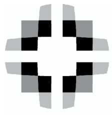

Physicians Insurance
A MUTUAL COMPANY

GENERAL PRACTICE CHANGE APPLICATION

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.

1. Name:______________________________ Policy/Reference No.______________

2. Effective date of change: ______________________ Desired limits of liability ______________________

3. Principal office address:____
   street city, state, zip telephone #

4. Other practice locations:____
   street city, state, zip telephone #

   Home address:____
   street city, state, zip telephone #

5. Your email address is:____

6. Principal medical specialty or subspecialty:______________________________

7. Your practice is: ☐ Full Time ☐ Part Time, total number of hours you work weekly:__________

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

8. Are you an active member of the Washington State Medical Association? Yes ☐ No ☐

9. Are you leaving a group? Yes ☐ No ☐ Last Day of Employment______________________

   If "Yes", name of group:______________________________

   Is this group requiring you to purchase the Extended Reporting Endorsement? Yes ☐ No ☐

10. Are you joining a group? Yes ☐ No ☐ First day of employment:______________________

    If "Yes," name of group?______________________________

    Is this group willing to purchase your prior acts? Yes ☐ No ☐ Should we send your billing statement to the group? Yes ☐ No ☐

11. Your relationship with the group i.e. employee, *independent contractor, partner, shareholder:

    ____

    ____

12. If you are not joining a group, describe your practice, i.e. individual (solo unincorporated), *independent contractor:

    ____

    ____

13. Do you have another position for which PI coverage is not required? Yes ☐ No ☐

    If "Yes," please describe:______________________________

    ____

14. Do you practice (other than strictly call-sharing arrangement) with any physicians who are not insured by Physicians Insurance?

    Yes ☐ No ☐

    If "Yes," please indicate name(s) of physician(s):______________________________

    ____

***Remark: Please submit a copy of your written contract**

15. How many of the following support personnel are employed or contracted by you at your new location? (If you are a member of a partnership or corporation, this does not apply):

______ RN/LPN
______ Medical Assistant
______ Lab/X-Ray Technician
______ Bookkeeper/Receptionist
______ Licensed Surgical Assistant
______ Nurse Practitioner
______ CRNA
______ Licensed Physician Assistant
______ Certified Nurse Midwife
______ Other (please describe)

____

16. Please list all hospitals where you currently hold and/or are applying for privileges at:

Hospital	Status	Send Confirmation of Coverage (Y or N)

17. Will there be any material changes in your practice that may affect your rating (e.g.: assisting at surgery on other than your own patients, performing minor surgery, major surgery, abortions, obstetrics, practice hours, etc.)? If so, please describe below and attach any additional training or continuing education materials if necessary:

____

____

18. Will you be performing the following (Please check medical techniques you perform):

- ☐ Acupuncture
- ☐ *Alternative or complementary medicine
- ☐ Angiography
- ☐ Appendectomies
- ☐ Assisting surgeries other than own patients ________% of practice.
- ☐ *Bariatric ________% of practice
- ☐ Body Imaging (non medical referral) ________% of practice
- ☐ Botox Injections (for cosmetics)
- ☐ Chemical peel (Baker or Phenol)
- ☐ Chemotherapy
- ☐ Cosmetic Procedures. (Please describe in **Remarks** section any other ophthalmologic plastic surgery procedures)
- ☐ Deep radiation / X-ray therapy (over 120 k.v.)
- ☐ Diagnostic Embolization
- ☐ Dilation and Curettage
- ☐ Endoscopy
- ☐ Epidural Injection
- ☐ Hair Transplants
- ☐ Hemorrhoidectomies
- ☐ Herniorrhaphies. Percentage of return patients ______________%
- ☐ Hysterectomies
- ☐ Hospitalist
- ☐ Laparoscopy
- ☐ Laser Procedures __________ # / month. Name of medication ____Percentage of patients ________%
- ☐ LASIK _____________ # / month
- ☐ Left Heart Catheterization
- ☐ Level III Neonatal intensive care nursery _________ % of practice
- ☐ Liposuction ______________ cc of fat removed
- ☐ Neuro-otological surgery
- ☐ MOHS technique
- ☐ Open reduction of fractures
- ☐ Other visualization of internal organs
  Please describe: ____
- ☐ *Pain Management __________% of practice
- ☐ Please describe: ____
- ☐ Plastic Surgery Procedures, please describe: ___________________
- ☐ Psychosomatic Medicine ____________% of practice
- ☐ Refractive Surgeries ___________number/month
- ☐ Right Heart Catheterization (other than Swan-Ganz)
- ☐ Scalp Reduction
- ☐ Shock Therapy
- ☐ Transluminal Angioplasty
- ☐ T&A
- ☐ Tubal Ligation
- ☐ Urgent Care ______________ (% of practice)
- ☐ Vasectomies
- ☐ Virtual Medicine
- ☐ Weight-reduction Drugs
- ☐ *Telemedicine
- ☐ *Teleradiology
- ☐ Other Procedures: ____
- ☐ Intensivist ____

If you do not perform any of the above, please check here ☐

Remarks: Further documentation or supplementary questionnaire maybe required for procedures with "*".

Note: If you answer "Yes" to any of the following questions, please describe on page 4 in the "Remarks" section.

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?

   Medical License Yes ☐ No ☐
   DEA License Yes ☐ No ☐

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 a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you **ever** been notified of intent to pursue such action? Yes ☐ No ☐

4. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification or 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 ☐

5. 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.

6. Have you **ever** been charged or convicted of a felony? Yes ☐ No ☐

7. 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 ☐

8. 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 ☐

9. 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 ☐

10. 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 ☐

11. Have you **ever** been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? Yes ☐ No ☐

12. 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.

13. Has **any** claim or suit for alleged malpractice **ever** been brought against you or your professional corporation that has not already been reported to Physicians Insurance? 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.

14. Have you **ever** been accused of sexual misconduct? Yes ☐ No ☐

15. Have you **ever** had contact of a sexual nature with a patient or former patient? Yes ☐ No ☐

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.***

POLICYHOLDER'S AUTHORIZATION AND RELEASE

(Please read carefully)

I acknowledge that as a condition of updating my application with Physicians Insurance, 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 authorize Physicians Insurance to conduct any such inquiry and investigation and 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, the Washington Physicians Health Program, any prior professional liability insurance carriers, prior employers or professional associates, and Physicians Insurance or its duly authorized representatives. I further release Physicians Insurance and any party responding to an inquiry by Physicians Insurance 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.

____
Policyholder'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.

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