

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers. If additional space is required, please use the "Remarks" section at the end of the application.

APPLICATION CHECKLIST

- Current curriculum vitae
- Insurer-produced evidence of *continuous* insurance coverage for the past 5 years (e.g., declarations pages, certificate of insurance, extended reporting endorsements (tails), FTCA letters, etc.)
- Insurer-produced evidence of claims history for the past 5 years (e.g., loss run report)

Please allow one week for Underwriter review. If approved, applications are valid for one year.

SECTION I: APPLICANT INFORMATION

1. Name: _____ 2. DOB: _____
last first middle mo/day/yr

3. Social Security Number: _____ 4. Current Medical License Number: _____
state number

5. Are you licensed to practice in any other state(s)? Yes No

_____ license number
state

_____ license number
state

6. Home address: _____
street city state zip code

Phone number: _____ E-mail address: _____
area code number

7. Male Female

8. Indicate below where you have you practiced medicine in the past 5 years. Include military and public service organizations. If you have not practiced medicine continuously, please explain/document those time periods in the "REMARKS" section.

a. _____
facility name

_____ dates
street address city state

_____ policy #
professional liability insurance carrier

b. _____
facility name

_____ dates
street address city state

_____ policy #
professional liability insurance carrier

9. Medical School: _____
name of school

city state year graduated degree

If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?

Yes No If "Yes," have you passed the FLEX? Yes No

10. Residency: _____
name of school

city state _____ to _____
dates attended

Was residency completed? Yes No

If "No," please explain: _____

11. Board Certification: _____
name of board date certified recertified

12. If you are not Board Certified, have you taken and failed board exams? Yes No

Are you Board eligible? Yes No Date eligibility expires: _____ / _____
month year

If not Board Certified and/or Board eligible, please explain in the "REMARKS" section.

13. Principal medical specialty: _____

14. If you hold any hospital privileges, please complete the following:

Hospital: _____ Category of privilege: _____
(active, consulting, courtesy, etc.)

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(active, consulting, courtesy, etc.)

SECTION II: REQUESTED COVERAGE INFORMATION

15. Name of clinic or physician you will be working for: _____

16. Desired dates of coverage: _____ to _____

If days are not consecutive, please indicate actual coverage dates: _____

17. If you will be practicing in an area outside of your specialty, or performing procedures not considered usual or customary to your specialty, please describe here: _____

SECTION III: PROFESSIONAL BACKGROUND INFORMATION

IF ANY ANSWER TO QUESTIONS 18 THROUGH 35 IS "YES," USE THE "REMARKS" SECTION TO PROVIDE DETAILS. PROVIDING ADEQUATE DETAIL AND DOCUMENTATION WILL ASSIST US IN EXPEDITING OUR UNDERWRITING REVIEW.

18. Has your license to practice medicine or dispense narcotics in any jurisdiction **ever** been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you?

Medical License Yes No

DEA License Yes No

19. Have any complaints **ever** been filed against you with a governmental agency, medical or professional society, or other medical entity? Yes No
20. Have you ever been subject to a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you ever been notified of an intent to pursue such action? Yes No
21. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification of your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society? Yes No
22. Have you **ever** been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
- NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.**
23. Have you **ever** been charged or convicted of a felony? Yes No
24. Have you **ever** been under punitive or disciplinary observation, preceptorship, or sponsorship in a hospital, or has any hospital notified you of its intent to pursue such action? Yes No
25. Have your hospital privileges **ever** been restricted, suspended, revoked, non-renewed, or denied, or has any hospital notified you of its intent to pursue such action? Yes No
26. Has the threat or avoidance of disciplinary action **ever** caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration? Yes No
27. Has any professional liability insurance carrier **ever** declined, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature? Yes No
28. Have you **ever** been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? Yes No
29. Have you **ever** incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, hearing or vision impairment, Hepatitis B or C, HIV)? Yes No
- 30. If "Yes," in the "REMARKS" section, state illness or disability with date(s), and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession.**
31. Has **any** claim or suit for alleged malpractice **ever** been brought against you or your professional corporation? Yes No
- 32. If "Yes," give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.**
33. Have you **ever** been accused of sexual misconduct? Yes No
34. Have you **ever** had contact of a sexual nature with a patient or former patient? Yes No
35. Have you practiced without insurance at **any** time? Yes No

SECTION V - REMARKS

Pg. # Question #

CLAIM INFORMATION

(NOTE: please make copies of this form for additional claims)

No claims. A signature is required regardless of claims history.

1. Name of patient: _____ 2. DOB: _____ 3. Sex: _____

4. Allegation: _____

5. Date of incident: _____ 6. Date reported: _____

7. Insurance carrier: _____

Was a lawsuit filed? Yes No

8. Additional defendants: _____

9. Location of occurrence: _____

10. Disposition of claim: _____

11. Amount of settlement or judgment: _____

If claim is still open, reserve amount: _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

12. Condition and diagnosis at time of incident: _____

13. Date and description of treatment rendered: _____

14. Condition of patient subsequent to treatment: _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Applicant's Signature *

Date

*** Signature line must be signed and dated even if you have no claims to report.**

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree that this shall be the basis of the locum tenens coverage provided to me and that I will notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application, an inquiry and investigation of my professional background, qualification and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultant of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives.

Applicant's Signature

Date

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I understand that signature of this application does not bind the company to complete this insurance.

(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)

Your application will not be reviewed if the following supporting documents are not included.

Please remember to attach these documents with your application:

1. Current Curriculum Vitae
2. Insurer-produced evidence of *continuous* insurance coverage for the past 5 years (e.g., declarations pages, certificate of insurance, extended reporting endorsements (tails), FTCA letters, etc.)
3. Insurer-produced evidence of claims history for the past 5 years (e.g., loss run report)

Please return to:

Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
PO Box 91220
Seattle, WA 98111
(206) 343-7300 (800) 962-1399
F (206) 343-7100

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398
F (509) 456-0821

