Premium Indication Request for Physicians

Please read carefully before completing:

This is a premium indication request only. It is not an application for medical malpractice insurance coverage and does not, in any way, bind coverage. The information contained in this request will be used to acquire premium indications from one or more insurance carriers as appropriate and will otherwise be held in the strictest confidence.

SIGNATURE
After completing the premium indication request, the applicant's signature is required, along with the date. Please complete the request completely.

CLAIMS INFORMATION
If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, complete a claim information sheet for each claim. Each Claim Information Sheet must be completed, signed and dated.

RETROACTIVE (“NOSE”) COVERAGE
If you wish to obtain nose coverage, a copy of your most recent declarations page from your current carrier indicating the original effective date of coverage and a current paid through date must be attached.

Tegner-Miller Insurance Brokers - CAMM
2001 Wilshire Boulevard Suite 101
Santa Monica, CA 90403
Phone: 800.775.8642
Fax: 310.453.7971
E-mail: insure@tmib.com

SECTION I — GENERAL INFORMATION

1. **PERSONAL INFORMATION**

a. Name ____

b. Residence Address ____

City ______________________ State________________ Zip ________________

c. Phone Number (_______) ______________________ Fax Number (_______) ______________________

d. E-Mail Address ____

e. Taxpayer I.D. / Social Security Number ______________________ Date of Birth ____/____/____

f. Mailing/Billing Address ____

City ______________________ State ________________ Zip ________________

2. **MEMBERSHIP, LICENSES AND AFFILIATION INFORMATION**

a. Medical License Number______________________ State ___________ Expiration Date ____/____/____

b. Drug Enforcement Agency License Number ____

c. I am Board ☐ Eligible ☐ Certified Date Eligibility Expires or Date Certified ____/____/____

d. Names of American Specialty Board(s), including eligibility ______________________________

e. List any Subspecialties ____

SECTION II — COVERAGE INFORMATION

3. **EFFECTIVE DATE**

Desired Effective Date ____

4. **LIMITS OF INSURANCE DESIRED**

Please consult your agent or broker for limits of insurance available under this policy.

Limits Requested: Per Claim $ ___________________ Aggregate Per Policy Period $ ________________

5. **RETROACTIVE ("NOSE") COVERAGE**

Retroactive ("Nose") coverage provides protection for claims first made against you after the effective date of coverage with the new company arising out of your acts or omissions prior to the effective date and after the retroactive date of such coverage. If you do not obtain "Nose" coverage, you will have no coverage from the new company for claims arising out of these acts or omissions.

a. I would like to include retroactive ("Nose") coverage in this premium indication request: ☐ Yes ☐ No

IF YES, YOU MUST ATTACH A COPY OF YOUR MOST RECENT DECLARATIONS PAGE FROM YOUR PRESENT CARRIER INDICATING THE ORIGINAL EFFECTIVE DATE OF COVERAGE AND THE CURRENT PAID THROUGH DATE.

b. Retroactive date requested ____________________

I have been continuously insured with claims made coverage since this date.

6. **PREVIOUS CARRIERS**

a. List the name(s), policy number(s), and policy period(s) for all previous claims made insurance carriers:

	INSURANCE CARRIER(S)	POLICY NUMBER(S)	POLICY PERIOD(S) From	To
i.	____________	____________	____________ Month/Day/Year	____________ Month/Day/Year
ii.	____________	____________	____________ Month/Day/Year	____________ Month/Day/Year
iii.	____________	____________	____________ Month/Day/Year	____________ Month/Day/Year

b. List all your medical specialty classifications while insured with each of the above previous claims made insurance carriers. IF YOU CHANGED MEDICAL SPECIALTIES WHILE INSURED WITH THE SAME CARRIER, LIST EACH MEDICAL SPECIALTY AND THE EFFECTIVE DATE OF EACH CHANGE. THIS IS TO ENABLE THE COMPANY TO CLASSIFY AND RATE YOU PROPERLY FOR YOUR PRIOR ACTS EXPOSURE.

	MEDICAL SPECIALTIES	INSURANCE CARRIER(S)	POLICY PERIOD(S) From	To
i.	____________	____________	____________ Month/Day/Year	____________ Month/Day/Year
ii.	____________	____________	____________ Month/Day/Year	____________ Month/Day/Year
iii.	____________	____________	____________ Month/Day/Year	____________ Month/Day/Year

SECTION III — MEDICAL SPECIALTIES INFORMATION

* a. Is there documented communication between the Hospitalist and

- ☐ Administrative Medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology (Pain Management Only)
- ☐ Anesthesiology
- ☐ Aviation Medicine
- ☐ Cardiovascular Disease
- ☐ Child Psychiatry
- ☐ Colon-Rectal Surgery
- ☐ Critical Care
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Room
- ☐ Family Practice (Office Surgery & Assist Only)
- ☐ Family Practice (Major Surgery - Excluding OB)
- ☐ Family Practice (Major Surgery - Including OB)
- ☐ Forensic Pathology
- ☐ Gastroenterology
- ☐ General Practice (Office Surgery & Assist Only)
- ☐ General Practice (Major Surgery - Excluding OB)
- ☐ General Practice (Major Surgery - Including OB)
- ☐ General Preventative Medicine
- ☐ General Surgery
- ☐ Gynecology Only
- ☐ Hand Surgery Only
- ☐ Hematology/Oncology
- ☐ Hospitalist *
- ☐ Industrial Medicine
- ☐ Internal Medicine
- ☐ Medical Genetics - No Amniocentesis
- ☐ Neonatology
- ☐ Nephrology
- ☐ Neurological Surgery
- ☐ Neurology
- ☐ Nuclear Medicine
- ☐ Nurse Anesthetist [1]
- ☐ Nurse Midwife [2]
- ☐ Obstetrics & Gynecology
- ☐ Occupational Medicine
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Oral/Maxillofacial Surgery
- ☐ Otolaryngology
- ☐ Pathology
- ☐ Pediatric Allergy
- ☐ Pediatric Cardiology
- ☐ Pediatrics (General)
- ☐ Physical Medicine & Rehabilitation
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Proctology
- ☐ Psychiatry
- ☐ Public Health
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Thoracic Surgery (No Cardiovascular)
- ☐ Thoracic Surgery (Including Cardiovascular)
- ☐ Undersea Medicine
- ☐ Urgent Care
- ☐ Urology
- ☐ Other________________________________

*a. Is there documented communication between the Hospitalist and the attending/primary care physician? ☐ Yes ☐ NO

IF NO, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 13.

b. Does the Hospitalist cover ER or do on-call for ER? ☐ Yes ☐ No

IF YES, PROVIDE EXPLANATION IN THE REMARKS SECTION, PAGE 13.

[1] MUST BE A SALARIED EMPLOYEE OF AN ANESTHESIOLOGIST INSURED BY THE COMPANY.
[2] MUST BE A SALARIED EMPLOYEE OF AN OBSTETRICIAN INSURED BY THE COMPANY.

7. Do you perform any of the following procedures or use any of the agents listed below?

PLEASE ANSWER EVERY ITEM AND, IF NECESSARY, PROVIDE EXPLANATIONS IN THE REMARKS SECTION, PAGE 13.

a. Hospital Surgery as Primary Surgeon ☐ Yes ☐ No
b. Assisting in Surgery Only ☐ Yes ☐ No
c. Office Surgery [3] ☐ Yes ☐ No
d. Surgery in Surgicenter [3] ☐ Yes ☐ No
e. Obstetrics ☐ Yes ☐ No
f. Therapeutic Abortions ☐ Yes ☐ No
   Number performed monthly ____________
g. Amniocentesis ☐ Yes ☐ No
h. Cosmetic/Plastic Surgery
   i. Minor [3] ☐ Yes ☐ No
   ii. Major ☐ Yes ☐ No
   iii. Chemical Peels [3] ☐ Yes ☐ No
   iv. Hair Transplants ☐ Yes ☐ No
   v. Radiation Therapy ☐ Yes ☐ No
   vi. Scar Revisions ☐ Yes ☐ No
   vii. Sclerotherapy ☐ Yes ☐ No
   viii. Silicone Injections ☐ Yes ☐ No
   ix. Suction Lipectomy [3 & 4] ☐ Yes ☐ No
i. Fracture Reductions
   i. Open ☐ Yes ☐ No
   ii. Closed ☐ Yes ☐ No
j. Cardiac Catheterization
   i. Right Heart ☐ Yes ☐ No
   ii. Left Heart ☐ Yes ☐ No
k. Anesthesia
   i. General ☐ Yes ☐ No
   ii. Nerve Block ☐ Yes ☐ No
   iii. Spinal/Caudal ☐ Yes ☐ No
   iv. Local ☐ Yes ☐ No
l. Laser Refractive Surgery ☐ Yes ☐ No
m. Blepharopigmentation ☐ Yes ☐ No
n. X-Ray
   i. Diagnostic ☐ Yes ☐ No
   ii. Therapeutic Radiation ☐ Yes ☐ No
   iii. Ultrasound ☐ Yes ☐ No
o. Coronary Angiography ☐ Yes ☐ No
p. Cerebral Angiography ☐ Yes ☐ No
q. Renal Dialysis ☐ Yes ☐ No
r. Electroconvulsive Therapy ☐ Yes ☐ No
s. Endoscopy ☐ Yes ☐ No
t. Sigmoidoscopy ☐ Yes ☐ No
u. Spinal Surgery ☐ Yes ☐ No
v. Weight Control
   i. Surgery [3] ☐ Yes ☐ No
   ii. Drugs - List Below ☐ Yes ☐ No

____

____

____

____

   iii. Percentage of Practice _____ %
w. Laser Procedures [3 & 4] ☐ Yes ☐ No

____

____

x. Other [3] ☐ Yes ☐ No

[3] PLEASE EXPLAIN (USE REMARKS SECTION, PAGE 13, FOR MORE DETAIL).
[4] ATTACH PROOF OF TRAINING.

8. Do you currently perform radial keratotomy? ☐ Yes ☐ No

IF YOU NO LONGER PERFORM RADIAL KERATOTOMY, WHEN DID YOU LAST PERFORM THIS PROCEDURE? ____/____/____

9. Do you research, use, administer, or prescribe any drug, pharmaceutical or medical device disapproved or not yet approved for marketing by the United States Food and Drug Administration for treatment of human beings (including any FDA approved studies/investigations)? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 13.

10. Do you provide any direct patient treatment during child delivery (including the immediate labor, puerperium, and/or neonatal period) at a facility other than a licensed acute care hospital? ☐ Yes ☐ No

NOTE: COVERAGE IS EXCLUDED UNDER THE POLICY UNLESS SPECIFICALLY ENDORSED.

11. Do you render emergency room care OTHER THAN TO YOUR OWN PATIENTS? ☐ Yes ☐ No

IF YES, ANSWER THE FOLLOWING:

a. Approximate number of hours per week ____________
b. A requirement for staff privileges ☐ Yes ☐ No
c. On a fee basis ☐ Yes ☐ No

d. On a salary basis ☐ Yes ☐ No

e. As a member of an independent emergency room unit ☐ Yes ☐ No

f. Name of Unit ____

g. Do you have professional liability insurance for your Emergency Room Practice? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 13.

12. Are you a County Medical Association, Society or Osteopathic Society Member? ☐ Yes ☐ No

IF YES, PLEASE NAME THE ORGANIZATION(S) ____

____

GENERAL ANESTHESIA INFORMATION (ORAL/MAXILLOFACIAL SURGEONS ONLY)

13. Do you use or have:

a. Oral/Maxillofacial Anesthesia Permit No.________________ State__________ Expiration Date ___/___/___

b. Continual blood pressure monitoring either by use of an intra-arterial and electronic monitor or standard blood pressure cuff with checks at appropriate intervals ☐ Yes ☐ No

c. Continuous electrocardiographic display ☐ Yes ☐ No

d. Continuous peripheral blood flow monitoring (Pulse Monitor) ☐ Yes ☐ No

e. Precordial, esophageal, or retracheal stethoscope ☐ Yes ☐ No

f. Pulse Oximeter ☐ Yes ☐ No

g. End-Tidal CO_2 or Capnometer ☐ Yes ☐ No

h. Any other devices (explain) ____

NOTE: COVERAGE IS DEPENDANT UPON EMPLOYMENT OF EITHER DEVICE b. OR c. AND TWO OF DEVICES d. THROUGH g.

SECTION IV — PRACTICE LOCATION INFORMATION

INSTRUCTIONS FOR SECTION IV - PRACTICE LOCATION INFORMATION

This section is devoted to showing where you practice and the relationships you have in your practice with others (if any). We have loosely termed the others with whom you practice "organizations", but it could refer to individuals as well (see further examples in the "Explanation of Question a.)" below).

Where requested, please also provide information regarding the Professional Liability Insurance that pertains to both you and those "organizations" with whom you practice. Note that not all of these questions will apply to all relationships.

On the next three pages (7, 8 and 9) of this Section, Questions 14., 15. and 16. ask about three (3) practice locations separately. If you practice at more than three (3) locations, please provide the same information in the Remarks Section Page 13.

If you practice at a location for which insurance coverage will be provided elsewhere, please provide information for that practice, but clearly indicate that coverage is not desired at that location.

Explanation of Question a.): List the name of the "organization" for which you practice:

- Your name
- Your DBA (if any)
- Another Physician's DBA
- Group
- Partnership
- Corporation
- Clinic
- Public or Private Entity
- HMO
- County/University
- Federal Government
- State Government

Explanation of Question f.): Not applicable to those physicians in solo practice. Information on the Professional Liability Insurance that the "organization" carries, whether it provides coverage for you or not.

14. **PRIMARY** PRACTICE LOCATION Coverage at this location desired? ☐ Yes ☐ No

a. Name of the Practice ____________________

Administrator's Name (if any) ____________________

Address ____________________

City ____________ State ________ Zip ______

Phone (____) ____________ Fax (____) ____________

b. Number of hours per week you provide services for this practice ________

c. Estimated number of patients seen weekly at above location ________

d. Do you own, lease or rent this location? ☐ Yes ☐ No ______ Sq. Ft.

e. **YOUR** Professional Liability Carrier at the location indicated above.

Name ____________________

Please indicate your relationship to the primary practice location. (Check all that apply)

- ☐ Individual Practitioner
- ☐ Solo Medical Corporations
- ☐ Independent Contractor
- ☐ Salaried Employee
- ☐ Officer/Director/Shareholder of Medical Corp (Not Solo) **List Owners in Remarks Section**
- ☐ Partner in a Medical Partnership **List Owners in Remarks Section**
- ☐ Other, please describe: ____________

f. Professional Liability Carrier for **"ORGANIZATION"** indicated above.

Name ____________________

Are you covered by the "organization's" professional liability policy? ☐ Yes ☐ No

If Yes, will coverage be maintained for you separate from the policy for which you are applying? ☐ Yes ☐ No

g. Do you: ☐ employ or retain any physicians; OR
☐ are you employed or retained by another physician at this location?

His/Her Name ____________ Carrier ________ ☐ Contracting Relationship ☐ Employment Relationship

His/Her Name ____________ Carrier ________ ☐ Contracting Relationship ☐ Employment Relationship

h. State the names of the following types of individuals who provide services in your office and indicate whether salaried employees or independent contractors. LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 13.

• Acupuncturist	• Dietitian	• Optometrist	• Podiatrist
• Certified Nurse Midwife	• Licensed Midwife	• Perfusionist	• Psychological Assistant [2]
• Chiropractor	• Nurse Anesthetist	• Pharmacist	• Psychologist [2]
• Dentist	• Optician	• Physician Assistant [1]	• Registered Nurse Practitioner[2]

Name	Title	Salaried Employee	Independent Contractor
		☐	☐
		☐	☐
		☐	☐

[1] YOU MUST ATTACH A COPY OF THE PHYSICIAN ASSISTANT'S LICENSE AND THE SUPERVISING PHYSICIAN'S LICENSE.
[2] PLEASE ATTACH A COPY OF THEIR LICENSE.

i. Indicate the number of the following types of other individuals who provide services at this location:

____ Audiologist	____ Nurse (Registered or Vocational)	____ Technician (Lab, Pathologist)
____ Clerical	____ Physical Therapist	____ Technician (X-Ray, Radium)
____ Dental Hygienist	____ Respiratory Therapist	____ Other (please describe)
____ Hearing Aid Dispensers	____ Social Worker	____________
____ Medical/Dental Assistant	____ Speech Pathologist	____________

NOTE: CERTAIN EMPLOYEES OF QUESTIONS h. AND i. ARE NOT COVERED UNLESS SPECIFICALLY APPROVED AND ENDORSED BY THE COMPANY. ALSO, INDEPENDENTLY CONTRACTED EMPLOYEES MAY BE REQUIRED TO OBTAIN SEPARATE PROFESSIONAL LIABILITY INSURANCE COVERAGE.

15. **SECONDARY** PRACTICE LOCATION Coverage at this location desired? ☐ Yes ☐ No

a. Name of the Practice ____________________

Administrator's Name (if any) ____________________

Address ____________________

City ____________________ State __________ Zip ________

Phone (______)____________________ Fax (______) ____________________

b. Number of hours per week you provide services for this practice____________

c. Estimated number of patients seen weekly at above location ____________

d. Do you own, lease or rent this location? ☐ Yes ☐ No _________ Sq. Ft.

e. **YOUR** Professional Liability Carrier at the location indicated above.

Name ____________________

Please indicate your relationship to the primary practice location.
(Check all that apply)

☐ Individual Practitioner
☐ Solo Medical Corporations
☐ Independent Contractor
☐ Salaried Employee
☐ Officer/Director/Shareholder of Medical Corp (Not Solo)
List Owners in Remarks Section
☐ Partner in a Medical Partnership
List Owners in Remarks Section
☐ Other, please describe:

____

f. Professional Liability Carrier for **"ORGANIZATION"** indicated above.

Name ____________________

Are you covered by the "organization's" professional liability policy? ☐ Yes ☐ No

If Yes, will coverage be maintained for you separate from the policy for which you are applying? ☐ Yes ☐ No

g. Do you: ☐ employ or retain any physicians; OR
☐ are you employed or retained by another physician at this location?

His/Her Name____________________ Carrier ____________ ☐ Contracting Relationship ☐ Employment Relationship

His/Her Name____________________ Carrier ____________ ☐ Contracting Relationship ☐ Employment Relationship

h. State the names of the following types of individuals who provide services in your office and indicate whether salaried employees or independent contractors. LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 13.

- Acupuncturist
- Certified Nurse Midwife
- Chiropractor
- Dentist
- Dietitian
- Licensed Midwife
- Nurse Anesthetist
- Optician
- Optometrist
- Perfusionist
- Pharmacist
- Physician Assistant [1]
- Podiatrist
- Psychological Assistant [2]
- Psychologist [2]
- Registered Nurse Practitioner[2]

Name	Title	Salaried Employee	Independent Contractor
		☐	☐
		☐	☐
		☐	☐

[1] YOU MUST ATTACH A COPY OF THE PHYSICIAN ASSISTANT'S LICENSE AND THE SUPERVISING PHYSICIAN'S LICENSE.
[2] PLEASE ATTACH A COPY OF THEIR LICENSE.

i. Indicate the number of the following types of other individuals who provide services at this location:

____ Audiologist
____ Clerical
____ Dental Hygienist
____ Hearing Aid Dispensers
____ Medical/Dental Assistant
____ Nurse (Registered or Vocational)
____ Physical Therapist
____ Respiratory Therapist
____ Social Worker
____ Speech Pathologist
____ Technician (Lab, Pathologist)
____ Technician (X-Ray, Radium)
____ Other (please describe)
____
____

NOTE: CERTAIN EMPLOYEES OF QUESTIONS h. AND i. ARE NOT COVERED UNLESS SPECIFICALLY APPROVED AND ENDORSED BY THE COMPANY. ALSO, INDEPENDENTLY CONTRACTED EMPLOYEES MAY BE REQUIRED TO OBTAIN SEPARATE PROFESSIONAL LIABILITY INSURANCE COVERAGE.

16. **ADDITIONAL** PRACTICE LOCATION Coverage at this location desired? ☐ Yes ☐ No

a. Name of the Practice ______________________________

Administrator's Name (if any) ______________________________

Address ______________________________

City ____________________ State __________ Zip ________

Phone (______)____________________ Fax (______) ____________________

b. Number of hours per week you provide services for this practice____________

c. Estimated number of patients seen weekly at above location ____________

d. Do you own, lease or rent this location? ☐ Yes ☐ No _________ Sq. Ft.

e. **YOUR** Professional Liability Carrier at the location indicated above.

Name ______________________________

Please indicate your relationship to the primary practice location.
(Check all that apply)

- ☐ Individual Practitioner
- ☐ Solo Medical Corporations
- ☐ Independent Contractor
- ☐ Salaried Employee
- ☐ Officer/Director/Shareholder of Medical Corp (Not Solo) **List Owners in Remarks Section**
- ☐ Partner in a Medical Partnership **List Owners in Remarks Section**
- ☐ Other, please describe:

____

f. Professional Liability Carrier for **"ORGANIZATION"** indicated above.

Name ______________________________

Are you covered by the "organization's" professional liability policy? ☐ Yes ☐ No

If Yes, will coverage be maintained for you separate from the policy for which you are applying? ☐ Yes ☐ No

g. Do you: ☐ employ or retain any physicians; OR
☐ are you employed or retained by another physician at this location?

His/Her Name____________________ Carrier ____________ ☐ Contracting Relationship ☐ Employment Relationship

His/Her Name____________________ Carrier ____________ ☐ Contracting Relationship ☐ Employment Relationship

h. State the names of the following types of individuals who provide services in your office and indicate whether salaried employees or independent contractors. LIST ADDITIONAL EMPLOYEES IN REMARKS SECTION, PAGE 13.

- Acupuncturist
- Certified Nurse Midwife
- Chiropractor
- Dentist
- Dietitian
- Licensed Midwife
- Nurse Anesthetist
- Optician
- Optometrist
- Perfusionist
- Pharmacist
- Physician Assistant [1]
- Podiatrist
- Psychological Assistant [2]
- Psychologist [2]
- Registered Nurse Practitioner[2]

Name	Title	Salaried Employee	Independent Contractor
____________	____________	☐	☐
____________	____________	☐	☐
____________	____________	☐	☐

[1] YOU MUST ATTACH A COPY OF THE PHYSICIAN ASSISTANT'S LICENSE AND THE SUPERVISING PHYSICIAN'S LICENSE.
[2] PLEASE ATTACH A COPY OF THEIR LICENSE.

i. Indicate the number of the following types of other individuals who provide services at this location:

____ Audiologist
____ Clerical
____ Dental Hygienist
____ Hearing Aid Dispensers
____ Medical/Dental Assistant
____ Nurse (Registered or Vocational)
____ Physical Therapist
____ Respiratory Therapist
____ Social Worker
____ Speech Pathologist
____ Technician (Lab, Pathologist)
____ Technician (X-Ray, Radium)
____ Other (please describe)
____
____

NOTE: CERTAIN EMPLOYEES OF QUESTIONS h. AND i. ARE NOT COVERED UNLESS SPECIFICALLY APPROVED AND ENDORSED BY THE COMPANY. ALSO, INDEPENDENTLY CONTRACTED EMPLOYEES MAY BE REQUIRED TO OBTAIN SEPARATE PROFESSIONAL LIABILITY INSURANCE COVERAGE.

SECTION V — OTHER PROFESSIONAL DUTIES

17. Are you (1) a partner, shareholder, owner, proprietor, superintendent, administrative or executive officer or medical director of any hospital, sanitarium, medical or other clinic, clinic with bed and board facilities, skilled nursing facility, convalescent hospital, surgical center, laboratory, health maintenance organization, preferred provider organization, exclusive provider organization or similar health care provider, or (2) a member of a peer review or other committee of any of the entities or organizations named in clause (1)? ☐ Yes ☐ No

    IF YES, DESCRIBE ACTIVITIES IN REMARKS SECTION, PAGE 13.

18. Are you an owner or do you have ownership interest in a blood bank, laboratory, or hemodialysis unit? ☐ Yes ☐ No

    IF YES, COMPLETE THE FOLLOWING:

    a. Name and address of the facility ______________________________

    ____

    b. Designate the exact capacity in which you serve (e.g., owner in whole or part, executive officer, administrator, departmental or ancillary service supervisor or physician with teaching responsibilities).

    ____

    c. Do you have professional liability coverage for this practice? ☐ Yes ☐ No

    IF YES, WHAT IS THE NAME OF YOUR INSURANCE CARRIER? ______________________________

    d. Number of hours per week in this capacity ______________________________

    NOTE: COVERAGE IS EXCLUDED FOR ADMINISTRATIVE ACTIVITIES UNLESS YOU ARE A RADIOLOGIST OR PATHOLOGIST OR UNLESS SUCH ACTIVITIES CONSTITUTE PROFESSIONAL COMMITTEE ACTIVITIES.

19. Are you employed by a state, federal or local public entity? ☐ Yes ☐ No

    IF YES, PLEASE COMPLETE SECTION IV WITH REGARD TO THAT PRACTICE.

20. If the total hours of practice described in the previous pages (7, 8 and 9) equal less than 20 hours, how is the remainder of your professional time spent?______________________________

SECTION VI — MEDICAL EDUCATION AND PRACTICE INFORMATION

21.	NAME (SCHOOL OR HOSPITAL)	DATES	SPECIALTY (IF APPLICABLE)
a. Medical School	________	____ to ____	________
Address	________		
b. Internship	________	____ to ____	________
Address	________		
c. Residency I	________	____ to ____	________
Address	________		
d. Residency II	________	____ to ____	________
Address	________		
e. Fellowship	________	____ to ____	________
Address	________		

22. I have practiced at the following locations during the past ten (10) years (not including training).

a. ______________________________ ____________ to ____________
Name of Practice — Month/Year — Month/Year

______________ ______________________________
Type of Practice (i.e., Medical Group, HMO) — Address — City — State — Zip

b. ______________________________ ____________ to ____________
Name of Practice — Month/Year — Month/Year

______________ ______________________________
Type of Practice (i.e., Medical Group, HMO) — Address — City — State — Zip

c. ______________________________ ____________ to ____________
Name of Practice — Month/Year — Month/Year

______________ ______________________________
Type of Practice (i.e., Medical Group, HMO) — Address — City — State — Zip

d. ______________________________ ____________ to ____________
Name of Practice — Month/Year — Month/Year

______________ ______________________________
Type of Practice (i.e., Medical Group, HMO) — Address — City — State — Zip

LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 13.

SECTION VII — UNDERWRITING INFORMATION

23. Has any insurance company canceled, declined coverage or modified (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any professional liability insurance? ☐ Yes ☐ No
IF YES, DESCRIBE IN REMARKS SECTION (PAGE 13) AND INCLUDE COMPANY NAME AND POLICY NUMBER.

24. Have you ever been investigated by any Dept. of Professional Regulations, State Medical Board of Examiners and/or Board of Dental Examiners, the State Licensing Authority, Osteopathy Board, Narcotics Bureau or other governmental agency? ☐ Yes ☐ No
IF YES, DESCRIBE IN REMARKS SECTION, PAGE 13.

25. Has a claim, incident or suit for alleged malpractice been brought against you within the last ten (10) years? ☐ Yes ☐ No
IF YES, COMPLETE A CLAIM INFORMATION SHEET, PAGE 14, FOR EACH CLAIM.

26. Do you know of any incident(s) that might provide a basis for any claim or suit to be brought against you? ☐ Yes ☐ No
IF YES, DESCRIBE IN REMARKS SECTION, PAGE 13.

27. Has any physician, patient or insurance company ever filed a complaint of any kind against you with your medical society or foundation?. ☐ Yes ☐ No
IF YES, PLEASE DESCRIBE IN REMARKS SECTION, PAGE 13.

28. Have you ever had your hospital privileges reduced, restricted, preceptored or suspended? ☐ Yes ☐ No
IF YES, DESCRIBE THE CIRCUMSTANCES IN REMARKS SECTION, PAGE 13.

29. List hospitals to which you are applying for staff privileges, or are currently a staff member and the percentage of patient admissions for each hospital during the last twelve (12) months, including consultations.

Hospital	%	Hospital	%

LIST ADDITIONAL LOCATIONS IN REMARKS SECTION, PAGE 13.

30. Briefly describe the type(s) and extent of your hospital privileges: ____________________

____

31. Are you providing medical services to any professional, college, or amateur athletic team on any basis? ☐ Yes ☐ No

IF YES, DESCRIBE IN REMARKS SECTION, PAGE 13.

32. How did you become aware of us?

☐ Medical Association/Society ☐ Physician Colleague ☐ Mailing

☐ Advertisement ☐ Presentation by a Company Representative

☐ Other ____________________

33. My decision to apply was primarily based on:

☐ Reputation of Company ☐ Premium Considerations ☐ Coverage Quality

☐ Special Features ☐ Joining a Company Insured Group

☐ Other ____________________

34. IMPORTANT: PLEASE PROVIDE A COPY OF YOUR LETTERHEAD, IF AVAILABLE.

SECTION IX — REMARKS (INDICATE QUESTION NUMBER REFERRED TO)

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED.

SECTION X — CLAIMS INFORMATION

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED.

NOTE: Please provide sufficient information for underwriters to evaluate the medical aspects of the case especially relating to your involvement.

1. Name of Patient ______________________________________ 2. Age _______ 3. ☐ Male ☐ Female

4. Allegation ____

____

____

____

5. Date claim was made or filed ______________ 6. Date of incident leading to allegation ____________

7. Insurance company ____

8. Additional defendants ____

9. Location of occurrence ____

10. Disposition of claim ☐ OPEN ☐ CLOSED

a. Exact date closed _______________________________

b. Total settlement or judgment $ _________________

c. Amount paid on your behalf $ _________________

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of the claimant's office and hospital records, laboratory reports and any other information that would be appropriate. Attach additional sheets as required.

11. Condition and diagnosis at time of incident (**Include dates of visits**)

____

____

____

12. Date and description of treatment rendered (**Include dates of visits**)

____

____

____

13. Condition of patient subsequent to treatment (**Include dates of follow-up treatment**)

____

____

____

Date _________________________ Signed ____

I HEREBY REPRESENT THAT THE STATEMENTS AND ANSWERS MADE WITHIN THIS PREMIUM INDICATION REQUEST ARE FULL, COMPLETE AND TRUE. ALSO, I UNDERSTAND THAT THIS IS NOT AN APPLICATION FOR INSURANCE OR A BINDER OF INSURANCE, BUT IS INSTEAD AN INSURANCE PREMIUM INDICATION REQUEST. A COMPLETED APPLICATION AS WELL AS UNDERWRITING REVIEW WILL BE NECESSARY PRIOR TO APPROVAL.

Name (Please type or print name)	Signature (Please sign your name)
Address	City State Zip
Date	