Physicians Insurance
A MUTUAL COMPANY

PHYSICIANS & SURGEONS

APPLICATION
FOR PROFESSIONAL LIABILITY INSURANCE

Claims - Made

PO Box 91220 | Seattle, WA 98111 | **T** (206) 343-7300 (800) 962-1399 | **F** (206) 343-7100 | www.phyins.com

IMPORTANT INFORMATION — READ THIS FIRST

1. **GENERAL INSTRUCTIONS:** It is essential that all statements be completed and all questions answered that apply to you or your specialty. If the answer to any question is "No," be certain to check "No" on the application. DO NOT LEAVE ANY QUESTION UNANSWERED. IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE THE "REMARKS" SECTION AT THE END OF THE APPLICATION. Please print or type your answers.

2. **PRIOR ACTS COVERAGE:** If you currently have a Claims-Made policy and want Prior Acts Coverage, the retroactive date is the date you first became insured under a Claims-Made policy. To apply for this coverage, please complete Section IV, Prior Acts, of the application.

   Physicians Insurance Prior Acts Coverage does not cover claims, suits, incidents or potential claims of which you are, or have reason to be, aware. These matters must be reported to your current carrier. You should always request confirmation in writing from that carrier that it will cover claims arising out of these reports.

   It is important that you realize that the coverage afforded under Prior Acts Coverage with Physicians Insurance, if granted, might differ from the coverage afforded by your current carrier. Any claims reported under a Physicians Insurance policy will be subject to the policy terms in effect at the time the claim is reported.

3. **APPLICATION CHECKLIST:** See below

4. **CONFIRMATION OF PROFESSIONAL LIABILITY COVERAGE TO HOSPITALS AND OTHER CREDENTIALING ORGANIZATIONS:** Under question #22 (page 4), you may request that we automatically send a Confirmation of Coverage Statement to the hospitals you list.

APPLICATION CHECKLIST:

Before submitting the application, please review this checklist to ensure all information listed below is attached.

Missing information may result in the return of your application.

Sign and date these pages on the application:
- Page 19 (even with no claim history)
- Page 20

Include a current Curriculum Vitae (CV).

For the past five years, please include:
- Insurer produced evidence of continous coverage (e.g. declarations page, confirmation of coverage, tail)
- Evidence of Extended Reporting (Tail) Coverage if not applying for prior acts (not applicable for new graduates just completing residency programs).
- An insurer-produced summary of your prior claims experience (loss run or loss history) for the past five years. We must have a claims experience from every one of your previous insurers. Residents or Fellows must provide a letter from their program regarding claims experience.

Complete the appropriate portion of **SECTION VI - Specialty Questions** of the application relating to your specialty.

Please list the next two credentialing dates for hospital privileges: Date: _____

Date: _____

Please submit this information if you are applying for coverage out of your residency and fellowship program:

Hospital: _____ Contact Person: _____

Phone: _____ Fax: _____

Hospital: _____ Contact Person: _____

Phone: _____ Fax: _____

Please complete the information, sign, and send it to us. Send by fax to (206) 343-7100, by e-mail to sam@phyins.com, or by mail to Physicians Insurance, PO Box 91220, Seattle, WA 98111. Please note that we require a signature for processing.

Once Physicians Insurance has the completed application and all requested information, allow 10 working days for processing. Underwriting may have additional questions after reviewing the application materials.

SECTION 1- APPLICANT INFORMATION - For which you are requesting Physicians Insurance to provide coverage

Broker name (if applicable): _____

Desired effective date: _ _ / _ _ / _ _ _ _ (MM/DD/YYYY) **Desired retroactive date** (if applicable): _ _ / _ _ / _ _ _ _

Desired Limits of Liability: ☐ $1,000,000/5,000,000 ☐ $2,000,000/6,000,000 ☐ $3,000,000/7,000,000 ☐ $4,000,000/8,000,000 ☐ $5,000,000/9,000,000

Your practice is: ☐ Full-time Part-time: ☐ 12 hours or less ☐ 13 - 22 hours ☐ 23 - 32 hours

(Include hospital rounds, charting, patient visits/consults, phone contact, and on-call hours involving patient contact.)

1. Name: (Last, First, Middle)	**2. Date of Birth:**	**3. Gender:**
_____ ☐ MD ☐ DO	_ _ / _ _ / _ _ _ _	☐ M ☐ F

Do you practice, or have you practiced, under any other name? ☐ Yes ☐ No If yes, please list:

Name: (Last, First, Middle)

_____ ☐ MD ☐ DO

4. Principal medical specialty or subspecialty in which you practice:	~~**5. Social Security number:**~~
_____	~~_ _ _ / _ _ / _ _ _ _~~
6. State in which your primary practice is/will be located:	License number:
_____	_____
7. Are you licensed to practice in any other state(s)? ☐ Yes ☐ No a. State License number	b. State License number
_____ _____	_____ _____

8. Desired policy mailing address: Street address	City	State	Zip
_____	_____	_____	_____

9. Preferred billing method

a. If you are a solo physician or member of a corporate/partnership policy and **will be responsible for payment of your premium**, please select one of the following payment options:

☐ Monthly (with a service charge assessed) ☐ Quarterly ☐ Semi-Annually ☐ Annually

b. **Desired billing address** if other than mailing address listed above:

Street address City State Zip

_____

10. Home address:

Street address | City | State | Zip

Area code | Telephone | Fax | E-mail address

( ) | ( )

11. Office practice location(s): *For which you are applying for coverage*
Clinic name:

a. Street address | City | State | Zip

Area code | Telephone | Fax | E-mail address

( ) | ( )

Average weekly practice time at this location: _____ hours per week

Do you perform surgical procedures at this location? ☐ Yes ☐ No

If "Yes," list all procedures in the "REMARKS" section.

b. Street address | City | State | Zip

Area code | Telephone | Fax | E-mail address

( ) | ( )

Average weekly practice time at this location: _____ hours per week

Do you perform surgical procedures at this location? ☐ Yes ☐ No

If "Yes," list all procedures in the "REMARKS" section.

NOTE: If you have more than two office practice locations, please use the "REMARKS" section.

12. Where have you practiced medicine in the past 5 years? Include military and any public service organizations.

If you have not practiced medicine continuously, or if you have more than two prior practices, **please explain/ document in the "REMARKS" section**. A CV or other application is not an acceptable substitute.

a. Facility name

Street address | City | State | Zip | Dates

Professional liability insurance carrier Policy number ☐ Claims-made ☐ Occurrence

b. Facility name

Street address City State Zip Dates

Professional liability insurance carrier Policy number ☐ Claims-made ☐ Occurrence

13. Have you practiced without insurance at any time? ☐ Yes ☐ No ***If "Yes," please explain:***

14. Are you a member of the Washington State Medical Association? ☐ Yes ☐ No If membership is pending, check here: ☐
Are you a member of any other professional societies or associations? ☐ Yes ☐ No ***If "Yes," please list:***

15. Medical school:

Name of school City State/Country Yr graduated Degree

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates?
☐ Yes ☐ No Have you passed the USMLE (United States Medical Licensing Examination) Steps I and II? ☐ Yes ☐ No
Have you passed CSA (Clinical Skills Assessment)? ☐ Yes ☐ No ***If "No," please explain:***

16. Residency:

Name of hospital Street City State/Country Zip

Type of residency: _____ Dates attended: _____ to _____

Was residency completed? ☐ Yes ☐ No ***If "No," please explain:***

17. Additional training: ☐ **Internship** ☐ **Fellowship** ☐ **Second residency** ***(Please check appropriate box)***

Name of facility (hospital):

Street address | City | State | Zip

Type of specialty _____ Dates attended: _____ to _____

Was training completed? ☐ Yes ☐ No ***If "No," please explain:***

18. Board certification:

Name of board | Date certified | Recertified

19. If you are not board certified, have you taken and failed board exams? ☐ Yes ☐ No

Are you in the certification process? ☐ Yes ☐ No If "Yes," when will this be completed?

If not board certified and/or board eligible, please explain in the "REMARKS" section.

SECTION II - CURRENT PRACTICE AND RATING INFORMATION – For which you are requesting Physicians Insurance to provide coverage

20. Principal medical specialty or subspecialty in which you practice and for which you are seeking professional liability insurance:

_____ principal specialty _____% of practice

21. Secondary medical specialty (if applicable):

_____ secondary specialty _____% of practice

22. Hospital privileges:

Primary hospital:

Hospital name:

City:

Dept. of:

Category of privileges:

Dates privileges held:

Secondary hospital:

Hospital name:

City:

Dept. of:

Category of privileges:

Dates privileges held:

Do you staff the E.R. at this hospital other than to maintain hospital privileges?

☐ Yes ☐ No If "Yes,"

Number of hours per week: _____

Do you staff the E.R. at this hospital other than to maintain hospital privileges?

☐ Yes ☐ No If "Yes,"

Number of hours per week:_____

23. Please list any other hospitals at which you hold/held privileges:

Hospital name: _____ Hospital name: _____

City: _____ City: _____

Dept. of: _____ Dept. of: _____

Category of privileges: _____ Category of privileges: _____

Dates privileges held: _____ Dates privileges held: _____

24. If you will not have hospital privileges, please explain why:

_____

25. Your practice is (check all that apply):

☐ Fellowship program coverage at:_____

☐ Individual (solo unincorporated)

☐ Sole shareholder of a medical corporation

Name of corporation:_____

☐ Employee of*: _____

☐ Partner of a partnership*

Name of partnership: _____

☐ Shareholder of a multi-shareholder corporation*

Name of multi-shareholder corporation:_____

*** Provide names of all physicians or attach a copy of letterhead of the organization:**

_____ _____

_____ _____

_____ _____

☐ Independent contractor for:_____

If you are an independent contractor, please complete the following statement:

My association with _____ _____(group/physician name) is that of an independent contractor, and the relationship conforms to the guidelines of the Internal Revenue Service.

Signature _____ Date _____

Group/Physician name _____ Carrier_____

A current Declarations Page or Certificate of Insurance for the above group/physician must be attached.

26. Are you a member of a PHO, IPA, MSO, PHCO, IPO, or similar physician organization? ☐ Yes ☐ No

Name of physician organization:_____

27. If you are a solo practitioner, do you employ other physicians? ☐ Yes ☐ No

If "Yes," have they applied to Physicians Insurance? ☐ Yes ☐ No

List names:

_____ _____

_____ _____

28. If you are a solo practitioner, indicate the extent of your professional relationship with any physician(s) with whom you are associated: (Please check all that apply)

☐ Not applicable
☐ Share office space only
☐ Common billing and/or letterhead
☐ Share professional employees
☐ See each other's patients (other than on-call)
☐ Maintain combined patient records

Names of physicians with whom you are associated:

_____ _____

_____ _____

29. How many of the following paramedical employees do you employ, contract, supervise, or sponsor:
(If you are a member of a partnership/corporation, this does not apply to you unless the paramedical employee is employed by you directly.)

_____ RN/LPN
_____ Nurse Practitioner*
_____ Licensed Surgical Assistant*
_____ Lab/X-ray Technician
_____ CRNA*
_____ Certified Nurse Midwife*
_____ Paramedic
_____ Physician Assistant*
_____ Licensed Midwife*
_____ Alternative Health Care Provider (please describe) _____

If you employ, contract, supervise, or sponsor any of the above, please contact us for an application for each individual.

30. Do you have a practice activity or position for which you do NOT require Physicians Insurance coverage? ☐ Yes ☐ No

If "Yes," please provide details and evidence of insurance: _____

31. Do you hold a Medical Director position? ☐ Yes ☐ No

Name and location of organization:_____

Do you have a financial interest in this organization? ☐ Yes ☐ No

32. Do you perform surgery in any non-hospital owned facilities? ☐ Yes ☐ No

If "Yes," please contact us for a separate Underwriting Information Form for Ambulatory Surgical Facilities, which is also applicable for an office surgical suite or freestanding surgical center.

33. Are you associated (except by medical staff appointment) with the following:

Skilled nursing facility/ Assisted living facility?	☐ Yes	☐ No	_____	hours per week
Jail/Penitentiary	☐ Yes	☐ No	_____	hours per week
Health care foundation, blood bank, or freestanding laboratory?	☐ Yes	☐ No	_____	hours per week
Medical service facility maintained by an industrial firm?	☐ Yes	☐ No	_____	hours per week
State, federal, or local public entity?	☐ Yes	☐ No	_____	hours per week
Urgent care facility?	☐ Yes	☐ No	_____	hours per week
In an administrative capacity for/with PPOs, HMOs, IPAs?	☐ Yes	☐ No	_____	hours per week

If the answer to any of the above is "Yes," please provide the full legal name and location of the facility(ies) and the department in which you serve:

Is insurance coverage provided by the entity or organization for the activities listed above? ☐ Yes ☐ No

Name of insurance company:_____

34. Do you participate in clinical research (including drug studies)? ☐ Yes ☐ No

If "Yes," please include your IRB (Institutional Review Board) statement.

35. Do you have a Web site? ☐ Yes ☐ No www. _____

Do you do online consultations? ☐ Yes ☐ No

How do you advertise? ☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Direct mail

☐ Other _____

SECTION III- EXTENDED REPORTING ENDORSEMENT HISTORY (TAIL)

36. Have you included a copy of your tail endorsement or evidence of occurrence coverage from each prior carrier within the last five years?

☐ Yes ☐ No

If "No," please explain:_____

37. Will you be purchasing a tail from your current carrier?

☐ Yes ☐ No

If "Yes," please provide a copy of the tail endorsement.

SECTION IV- REQUEST FOR PRIOR ACTS (to be completed by all applicants requesting Prior Acts Coverage)

NOTE: Include current copy of the declarations page from your current or previous insurer.

Retroactive date: _ _ / _ _ / _ _ _ _ (MM/DD/YYYY)

38. Have you been continuously covered by an individual Claims-Made policy for your primary practice from the retroactive date stated on page 1 to the requested effective date of your coverage with Physicians Insurance?

☐ Yes ☐ No

If "No," please explain in the "REMARKS" section.

39. Indicate all practice locations during the period for which you are requesting Prior Acts Coverage:

City: State: Dates:

City: State: Dates:

40. During the period for which you are requesting Prior Acts Coverage, did you practice with other physicians:

In an employer-employee relationship? ☐ Yes ☐ No

Locum tenens relationship? ☐ Yes ☐ No

Formal partnership or informal association? ☐ Yes ☐ No

Corporation? ☐ Yes ☐ No

If "Yes," list the full names of all physicians with whom you have been associated during this period:

_____ _____

_____ _____

41. Indicate below the health care providers you employed, contracted, or supervised during the period for which you are requesting Prior Acts Coverage and please describe the nature of your relationship. If none, please indicate.

Physician Assistant ☐ Yes ☐ No Dates _____

Nurse Practitioner ☐ Yes ☐ No Dates _____

Nurse Midwife ☐ Yes ☐ No Dates _____

Nurse Anesthetist ☐ Yes ☐ No Dates _____

Licensed Surgical Assistant ☐ Yes ☐ No Dates _____

42. During the period for which you are requesting Prior Acts Coverage, was your practice different from your practice as described in Section II of this application? For example, did your practice formerly include obstetrical care or emergency medicine services that you are no longer providing?

☐ Yes ☐ No If "Yes," describe below the changes in your practice, including all applicable dates. Attach additional pages as needed.

_____

_____

43. Are you aware of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?

a. Patient or attorney request for records related to an adverse outcome? ☐ Yes ☐ No

b. A letter from an attorney regarding your medical treatment of a patient? ☐ Yes ☐ No

c. Intra-operative or postoperative complications or other complications resulting in death, paralysis, or other significant disabilities? ☐ Yes ☐ No

d. Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ☐ Yes ☐ No

e. A patient who is suing another physician or hospital for the same treatment at issue? ☐ Yes ☐ No

f. Any other circumstance that might reasonably lead to a claim or suit? ☐ Yes ☐ No

Explain any "Yes" answers on the attached Claim Information Supplement.

44. Have you reported to your current insurance company all the above circumstances of which you are aware that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit)?

- ☐ Yes Please attach documentation of all such reports.
- ☐ No ***Please explain in the "REMARKS" section.***
- ☐ None to report

SECTION V - PROFESSIONAL BACKGROUND

NOTE: **If any answer to questions 1 through 13 is "YES," use the "REMARKS" section to provide details. Providing adequate detail and documentation will assist us in expediting our underwriting review.**

1. 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?

☐ Yes ☐ No Medical license
☐ Yes ☐ No DEA license

2. Have any complaints ever been filed against you with a governmental agency, medical or professional society, or other medical entity?

☐ Yes ☐ No

3. Have you ever been subject to disciplinary proceedings or investigations by a governmental agency, medical or professional society, or other medical entity, or have you ever been notified of an intent to pursue such action?

☐ Yes ☐ No

If "Yes," did the proceedings or review result in stipulation to informal disposition, 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

4. Have you ever been convicted for an act committed in violation of any law or ordinance?

☐ Yes ☐ No

NOTE: A conviction record will not automatically disqualify you from obtaining insurance.

5. Have you ever been charged with or convicted of a crime?

☐ Yes ☐ No

6. Have your hospital privileges ever been reviewed or restricted, suspended, revoked, nonrenewed, or denied, or has any hospital notified you of its intent to pursue such action?

☐ Yes ☐ No

7. 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

8. **Has any professional liability insurance carrier ever declined to quote or issue coverage, 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

9. **Have you ever been diagnosed with or been treated for alcoholism or chemical dependency, or are you currently being treated for alcoholism or chemical dependency?**

☐ Yes ☐ No

If yes, please provide proof that you are in compliance with your treatment program.

10. **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

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.

11. **Has any incident alleging malpractice been reported, or has any claim or suit alleging malpractice ever been brought, against you or your professional corporation?**

☐ Yes ☐ No

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.

12. **Have you ever been accused of sexual misconduct?**

☐ Yes ☐ No

13. **Have you ever had contact of a sexual nature with a patient or former patient?**

☐ Yes ☐ No

SECTION VI - SPECIALTY QUESTIONS

Please answer the following questions AND all questions applicable to your specialty.

1. **List any procedures you perform that are NOT considered usual or customary to your specialty or subspecialty.**

_____

2. **If you are NOT a radiologist or pathologist, do you read your own films or specimens?** ☐ Yes ☐ No

   If "yes," do you have them overread by a radiologist or pathologist? ☐ Yes ☐ No

3. **Do you own or work at a medi spa?** ☐ Yes ☐ No

   If "yes," are you (check all that may apply): ☐ Employed? ☐ Contracted? ☐ Medical Director? ☐ Owner?

   Name of medi spa: Location of medi spa:

_____ _____

4. **Are you performing any non-FDA approved procedures?** If yes, please list procedure:

_____

A. ANESTHESIOLOGY

1. **Do you practice in other than a hospital setting (office surgical suite, surgery center, etc.)?** ☐ Yes ☐ No

   a. If "Yes," please provide name and location of facility:

   Name: Location:

   _____ _____

   b. If "Yes," is the suite/center certified by the American Association for Accreditation of Ambulatory Surgery Facilities? ☐ Yes ☐ No

   c. If "No," is it certified by any other state and/or federal organization?

   Please list:

   _____ _____

   _____ _____

2. **Please indicate type of anesthesia used outside of hospital setting:**

   _____

3. **Do you practice in the field of pain management?** ☐ Yes ☐ No

   a. If "Yes," are you board certified in Pain Management by the American Board of Anesthesia? ☐ Yes ☐ No

   Percent of practice _____ %

   b. Please list all procedures you use for pain management, including surgical or other minimally invasive procedures:

   c. What types of narcotics do you prescribe for relief of pain?

   d. Do you use a dictated record for pain patients? ☐ Yes ☐ No

4. **Do you perform acupuncture?** ☐ Yes ☐ No

5. **What portion of your practice consists of the following:**

   Pediatrics _____ % OB _____ % Cardiac _____ %

   Pain Management _____ % Bariatrics _____ % All other _____ %

6. **Please indicate the type of monitoring you utilize during the administration of IV sedation, spinal, caudal, epidural and major nerve blocks:**

   ☐ Continuous EKG display
   ☐ Non-invasive blood pressure monitoring
   ☐ Pulse Oximeter
   ☐ End tidal CO_2 monitor
   ☐ Other: _____

7. **Do you supervise CRNAs?** ☐ Yes ☐ No

Maximum number of CRNAs you will supervise ***at any one time:*** _____

Are the CRNAs you supervise: ☐ Hospital employees? ☐ Your own employees? ☐ Other: _____

8. **If you provide anesthesia care for Obstetrics, are you on call within the hospital or from home?**

☐ Hospital ☐ Home ☐ Not applicable

a. What is the response time requirement for routine C-sections? _____ minutes

b. What is the response time requirement for emergent C-sections? _____ minutes

B. GENERAL, CARDIAC, NEUROLOGICAL, THORACIC, UROLOGICAL & VASCULAR SURGERY

1. **Do you perform organ transplants?** ☐ Yes ☐ No

If yes, what types?

_____ _____

2. **Do you perform bariatric surgery?** ☐ Yes ☐ No

If "Yes," please contact Physicians Insurance for a bariatric questionnaire.

Percent of practice _____ %

3. **Please indicate the percentage of your practice that the following surgeries constitute:**

Bariatric surgery _____%	Cardiac surgery_____ %	Colon surgery _____%
Cosmetic plastic surgery_____%	General surgery_____ %	Neurological surgery _____%
Neuro-otological surgery _____%	Orthopedic surgery _____ %	Reconstructive plastic surgery _____%
Rectal surgery _____%	Thoracic surgery _____ %	Traumatic surgery_____%
Urological surgery _____ %	Vascular surgery _____ %	

4. **Do you subspecialize?** ☐ Yes ☐ No

If "Yes," subspecialty: _____

Percent of practice _____ %

5. **Do you perform any surgery that is not categorized as part of your specialty?** ☐ Yes ☐ No

If "Yes," please list procedures performed: _____

C. GENERAL/FAMILY PRACTICE, DERMATOLOGY, GYNECOLOGY, EMERGENCY MEDICINE & OTHER NONSURGICAL SPECIALTIES

1. **Do you perform induced, non-spontaneous abortions?** ☐ Yes ☐ No

First trimester, through 12 weeks _____ (number/month)

Second trimester, 13-18 weeks _____ (number/month)

Second trimester, 19-27 weeks _____ (number/month)

Third trimester, 28 weeks or over _____ (number/month)

List hospitals, clinics, or other facilities where performed:

_____

2. Do you provide obstetrical care? ☐ Yes ☐ No

☐ Uncomplicated prenatal care, labor, and delivery?

_____ Number of deliveries performed per year

☐ High-risk pregnancies, including but not limited to cesarean section, VBAC, or identifiable prospects of multiple births, preeclampsia, insulin-dependent diabetes, cardiac disease, renal disease, morbid obesity, or other life-threatening conditions?

_____ Number of deliveries performed per year

Are deliveries undertaken in other than a licensed hospital (except in an emergency)? ☐ Yes ☐ No

3. Do you ever administer any spinal, caudal, epidural, or general anesthesia? ☐ Yes ☐ No

4. Do you perform in-office anesthesia? ☐ Yes ☐ No

If "Yes," please indicate level:

☐ Local anesthesia ☐ Analgesia ☐ Conscious sedation ☐ Deep sedation ☐ General anesthesia

5. If you do not perform any of the procedures below, please check here: ☐

Check all that apply	☐ Assisting at surgery more than 50% of your practice
☐ Assisting at surgery on other than own patients (incidental)	☐ Catheterization: heart, left side
☐ Biopsies: breast and cone	☐ Chemical peels: Baker's/Phenol
☐ Capsulotomies performed with the Nd:YAG laser	☐ Dermabrasion
☐ Cardiac catheterization: right side	☐ Endometrial ablation
☐ Closed reduction of displaced fractures	☐ Hair transplants
☐ Dilatation & curettage (D&C)	☐ Herniorrhaphies
☐ Myringotomy	☐ Open reduction of fractures
☐ Percutaneous insertion of Hickman catheter	☐ T&A
☐ Post-partum/mini-lap tubal ligation	☐ Transluminal angioplasty
☐ Umbilical hernia repair (outpatient only)	☐ Tubal ligations (other than post-partum and mini-lap)
☐ Vasectomy	☐ Urgent care _____% of practice ☐ Percent of return patients____%
	☐ Other procedures performed under general, spinal, or caudal anesthesia Please list: _____

☐	Alternative or complementary medicine including acupuncture. Please list procedures: _____
☐	Chelation therapy (for other than heavy metal toxicity)
☐	Shock therapy
☐	Weight reduction drugs Name of medication _____ Percentage of patients_____%
☐	Virtual medicine
☐	Telemedicine

6. **Do you or your staff perform aesthetic or cosmetic procedures, including Botox and fillers?** ☐ Yes ☐ No If "Yes," please list below and include proof of training:

Procedure:	% of practice:	Performed by any other staff:
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

7. **Does your practice include videoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.)?**
☐ Yes ☐ No

8. **Are you a:** ☐ Hospitalist ☐ Intensivist ☐ Not applicable

D. OBSTETRICS & GYNECOLOGY

1. **Do you limit your practice to Gynecology only?** ☐ Yes ☐ No
If "Yes," are you:
a. obligated to cover for a colleague doing OB? ☐ Yes ☐ No
b. required to be available for OB consultations and deliveries as a part of your hospital staff privileges? ☐ Yes ☐ No

2. **Do you provide obstetrical services?** ☐ Yes ☐ No If "Yes," please provide:
_____ Number of vaginal deliveries per year
_____ Number of cesarean sections per year

3. **Do you perform induced, non-spontaneous abortions?** ☐ Yes ☐ No
_____ First trimester, through 12 weeks (number/year)
_____ Second trimester, 13 through 18 weeks (number/year)
_____ Second trimester, 19 through 27 weeks (number/year)
_____ Third trimester, 28 weeks or over (number/year)

4. **Do you perform deliveries or abortions in a nonhospital facility?** ☐ Yes ☐ No If "Yes," please list facility name(s):

_____

5. **Does your practice include infertility patients?** ☐ Yes ☐ No If "Yes," please elaborate on this activity and procedures performed:

_____

6. **Do you follow ACOG guidelines for genetic screening?** ☐ Yes ☐ No If "No," please explain:

_____

7. **Do you co-manage high-risk* prenatal care/deliveries with your own nurse midwives or ARNPs?** ☐ Yes ☐ No

8. **Do you co-manage high-risk* prenatal care/deliveries with any non-employed midwives or ARNPs?** ☐ Yes ☐ No

High-risk pregnancies, see section C question 2, page 13.

E. OPHTHALMOLOGY

1. **Do you perform the following procedures?**

Laser procedures ☐ Yes ☐ No _____(number/month)

Refractive Surgeries* ☐ Yes ☐ No _____ (number/month)

2. **Do you perform CLE (Clear Lens Extraction)?** ☐ Yes ☐ No

If "Yes,"for what purpose?

_____

3. **Do you perform any ophthalmologic plastic surgery procedures?** ☐ Yes ☐ No

If "Yes," please specify type(s) of procedures performed:

_____

If you perform Refractive Surgery as part of your practice, please contact Physicians Insurance for a Refractive Surgery Questionnaire

F. ORTHOPEDIC SURGERY

1. **Do you perform any of the following?**

Laminectomies: ☐ Yes ☐ No Vertebroplasty: ☐ Yes ☐ No Kyphoplasty: ☐ Yes ☐ No

2. **Do you subspecialize within your orthopedic practice?** ☐ Yes ☐ No

Subspecialty:_____ Percent of practice_____%

3. **Do you perform any spinal surgery?** ☐ Yes ☐ No

G. OTORHINOLARYNGOLOGY

1. **Please check the surgical procedures and medical techniques you perform:**

☐ Traumatic/pathologic plastic surgery ☐ Cosmetic plastic surgery ☐ Neuro-otological surgery

☐ Liposuction _____ cc of fat removed

H. PATHOLOGY AND RADIOLOGY

1. **Do you perform telemedicine or professional services for outside facilities, practitioners, or labs?** ☐ Yes ☐ No

   If "No," you may move on to question 9.

2. **If you perform telemedicine or professional services for outside facilities, practitioners, or labs, is there a contractual relationship?**

   ☐ Yes ☐ No ***If "yes," please provide a copy of the contract and proof of their insurance***

3. **Do any of your professional services involve reads that originate outside the state of which your practice is located?**

   ☐ Yes ☐ No

   State _____ License number _____ Percentage of practice: _____%

   State _____ License number _____ Percentage of practice: _____%

   State _____ License number _____ Percentage of practice: _____%

4. **What types of specimens/images are received, and how are they sent?**

   _____

5. **What is the expected turnaround time?**

   _____

6. **Is the original read permanently retained on file in your facility?** ☐ Yes ☐ No

7. **What is the average number of reads processed per day?**

   _____

8. **Are there protocols in place to prevent communication failures involving technology, sending/receipt of specimens or films, communication of results, etc.?** ☐ Yes ☐ No If "Yes," please provide a copy of the protocols.

9. **If you are a *Radiologist*, please check all procedures or medical techniques that you perform or intend to perform:**

   If you do not perform any of the procedures below, please check here: ☐

☐ Abdominal aortic aneurysm stent graft	☐ Left heart catheterization
☐ Aneurysm embolization	☐ Nerve root block: ☐ cervical ☐ thoracic ☐ lumbar
☐ Angiography	☐ Percutaneous gastrostomy
☐ Arteriography	☐ Percutaneous nephrotomy or other drainage procedures
☐ Automated percutaneous discectomy	☐ Pseudoaneurysm thrombosis
☐ Biopsy	☐ Radiation therapy
☐ Brain/spine AVM embolization	☐ Radiofrequency ablation (RFA)
☐ Chemoembolization	☐ Radium implants
☐ Cryotherapy	☐ Right heart catheterization (other than Swan Ganz)
☐ Cyst. lymphatic sclerosis	☐ Sedation
☐ Deep radiation/X-ray therapy	☐ Stenting
☐ Diagnostic embolization	☐ Stroke therapy
☐ Discography	☐ Swan Ganz catheterization
☐ Embolization	☐ Thrombolysis
☐ Fibroid embolization	☐ Tips
☐ Gastric band fills	☐ Transluminal angioplasty
☐ Injection of radiopaque dye	☐ Vertebroplasty
☐ IVC filter	☐ Yttrium-90 Microsphere Radioembolization
☐ Kyphoplasty	

I. PEDIATRICS

1. **Do you provide care in a Level II neonatal intensive care nursery?** ☐ Yes ☐ No

2. **Do you provide care in a Level III neonatal intensive care nursery?** ☐ Yes ☐ No

3. **If your practice includes neonatology, please indicate percentage: _____ %**

4. **Do you perform surgical procedures?** ☐ Yes ☐ No _____ % of practice?
   If "Yes", please list procedures: _____

5. **Do you assist at C-section?** ☐ Yes ☐ No

6. **Do you assist at surgery?** ☐ Yes ☐ No _____ % of practice?
   If "Yes", are those patients your own patients? ☐ Yes ☐ No

7. **Do you practice urgent care?** ☐ Yes ☐ No If "Yes", _____ % of practice? _____ % of return patients?

8. **Are you a:** ☐ Hospitalist ☐ Intensivist ☐ Not applicable

J. PLASTIC SURGERY

1. **Do you perform liposuction?** ☐ Yes ☐ No If "Yes," _____ cc of fat removed

2. **Do you perform any laser treatments or procedures?** ☐ Yes ☐ No ***If "Yes," please list:***

Procedure:	% of practice:	Performed by any other staff:
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

3. **Are any of your staff performing cosmetic procedures?** ☐ Yes ☐ No ***If "Yes," please list:***

Employee:	Procedure Performed:
_____	_____
_____	_____

SECTION VII - REMARKS

Pg. #	Question #	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Claim Information (Please make additional copies if necessary)

No claims: ☐ ***A signature is required regardless of claim history***

1. Name: (Last, First, Middle) _____ **2. Date of Birth:** (MM/DD/YYYY) _____ / _____ / _____ **3. Gender:** ☐ M ☐ F

4. Allegation: _____

_____

_____

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

7. Insurance carrier: _____

Was a lawsuit filed? ☐ Yes ☐ No Are/were you the primary defendant? ☐ Yes ☐ No

If "No," please describe your involvement in patient care: _____

_____

_____

8. Additional defendants: _____

9. Location of occurrence: _____

10. Claim status:

☐ Open ☐ Closed Date closed: _____

If open, indicate reserve amount: $ _____

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment

b. Amount of settlement or judgment: $ _____

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.

11. Condition and diagnosis at time of incident: _____

12. Dates and description of treatment rendered: _____

13. Condition of patient subsequent to treatment: _____

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

_____ _____

Signature Date

(Signature Required)

APPLICANT'S AUTHORIZATION AND RELEASE OF CLAIMS INFORMATION (PLEASE READ CAREFULLY)

I authorize and consent to the release of claims information by Physicians Insurance and its authorized representatives to my employer or to any group of which I am an employee, partner, member, or shareholder. I hereby release Physicians Insurance and its authorized representatives from any liability for the release of said claims information, provided that such release is done in a good faith belief that the receiving party is my employer or a group of which I am an employee, partner, member, or shareholder.

This release shall remain in effect until revoked by me in writing.

APPLICANT'S REPRESENTATION (PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary 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 policy of insurance requested and that I will notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (PLEASE READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications 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 of my attending or treating physicians, the Washington Physicians Health Program, 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 consultants 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.

I understand all health care providers with whom I practice, including physicians and health care extenders, must be insured by Physicians Insurance. Should any health care providers with whom I practice change their insurance coverage from Physicians Insurance to another carrier, while still practicing with me, I understand that my insurance may be canceled. Any exceptions are to be approved by Physicians Insurance.

I agree to notify Physicians Insurance immediately, in writing, if there are any changes from which I have described in this application, including changes in my practice, in my partners or associates, medical license, professional office premises, practice locations, medical procedures or administrative responsibilities and hospital privileges.

I understand that Physicians Insurance does not cover any liability of another person or organization with whom I assume an oral or written contract or agreement.

_____ _____

Signature Date

(Signature Required)

A photocopy of this Authorization shall be considered as effective and valid as the original

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THIS INSURANCE.

For 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.