Physicians Insurance
A MUTUAL COMPANY

APPLICATION FOR MOONLIGHTING RESIDENTS & FELLOWS

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.

APPLICATION CHECKLIST

Copy of license
Current curriculum vitae

Name: _____ DOB: _____
last first middle mo/day/yr

Address: _____
street city state zip code

Phone number: _____
area code number

Request effective date of 12:01 a.m. on _____ Limits: $1,000,000 each incident/$5,000,000 annual aggregate.
mo/day/yr **If joining a Group, your limits will be set to that of the Group.**

1. Your residency/fellowship training is in what medical specialty? _____
2. In which states do you hold a license to practice medicine? _____
   State License Numbers: _____
3. Are you a U.S. citizen? Yes ☐ No ☐ No Social Security No.: _____
   If graduated from a foreign medical school, are you ECFMG-certified? Yes ☐ No ☐
4. Medical school attended: _____
   Name
   _____
   City, State, Country Year Graduated Degree
   Internship: _____
   Name of Hospital City, State, Country From To
   Residency: _____
   Name of Hospital City, State, Country From To
   _____
   Name of Hospital City, State, Country From To
   Fellowship: _____
   Name of Hospital City, State, Country From To
5. When do you complete your formal training? _____
6. List current hospital staff appointments or privileges you will have while moonlighting:
   Name: _____ City: _____
   Name: _____ City: _____

7. Based upon the following, check the appropriate box indicating the extent of surgery/procedures you will be performing while moonlighting:

   a) No surgery .....
   b) No surgery except incision of boils, cysts, other superficial abscesses, or suturing of minor lacerations .....
   c) Pregnancy terminations or D&Cs.....
   d) Obstetrics – please describe.....
   e) Assisting in surgery.....
   f) Major surgery – includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen or pelvis. It also includes removal of tumors, open bone fractures, amputations, plastic surgery, and most other procedures done under general, spinal, or caudal anesthesia .....

8. What other procedures or minor surgery will you perform while this moonlighting policy is in force? _____

   _____

   _____

9. Where will you be moonlighting? Please describe the nature of each practice location (e.g., laboratory, private physician's office, urgent care, industrial clinic, emergency room).

   a) Name (employed or contracted by): _____ Name (employed or contracted by): _____

      Address: _____ Address: _____

      _____

      How many hours per week? _____ How many hours per week? _____

      Type of facility: _____ Type of facility: _____

10. Please answer the following questions and fully explain any "Yes" answers on a separate sheet of paper and attach:

    a) Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, or voluntarily surrendered or subject to probationary terms (in any jurisdiction)? Medical License Yes ☐ No ☐ DEA License Yes ☐ No ☐

    b) Has your membership in any medical society or professional organization ever been denied, suspended, revoked, or voluntarily surrendered (other than for relocation of your practice)?.....Yes ☐ No ☐

    c) Have you ever been subject to governmental agency, medical society, or professional society disciplinary proceedings resulting in reprimand, censure, sanction, or modification of practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by any such agency or society?.....Yes ☐ No ☐

    d) Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? (NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.).....Yes ☐ No ☐

    e) Has any application for hospital staff privileges ever been denied or restricted? .....Yes ☐ No ☐

    f) Have your hospital privileges ever been modified (voluntarily or involuntarily), revoked or non-renewed, or have you been subject to probation or disciplinary action? .....Yes ☐ No ☐

    g) Has your professional liability insurance ever been declined, cancelled, refused renewal, or issued on special terms (e.g., premium surcharge, deductible)? .....Yes ☐ No ☐

    h) Have you ever had or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., alcoholism, convulsive disorders, mental illness, multiple sclerosis, narcotics addiction, rheumatoid arthritis, HIV, etc.)? If "Yes," on a separate sheet of paper, 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. .....Yes ☐ No ☐

    i) Has any claim or suit for alleged malpractice ever been brought against you or your professional corporation? If "Yes," give full details on a separate sheet of paper.....Yes ☐ No ☐

APPLICANT'S REPRESENTATION (READ CAREFULLY)

It is hereby understood that if this application results in a policy being issued, coverage under this policy will be limited to direct patient treatment provided within the scope of your employment by the employers listed in item 9. The applicant agrees to notify Physicians Insurance, in writing, of changes in his/her answer to question 9 and await approval of coverage for said change from Physicians Insurance prior to beginning employment with the new employer as a condition precedent to coverage under the policy.

I hereby represent that the information continued 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 (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 attending or treating physicians, the Washington Monitored Treatment 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.

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.