE:
 Your PLICA policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.

1. NAME OF HOSPITAL _____ STATE _____ COUNTRY _____ FROM (MM//DD/YY) _____ TO (MM/DD/YY) _____ TYPE COMPLETED _____

2. NAME OF HOSPITAL _____ STATE _____ COUNTRY _____ FROM (MM//DD/YY) _____ TO (MM/DD/YY) _____ TYPE COMPLETED _____

3. NAME OF HOSPITAL _____ STATE _____ COUNTRY _____ FROM (MM//DD/YY) _____ TO (MM/DD/YY) _____ TYPE COMPLETED _____

ADDITIONAL TRAINING (FELLOWSHIPS, ETC)

4. NAME OF HOSPITAL _____ STATE _____ COUNTRY _____ FROM (MM//DD/YY) _____ TO (MM/DD/YY) _____ TYPE COMPLETED _____

- C. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME? YES NO
- D. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS? YES NO
 If "yes", how many category 1 credit hours? _____
- E. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE PAST TWELVE (12) MONTHS? YES NO
- F. IF YOU ANSWERED YES, DID THE COURSE PROVIDE ALL THE FOLLOWING?
 A minimum of three category 1 continuing medical education (CME) hours;
 Provide the CME hours through an approved national/regional medical education sponsor; and
 Strictly adhere to risk management (loss prevention) curriculum? YES NO

Please attach your completion (attendance) certificate from the CME program.

III PRACTICE INFORMATION

- A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? YES NO
 IF YES, WHICH STATE(S) _____

- B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE (Use supplemental sheet if necessary)

1.STATE _____ LICENSE# _____ 2.STATE _____ LICENSE# _____

- C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST

CITY	STATE	SPECIALTY	FROM MONTH/YEAR TO MONTH/YEAR
CITY	STATE	SPECIALTY	FROM MONTH/YEAR TO MONTH/YEAR

- D. TO WHICH STATE/LOCAL MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG?

IV. RATING INFORMATION

- A. WHAT IS YOUR PRESENT SPECIALTY? _____ SUB-SPECIALTY? _____
 What percentage of your practice is devoted to your specialty? _____ Subspecialty? _____

- B. AMERICAN BOARD CERTIFIED? YES NO _____
 IF NO, ARE YOU BOARD ELIGIBLE YES NO _____
 SPECIALTY BOARD DATE CERTIFIED

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS? _____

- C. INDICATE THE AVERAGE WEEKLY NUMBERS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE PLICA COVERAGE. (If you practice in multiple state, please identify the following information for each state.)
 PATIENTS SEEN PER WEEK _____ HOURS PER WEEK _____ WALK-IN PATIENTS PER WEEK _____

Check box appropriate to practice:

- No surgery**-permits incision of boils and superficial abscesses, or suturing of skin or superficial fascia
 - Minor surgery- and/or assisting in major surgery on own patients**-includes minor obstetrical procedures, D & C's vasectomies, or any minor operation done under local anesthesia
 - Major surgery**- includes any operation done under general anesthesia, including tonsillectomies, adenoidectomies, caesarean sections, and assisting in major surgery patients other than your own (major surgery does not include D&C's)
- List the surgical procedures you perform in your office or non-hospital facility:

Are you permanently retired from the practice of clinical medicine? YES NO

D. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- | | | |
|--|---|--|
| <input type="checkbox"/> ABORTIONS | <input type="checkbox"/> LAPAROSCOPIC CHOLECYSTECTOMY | <input type="checkbox"/> BIOPSY (ENDOSCOPIC) |
| <input type="checkbox"/> ACUPUNCTURE | <input type="checkbox"/> LAPAROSCOPY | <input type="checkbox"/> PERITONEOSCOPY |
| <input type="checkbox"/> THERAPEUTIC/LOCAL ANESTHETIC | <input type="checkbox"/> LASER SURGERY | <input type="checkbox"/> LASER THERAPY (ENDOSCOPIC) |
| <input type="checkbox"/> GENERAL ANESTHETIC | <input type="checkbox"/> LIPOSUCTION | <input type="checkbox"/> PACEMAKERS UNDER GENERAL ANESTHESIA |
| <input type="checkbox"/> ANGIOGRAPHY | <input type="checkbox"/> LYMPHANGIOGRAPHY | <input type="checkbox"/> SILICONE INJECTIONS |
| <input type="checkbox"/> ANGIOPLASTY | <input type="checkbox"/> LITHOTRIPSY | <input type="checkbox"/> SKIN FLAP/GRAFTS |
| <input type="checkbox"/> ARTHROSCOPY | <input type="checkbox"/> MAJOR GYNECOLOGICAL SURGERY | <input type="checkbox"/> COSMETIC _____ %OF PRACTICE |
| <input type="checkbox"/> ARTERIOGRAPHY | <input type="checkbox"/> MYELOGRAPHY | <input type="checkbox"/> RECONSTRUCTION _____ %OF PRACTICE |
| <input type="checkbox"/> ASSISTING IN MAJOR SURGERY | <input type="checkbox"/> NEEDLE BIOPSY | <input type="checkbox"/> SWAN-GANZ CATHETERIZATION |
| <input type="checkbox"/> OWN PATIENTS ONLY | <input type="checkbox"/> NERVE BLOCKS | <input type="checkbox"/> TUBAL LIGATIONS |
| <input type="checkbox"/> OWN & OTHER THAN OWN PATIENTS | <input type="checkbox"/> LUMBAR EPIDURAL STEROID | <input type="checkbox"/> VASECTOMIES |
| <input type="checkbox"/> BLEPHAROPIGMENTATION | <input type="checkbox"/> PARASPINAL | <input type="checkbox"/> ON OWN PATIENTS |
| <input type="checkbox"/> BLEPHAROPLASTY-BROW LIFTS | <input type="checkbox"/> SCIATIC | <input type="checkbox"/> ON OTHER THAN OWN PATIENTS |
| <input type="checkbox"/> COSMETIC _____ % OF PRACTICE | <input type="checkbox"/> FACET | <input type="checkbox"/> WEIGHT CONTROL THERAPY/SURGERY _____ %OF PRACTICE |
| <input type="checkbox"/> RECONSTRUCTION _____ % OF PRACTICE | <input type="checkbox"/> PARAVERTEBRAL | <input type="checkbox"/> MEDICATION-WEIGHT CONTROL |
| <input type="checkbox"/> BREAST IMPLANTS | <input type="checkbox"/> PERIPHERAL | <input type="checkbox"/> GASTRIC BUBBLE |
| <input type="checkbox"/> COSMETIC _____ %OF PRACTICE | <input type="checkbox"/> MYOFASCIAL | <input type="checkbox"/> GASTRIC STAPLING |
| <input type="checkbox"/> RECONSTRUCTION _____ %OF PRACTICE | <input type="checkbox"/> OCCIPITAL | <input type="checkbox"/> OTHER WEIGHT CONTROL PROCEDURES |
| <input type="checkbox"/> BRONCHOSCOPY | <input type="checkbox"/> TRIGGERPOINT INJECTION | <input type="checkbox"/> PRENATAL PRACTICE |
| <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> PHLEBOGRAPHY | <input type="checkbox"/> SEE PATIENTS DURING THE FIRST & SECOND TRIMESTER |
| <input type="checkbox"/> CRYOSURGERY (OTHER THAN EXTERNAL LESIONS) | <input type="checkbox"/> PNUOMOENCEPHALOGRAPHY | <input type="checkbox"/> SEE PATIENTS TO TERM BUT DO NOT PERFORM DELIVERY |
| <input type="checkbox"/> ERCP | <input type="checkbox"/> RADIAL/LASER KERATOTOMY | <input type="checkbox"/> SEE PATIENTS TO TERM AND PERFORM DELIVERY |
| <input type="checkbox"/> PHENOL FACIAL PEEL | <input type="checkbox"/> RADIATION/X-RAY THERAPY | <input type="checkbox"/> NORMAL OBSTETRICAL DELIVERIES |
| <input type="checkbox"/> DIAGNOSTIC EMBOLIZATION | <input type="checkbox"/> RADIOPAQUE DYE | <input type="checkbox"/> HOW MANY PER YEAR? _____ |
| <input type="checkbox"/> GENERAL/SPINAL/CAUDAL ANESTHESIA | <input type="checkbox"/> NON-TOXIC ONLY | <input type="checkbox"/> CESAREAN SECTION |
| <input type="checkbox"/> PULSE OXIMETRY | <input type="checkbox"/> SHOCK THERAPY | <input type="checkbox"/> HOW MANY PER YEAR? _____ |
| <input type="checkbox"/> END TIDAL CO ² ANALYZER | <input type="checkbox"/> SIGMOIDOSCOPY | <input type="checkbox"/> OTHER MEDICAL TECHNIQUES |
| <input type="checkbox"/> HAIR TRANSPLANTS | <input type="checkbox"/> LESS THAN 60 CM | LIST PROCEDURES _____ |
| <input type="checkbox"/> SCALP EXCISION/TRANSPLANTATIONS | <input type="checkbox"/> GREATER THAN 60 CM | _____ |
| <input type="checkbox"/> PLUG TECHNIQUE/MINIGRAPH | <input type="checkbox"/> COLONOSCOPY | _____ |
| | <input type="checkbox"/> POLYPECTOMY | |
| | <input type="checkbox"/> GASTROINTESTINAL ENDOSCOPY | |

E. INDICATE THE PERCENTAGE OF YOUR SURGICAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

_____ % PLASTIC (RECONSTRUCTION ONLY)	_____ % THORACIC	_____ % ORTHOPEDIC (INCLUDING BACK)
_____ % PLASTIC (COSMETIC ENHANCEMENT ONLY)	_____ % CARDIAC	_____ % ORTHOPEDIC (NOT INCLUDING BACK)
_____ % TRAUMATIC	_____ % OBSTETRIC	_____ % OTHER (DESCRIBE) _____

F. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures? YES NO
If yes, list procedures and date discontinued _____
2. Have you performed weight control surgery or prescribed weight control medication? YES NO
3. If Yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs
 <1% 1%-10% 11%-50% >50%
4. If Yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?
 <1% 1%-10% 11%-50% >50%
5. Do you have ownership interests in a weight control clinic? YES NO
6. If Yes, what is the name of the weight control clinic with which you are affiliated: _____

J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP THE PROFESSIONAL LIABILITY INSURANCE COMPANY OF AMERICA BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE _____

V. ADDITIONAL PROFESSIONAL INFORMATION

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:

- 1. Do you perform surgery on professional athletes? YES NO
If Yes, what percentage of your professional athletes? _____ %
- 2. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? YES NO
If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company. (if you are covered by other insurance for this activity, please complete Section IV I)
- 3. Do you treat or review treatment of Federal prison inmates? YES NO
- 4. Do you treat non-federal prison inmates? YES NO
If Yes, what percentage of your practice is devoted to treating non-federal inmates? _____ %
- 5. Do you use a collection agency which has the authority to file collection suits without your knowledge? YES NO
- 6. Do you practice as a Medical Director at a blood bank? YES NO
- 7. Do you devise or review plant/employer safety standards? YES NO
(1) What products are manufactured by the company? _____
(2) Company Name _____ Location _____
- 8. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license, or Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? YES NO
If Yes, please indicate the date(s): _____
- 9. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? YES NO
(e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)
If Yes, state condition, date(s) and identify your treating physician in the space below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type	Duration	Treating Physician (Name & Address)
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- 10. Have you had a State medical license or Federal narcotics license revoked, restricted, limited, denied, suspended, subject to probationary conditions, voluntarily relinquished or otherwise sanctioned? YES NO
- 11. Have you had a complaint filed against you by any State Board of Medicine? YES NO

B. PRACTICE ORGANIZATION:

Please check the boxes that best describes your practice affiliation(s): ("X" applicable boxes under B1 and B2).

B1. Employment status:

- Employee
- Shareholder/Partner
- Independent Contractor
- Solo Unincorporated/Sole Proprietor
- Other: _____

B2. Entity Type:

- Multi-Shareholder Corporation, Partnership, Limited Liability Company
- Solo Incorporated-No employed or contracted physicians
- Hospital
- Government
- Industrial
- Other- Please explain: _____

C. NAME OF YOUR PARTNERSHIP, PROFESSIONAL CORPORATION OR ASSOCIATION:

D. IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED BY ANOTHER MEDICAL PROFESSIONAL LIABILITY COMPANY? YES NO

If Yes, please provide a copy of the Policy Declarations Page.

E. IF THE BUSINESS PURPOSE OF THE ENTITY IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN:

- F. DO YOU DESIRE COVERAGE FOR THIS ENTITY? YES NO
 Indicate below whether you want to share your policy limits with this entity, or desire separate limits for the entity.
 Separate limits only available if entity is not a Solo Corporation.
 separate limits shared limits

VI. LOSS INFORMATION (IMPORTANT ! COMPLETE FULLY)
 COMPLETE AND ATTACH A CLAIM FORM FOR EACH SUCH CLAIM, POTENTIAL CLAIM OR SUIT

- A. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? YES NO
 If "Yes", how many? _____
 If "Yes", have these been reported to your insurer? YES NO
- B. Do you have knowledge of any incident, claim, circumstance, unexpected result, potential claim or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to claim? YES NO
 If "Yes", how many? _____
 If "Yes", have these been reported to your insurer? YES NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

VII. CLAIM/SUIT INFORMATION FORM (Please make copies if additional forms are needed)

If making additional copies, please enter applicants name here:

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

1. Patient/Claimant Information-Name: _____ Age: _____ Gender _____ Male Female
2. Date of treatment and/or surgery, which led to the allegations against you: _____
3. Date claim/incident notice received (MM/YY): _____
4. Date claim reported to prior insurer (MM/YY): _____
5. Name of other doctor(s), hospital(s), or health care provider(s), if any, involved in the claim or suit: _____
6. Disposition or current status of claim or suit: Open CLOSED Date of Closing/Settlement or award (MM/YY): _____
7. Indicate case value established by carrier, if known (in\$): _____
8. Defending Insurance carrier name: _____
9. Claim file number, if known: _____
10. Was this matter closed with your consent? YES NO
 Was a suit filed? YES NO
 Was a payment made? YES NO
 If no, was claim or suit withdrawn? YES NO
 If Yes, indicate total amount of settlement or award (in\$) : _____
 Amount paid on your behalf (in\$) : _____
11. Nature of allegations in the claim or suit:
 Conditions treated: _____
 Treatment provided: _____
 Alleged Negligence: _____
 Alleged injury: _____
12. Please provide a narrative description of the medical facts: (must include, but not limited to the type of treatment and/or surgery; your involvement) _____

VIII. COVERAGE INFORMATION

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS. LIST CURRENT INSURER FIRST. (Use a supplemental sheet if needed).

1. _____ OCCURRENCE / / TO / /
INSURER CLAIMS-MADE

2. _____ OCCURRENCE / / TO / /
INSURER CLAIMS-MADE

3. _____ OCCURRENCE / / TO / /
INSURER CLAIMS-MADE

B. COVERAGE DESIRED

- Claims-made Coverage with Prior Acts Coverage.
(A copy of current declaration page showing current retroactive date must be attached).
- Claims-Made Coverage without Prior Acts Coverage.
- An extended reporting period endorsement (tail coverage) has been purchased (copy of tail is attached).
- An extended reporting period endorsement has not and will not be purchased.
I will not purchase tail coverage (reporting period endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise in the future as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am purchasing from Professional Liability Insurance Company of America will not provide prior acts coverage. Initial Here:

Claims-made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claim-made and occurrence coverage or the additional expense associated with an "extension contract or "tail coverage".

C. REQUESTED COVERAGE EFFECTIVE DATE From: _____ / _____ / _____ 12:01a.m.
This date cannot be earlier than the expiration date of your current policy. MONTH DAY YEAR

Annual policy terms will begin and end on the same month and day. To: _____ / _____ / _____ 12:01a.m.
MONTH DAY YEAR

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS _____ / _____ / _____ 12:01 a.m.
MONTH DAY YEAR

E. IF YOU PRACTICE IN THE FUND STATES OF INDIANA, KANSAS LOUISIANA, NEBRASKA, NEW MEXICO, PENNSYLVANIA OR WISCONSIN, PLEASE INDICATE YOUR CURRENT FUND RETROACTIVE DATE IF DIFFERENT THAN THE RETROACTIVE DATE STATED ABOVE: _____ / _____ / _____ 12:01a.m.
MONTH DAY YEAR

Are you aware of any gaps in your Fund coverage? YES NO
If Yes, please provide the exact date and written explanation:

F. LIMITS DESIRED _____ per claim
_____ annual aggregate

IX. ASSIGNMENT OR RIGHT TO CANCEL COVERAGE

I assign to my employer both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g.termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last known address of record.

This may be revoked by me at any future time by sending written notice to the Professional Liability Insurance Company of America's Home Office, 10 S. Brentwood, St. Louis, MO 63105, Suite # 500.

Initial Here

