Application for Professional Liability Insurance

Surgeons, Physicians, and Podiatrists

APPLICATION CHECKLIST

- ☐ Completed application
- ☐ A copy of your current curriculum vitae (CV)
- ☐ Copy of medical license
- ☐ A copy of the Declarations page or a Certificate of Insurance. If an extended reporting endorsement (tail) has been purchased, please provide a copy as well.
- ☐ Loss runs for the past 10 years, or since the date you began practicing medicine if you began within the last 10 years.

SECTION I: General Information

CONTACT INFORMATION

First Name | Middle Name | Last Name | Suffix | Title

_____/_____/_____ Date of birth (mm/dd/yyyy)

_____-_____-_____ SSN

☐ M ☐ F

DEA License #

FEIN License #

Office Representative | Title | Email

Practice website

(_____)_____-_____ Primary office phone

(_____)_____-_____ Mobile phone

(_____)_____-_____ Fax

Primary office address | City | State

Home address | City | State

Please check box to indicate your preferred mailing address.

MEDICAL LICENSURE

State	License #	Expiration Date	% of Practice	Status of License
				☐ Active ☐ Inactive ☐ Pending
				☐ Active ☐ Inactive ☐ Pending

Please indicate any additional licenses on page 8 Remarks Page

SECTION II: Coverage Desired

☐ Claims-made WITHOUT prior acts coverage. Under this option, the retroactive date will be the same as the effective date of coverage. Coverage for claims arising from an act or omission that occurred prior to the effective date of this policy will not be provided.

☐ Claims-made WITH prior acts coverage. Under this option, the retroactive date will be the same as the retroactive date on your current policy.

_____/_____/_____ Requested effective date

_____/_____/_____ Requested retroactive date

Number of hours working with patients per week _____

Number of patients seen per week _____

Do you currently have employment for which DDI will not be covering? ☐ Y ☐ N

If yes, Please indicate the work that needs to be excluded:

_____

_____

SECTION III: Specialty and Practice Information

	Medical Specialty	% of Practice (must total 100%)	Board certified	Board eligible
Primary Specialty			☐ Yes ☐ No	☐ Yes ☐ No
Sub Specialty			☐ Yes ☐ No	☐ Yes ☐ No

Please check the appropriate box, indicating the extent of surgery you perform:

_____% **No surgery** includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery". This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done

_____% **Minor surgery** includes all listed in definition of "No Surgery", as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.

_____% **Major surgery** includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, any other operation, which because of the conditions of the patient or the length or circumstances of the operations presents a district hazard to life, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.

Does your practice include Pain Management? ☐ Y ☐ N If Yes, what percent? _____%

Please review the following list of procedures and check any procedures you have performed in the past thirty-six months or will perform in the next twelve months?

- ☐ Abdominoplasty
- ☐ Abortion
- ☐ Acupuncture/Acupressure
- ☐ Addiction medicine
- ☐ Anesthesia (General/Spinal/Caudal)
- ☐ Angiography/Arteriography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
- ☐ Bariatric Surgery
  - ☐ Gastric bands # per year:
  - ☐ Bypass # per year:
  - ☐ Staples # per year:
  - ☐ Gastric sleeve # per year:
  - ☐ Other # per year:
- ☐ Botox # per year:
- ☐ Bronco-esophagology
- ☐ Bronchoscopy
- ☐ Cardiac catheterization
- ☐ Cataract Surgery
- ☐ Chelation Therapy
- ☐ Cryosurgery (non external lesions)
- ☐ Circumcision (newborns)
- ☐ D & C
- ☐ Dermatology procedures
  - ☐ Chemabrasion/Dermabrasion
  - ☐ Chemical peels Circle: Deep or Superficial
  - ☐ Facial Fillers
  - ☐ Hair Transplants
  - ☐ Liposuction/Lipoinjection
  - ☐ MOHs surgery
  - ☐ Silicone injections
  - ☐ Skin flaps/grafts
- ☐ Electromagnetic Therapy
- ☐ Embolization
- ☐ Endoscopic Procedures
  - ☐ Colonoscopy
  - ☐ Gastrointestinal endoscopy
  - ☐ Sigmoidoscopy only
  - ☐ Other than sigmoidoscopy
  - ☐ Upper GI Endoscopy
- ☐ Fertility/Infertility Treatment
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ General Surgery
- ☐ HVLA Surgery (on minors)
- ☐ Hysterectomy
- ☐ Kyphoplasty
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Lithotripsy
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- ☐ Needle Biopsy Type:
- ☐ Oxidation Therapy
- ☐ Pacemaker Installation
  - ☐ Epicardial
  - ☐ Endocardial
  - ☐ Permanent Pacemakers
- ☐ Pain management
  - ☐ Implants (incl. Intrathecal Pumps)
  - ☐ Medication only
  - ☐ Nerve Block Circle: Spinal, Paraspinal, Paravertebral, Epidural)
  - ☐ Other:
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Radio Frequency Procedures
  - ☐ Spinal Simulators
- ☐ Prenatal/Gynecological
  - ☐ Prenatal 1st trimester only
  - ☐ Prenatal 1st & 2nd Trimester
  - ☐ Prenatal to full term, no deliveries
  - ☐ Prenatal to full term incl. delivery
- ☐ Obstetrics Circle: Performing or Assist
  - ☐ Cesarean, deliveries per year:
  - ☐ Vaginal, deliveries per year:
  - ☐ VBAC's, per year:
- ☐ Orthopedics
  - ☐ Incl. Spine
  - ☐ No Spine
- ☐ Plastic surgery
  - ☐ Reconstructive, % of practice:
  - ☐ Cosmetic, % of practice:
- ☐ Podiatry
  - ☐ Soft tissue
  - ☐ Major surgery
- ☐ Prolotherapy
- ☐ Radiology
  - ☐ Interventional
  - ☐ Radiopaque dye
- ☐ Radiation/X-Ray Therapy
- ☐ Renal Dialysis
- ☐ Sclerotherapy
- ☐ Spinal Surgery
- ☐ Thoracic surgery, % of practice
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Transgender surgery
- ☐ Trauma surgery, % of practice:
- ☐ Tubal Ligations
- ☐ Vascular surgery
- ☐ Vasectomies
- ☐ Wound care
  - ☐ Hyperbaric Medicine
  - ☐ Surgical debridement
- ☐ Other (not listed) Please describe below or on page 8 Remarks Page

List any procedures you have performed in the past thirty six months or will perform in the next twelve months:

_____ _____

_____ _____

_____ _____

_____ _____

Please indicate any additional procedures on page 8 Remarks Page

List the percentage of your practice devoted to each of the following surgical specialties:

_____% Bariatric	_____% Ophthalmology
_____% Cardiac	_____% Orthopedic (c-spine)
_____% Dermatology	_____% Orthopedic (t-spine)
_____% Gastrointestinal	_____% Orthopedic (no spine)
_____% General	_____% Otorhinolaryngology
_____% Gynecology	_____% Plastic (cosmetic)
_____% Hand	_____% Plastic (reconstructive)
_____% Neurosurgery (c-spine)	_____% Thoracic
_____% Neurosurgery (t-spine)	_____% Traumatic
_____% Neurosurgery (Intracranial)	_____% Urology
_____% Neurosurgery	_____% Vascular
_____% Obstetrics	_____% Other: _____

Do you perform or provide any of the following services as a part of your practice:

_____% Telemedicine	_____% Medical Spa Services
_____% Independent medical exams	_____% Weight control medication

**Please provide description of services on page 8 Remarks Page*

PRACTICE INFORMATION

Do you currently practice at any additional locations other than the primary office location listed in Section I? ☐ Y ☐ N

If yes, please describe:

Practice Name	Location (city, state, zip)	Hours (per week)	Specialty (If different than above)	Start date (mm/dd/yyyy)

Have you changed medical specialties in the last five years? ☐ Y ☐ N

If yes, please explain:

_____

_____

Do you currently have hospital privileges? ☐ Y ☐ N

Hospital	Location (city, state, zip)	Type of Privileges	Current Restrictions? If yes, please comment*
		☐ Staff ☐ Courtesy ☐ Other	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other	☐ Yes ☐ No
		☐ Staff ☐ Courtesy ☐ Other	☐ Yes ☐ No

**Please provide comments pertaining to restrictions on page 8 Remarks Page*

Do you work as an emergency room physician, other than for maintaining hospital privileges? ☐ Y ☐ N

If yes: Do you have separate coverage for this exposure? ☐ Y ☐ N How many hours per month?_____

Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director, or attending physician at any of the following:

☐ Hospital
☐ Sanitarium
☐ Nursing home
☐ Blood bank
☐ Birthing clinic
☐ Clinic
☐ Laboratory
☐ Other:
☐ Prepaid health plan
☐ HMO
☐ Surgery Center

If yes, do you have separate coverage for this exposure? ☐ Y ☐ N

SECTION IV: Entity/Organization Structure

Please indicate which practice organization applies to you:

☐ Solo Unincorporated	☐ Partner or Partnership	☐ Corporate Shareholder	☐ Government Employee
☐ Solo Corporation	☐ Independent Contractor	☐ Employee	☐ Other:

Name of entity/organization: _____

Are you interested in receiving coverage for this entity/organization? ☐ Y ☐ N

Please indicate if you would like Shared or Separate limits: ☐ Shared ☐ Separate
**If separate limit is selected, additional charge will apply*

MEDICAL STAFF

Do you currently employ, independently contract, or otherwise maintain an association with any other health care providers?

☐ Y ☐ N

If yes, please indicate their name, position, license number, and start date

_____ _____

_____ _____

_____ _____

_____ _____

SECTION V: Previous Medical Malpractice Policies

Carrier	Policy Number	Policy Period	Premium

SECTION VI: Claims Information

Within the past 10 years, has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐ Y ☐ N

If yes, complete the following and a **claim/suit/incident supplemental form** at the end of this application for each claim or suit and provide loss runs for the past 10 years, or since the date you began practicing medicine if you began within the past 10 years.

Total number of claims and suits: _____ # Open/Reserved: _____/_____ # Closed: _____

SECTION VII: Additional Information

If you check yes to any of the following questions, please provide the details on page 8 Remarks Page

1. Has your medical professional liability insurance ever been declined, non-renewed, or cancelled including cancellation for nonpayment of premium? (Not applicable to Missouri applicants) ☐ Y ☐ N
2. Has your medical professional liability insurance ever been surcharged, reduced, or issued with a deductible or other special terms? ☐ Y ☐ N
3. Have you been charged or convicted of any crime other than minor traffic violations? ☐ Y ☐ N
4. Have you ever had your medical license or DEA license revoked, limited, refused, suspended, or denied? ☐ Y ☐ N
5. Have you ever been investigated by a state medical board? ☐ Y ☐ N
6. Have you ever failed to pass a Board Examination? ☐ Y ☐ N
7. Have your hospital privileges ever been surrendered, limited, or revoked voluntarily or involuntarily? ☐ Y ☐ N
8. Have your hospital privileges ever been expanded or reduced in the last 12 months? ☐ Y ☐ N
9. Has membership of any Medical Association or Society ever been refused, revoked, or limited in any way? ☐ Y ☐ N
10. Are you aware of any chronic illness or physical defect that could impair your ability to practice your specialty? ☐ Y ☐ N
11. Have you ever been treated for alcoholism, narcotic addiction, or mental impairment? ☐ Y ☐ N
12. Have you ever been accused of sexual misconduct? ☐ Y ☐ N
13. Have you ever had any contact of a sexual nature with a patient or a former patient? ☐ Y ☐ N
14. Have you treated or will you treat celebrities or professional athletes? ☐ Y ☐ N
15. Have you practiced or will you practice at a prison, correctional facility, or other similar facility, or have you provided or will you provide health care services to prisoners or inmates? ☐ Y ☐ N
16. Do you enter into arbitration or similar agreements with your patients? ☐ Y ☐ N
    If yes, please attach a copy of the agreement(s).
17. Do you participate in clinical trials? ☐ Y ☐ N
18. Do you use any non-FDA approved devices, drugs, or procedures? ☐ Y ☐ N

REMARKS SECTION

Please provide any additional information/explanations for your application below:

SECTION VIII: Representation and Warranty Information

I hereby declare that the above statements and particulars are true and that I have not omitted or misstated any material facts and agree that this form constitutes part of the application which shall be the basis of the contract with Doctors Direct Insurance, Inc. (the "Company"). The complete application consists of this form and any other forms submitted by or on behalf of any other physician(s) or entity(ies) seeking to be insured, and any information, documents and material submitted in connection therewith. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in operations, healthcare or professional services provided. I understand that the Company will rely on the truth and accuracy in my application and supporting materials both in deciding whether to offer insurance coverage as well as the amount to charge for such insurance.

I also certify that I have reported all known incidents which may result in a claim and/or claims to my previous insurance carrier(s) and have no knowledge of any existing professional services or any other acts, errors or omissions that might result in a claim.

I understand that any material misrepresentation or omission made on this form, or elsewhere in the application, may act to render any contract of insurance null and without effect or provide the company with the right to rescind it or to increase the premiums charged for insurance coverage provided. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

It is further understood and agreed that the Company has no obligation to issue a policy or provide coverage unless and until the Company has: received the complete application, offered a premium quotation, and received, as a precondition to coverage, the total premium due, or, if the Company has agreed to provide premium installments options(s), deposit and all installment premiums due have been paid and received by the Company. In addition, it is understood that payment by check will not be considered as received by the Company until it has been honored by the Company's bank.

It is agreed that failure to comply with these terms will result in no coverage for any claim under any insurance for which I am applying.

It is also understood that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding persons and entities to be covered by the policy which is being applied for, which the Company, in good faith, believes to be applicable and pertinent to this application and the contract of insurance which may be issued.

Authorized Representative's Signature

Date Signed (mm/dd/yyyy)

Name and Title of Authorized Signor (Please Print)

This application is not valid without your complete signature

ddi Doctors Direct Insurance
1140 West Lake Street, Suite 500
Oak Park, IL 60301
P: (630)574-9800
F: (866)422-2300
sales@ddiimail.com
www.doctorsdirectinsurance.com

CLAIM | SUIT SUPPLEMENTAL FORM

Attach a detailed narrative, which includes at least the information requested below, or complete this form for each claim our suit within the past 10 years. Provide adequate detail to allow proper evaluation. Additional information may be requested.

_____ ☐ M ☐ F
Patient Name Age

_____/_____/_____ _____
Date of incident (mm/dd/yyyy) Location of Incident

_____ _____/_____/_____
Name of Insurer Date Reported to Insurer (mm/dd/yyyy)

_____
Office Representative Title Email

1. Description of treatment rendered and description of allegations:

_____

2. Were any other physicians or entities names in this suit? ☐ Y ☐ N
If yes please list below:

_____

3. Status/Disposition:
☐ Open Describe current status and defense strategy: _____

☐ Closed without indemnity payment Date closed (mm/dd/yyyy): _____/_____/_____

☐ Settled ☐ Judgment/Verdict for defense

☐ Judgement/verdict for Plaintiff

Amount reserved for you: Indemnity: $ Defense $:

Amount reserved for other defendants: Indemnity: $ Defense $:

Amount paid on your behalf: Indemnity: $ Defense $:

Has there been a change in practice as a result of this claim, suit, or incident? ☐ Y ☐ N

Please explain: _____

_____
Signature Printed name Date (mm/dd/yyyy)