



**PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION –
CLAIMS-MADE FORM**

The following documentation must be submitted with the fully completed application:

- 1. Copy of your curriculum vitae.**
- 2. Copy of your current policy declarations page. (Claims-Made policies must reflect retroactive date.)**
- 3. Copy of all licenses and board certifications.**
- 4. Copy of all prior reporting endorsements issued to you.**
- 5. Currently valued 5-year claims/loss history from prior companies.**
- 6. Copy of your business letterhead**
- 7. Copy of all advertising that you use.**

NOTE: Submission of a completed application confers no obligation upon the company to bind coverage.



**James River Insurance
Company**

**Physicians and Surgeons Professional
Liability Application – Claims-Made Form**

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION CLAIMS-MADE FORM

PLEASE TYPE OR PRINT IN INK

(If more space is needed to answer any questions, use page 10 or a separate sheet.)

I. GENERAL INFORMATION

1. A. Full Name of Applicant _____ Degree _____

B. Practice Address: _____

Street

County

City

State

Zip Code

C. Mailing Address: _____

Street

County

City

State

Zip Code

D. Phone: _____

E. Fax: _____

F. E-Mail Address: _____

G. Website Address: _____

H. Secondary Practice Locations _____

I. Social Security No. _____

J. Date of Birth _____

2. Are you a U. S. Citizen? Yes No If no, please indicate your status and date of entry into USA on page 10.

3. A. Are you a Foreign Medical School Graduate? Yes No B. Date of ECFMG Certification: _____

4. Provide the following information for all the states in which you are licensed to practice:

State	% of Practice	License No.	Active	Inactive	Temporary	Pending
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Federal DEA License Number and status _____

6. List all locations and dates where you have practiced in the last ten (10) years.

Practice Name	City/State	Specialty Practiced	From	To

7. Current Practice Specialty: _____ Percentage of Practice: _____

8. Subspecialty: _____ Percentage of Practice: _____

9. Board Certification:

Board Certified By: _____ Board Eligible – Date of Exam: _____

Neither Board Certified Nor Board Qualified (please explain) Board Qualified (completed required training)

If Board Eligible for Over Five Years, But Not Board Certified, Please Explain:

II. MEDICAL EDUCATION AND TRAINING

10. Medical Education – please complete the following:

	Name of Institution	Degree/ Specialty	Location	From	To	Completed (Yes/No)
Medical School						
Internship						
Residency						
Residency						
Fellowship						

11. How many hours of continuing medical education have you completed within the past three (3) years? _____

III. PRACTICE INFORMATION

12. A. Type of Practice:

Are You:

- 1. Self Employed? Yes No
- 2. An employee of another physician? If yes please explain on page 10 Yes No
- 3. An employee of an organization, other than a hospital, engaged in the delivery of medical services? Yes No
- 4. An independent contractor to an organization, other than a hospital, engaged in the delivery of medical services? Yes No

Type of Practice: (continued)

5. Are you a partner, stockholder or employee in a Medical partnership, Professional Association or professional services corporation? Yes No

If yes, are you a Partner Stockholder Employee

If yes, please give the following details:

a. Type of Entity: Medical Partnership Professional Association Professional Services Corporation

b. List all stockholders, partners and associates: _____

c. Are you requesting that the legal entity be named on your policy? If yes, please forward the articles of incorporation. Yes No

B. Do you practice with any physician(s) not named in Item 12.B. above? Yes No

If yes, provide the name of each physician and the practice relationship: _____

C. Do you employ, contract with or supervise any physician(s) or surgeon(s)? Yes No

If yes, provide the number and attach a current certificate of insurance for each. Number: _____

D. Do you have any office or expense sharing arrangement with any other physician(s) or surgeons(s) other than those named in 12.B. or 12.C. above? Yes No

If yes, provide the number and attach a current certificate of insurance for each. Number: _____

E. Do you employ, contract with or supervise any non-physician health care extenders? Yes No

If yes, enter the information below:

	# Employed	Is Coverage Desired?	# of Independent Contractors	Are they insured?
Nurse Practitioner		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Assistant		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
CRNA*		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Nurse Midwife*		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgeon Assistant		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapist		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Nurses (RN, LPN, LVN)		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Assistants		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

* If coverage is desired, please complete an Allied Personnel application for each.

13. Are you employed full-time or part-time by the federal, state, or local government, or are you on active military duty? Yes No

If yes, please explain: _____

14. Provide the following information for all hospitals or surgery-centers where you are currently on staff:

Name	City	State	% of Work	Type of Privileges

15. Are you currently a hospital chief of staff or head of any hospital department? Yes No
 If yes, please describe: _____
16. Do you or any entity named in 12.A. above own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgery-center, abortion clinic, walk-in clinic, or birthing center? Yes No
 If yes, attach a detailed explanation and include the location name, size, and number of beds.
17. Do you serve as a medical director of a nursing home, clinic, commercial enterprise or any other organization? Yes No
 If yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position: _____
-
18. Average weekly patient load: _____ Average weekly practice hours: _____ Percentage of Locum Tenens work: _____
19. Do you work in an Emergency Room, other than to maintain hospital privileges? Yes No
 If yes, provide the average number of hours you work in the Emergency Room each month: _____
20. Are you ACLS certified? Yes No Are you ATLS certified? Yes No
21. Do you work for any locum-tenens companies as an employee or independent contractor? Yes No
 If yes, number of hours each month in which you work in locum-tenens positions: _____
 If yes, does each company provide you with Professional Liability insurance for locum positions? Yes No
 If Yes, attach a copy of your Certificate(s) of Insurance.
22. Do you now or have you ever provided services to any state, local or federal correctional facility, jail, or prison? Yes No
 If yes, please describe: _____
23. Have there been any changes in your specialty or practice activities within the past ten (10) years? Yes No
 If yes, describe the changes: _____
24. Do you anticipate any changes in your specialty or practice in the next year? Yes No
 If yes, describe the anticipated changes: _____
25. Do you perform any procedure not routinely performed by other persons practicing your specialty or subspecialty? Yes No
 If yes, please provide complete details: _____
26. Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering medical services? Yes No
 If yes, indicate all states where the patients being treated reside: _____
 If yes, what percentage of your practice does this outside state activity constitute? _____
27. Do you read or interpret films, slides or specimens of patients who reside in states other than your indicated practice states? Yes No
 If yes, indicate all states in which the patients reside and indicate the percentage of your practice corresponding to each state: _____
28. Do you read your own x-rays? Yes No
 If yes, will they subsequently be read by a radiologist? Yes No
 If yes, within how many hours? _____
29. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? Yes No
30. Do you perform surgical procedures at a same day surgery center other than your own office? Yes No

31. Do you perform surgery in your office or private suite using anesthesia other than local or topical? Yes No
 If yes, complete the following information: (Use supplemental sheet if more space is needed.)

Procedure	Anesthetic or Parenteral Sedation	Emergency Equipment and/or Emergency Procedures in Place in Case of Complications

32. Are you a sports team physician for any college, university, semi-professional or professional team? Yes No
 33. Do you practice any forms of "Alternative Medicine" including but not limited to Ayurvedic Medicine, Chinese Medicine, Homeopathic Medicine, Chiropractic Medicine, Holistic Medicine or Naturopathic Medicine? Yes No

If yes, please describe your practice: _____

34. Are you engaged in any "moonlighting" activities? Yes No
 If yes, do you desire coverage for "moonlighting" activities? Yes No
 If yes, describe the activities: _____

35. Do you treat patients in a nursing home or similar facility? Yes No
 If yes, how many patients do you treat there per month, on average? _____

36. Do you now or have you ever performed experimental or investigational procedures or prescribed or dispensed experimental drugs? Yes No
 If yes, please explain on page 10 or on a separate sheet.

37. A. With the exception of surgery for obesity, does your practice include weight reduction or control other than by diet or exercise? Yes No

B. Percentage of your patient that are weight control patients: _____%

- C. Do you dispense any drugs? Yes No

If yes, provide the names of the drug(s) dispensed: _____

38. Check All Procedures/Treatments That You Perform. Indicate In Appropriate Column, Where Performed.

Office	Hospital	Other	Procedure
			Abortion (Do you perform non-therapeutic abortions? Yes [] No []) Which Trimester? ___ No. per yr. ___
			Acupuncture
			Anesthesia – Non-Obstetrical
			Anesthesia – Obstetrical
			Angiography
			Angioplasty
			Assisting In Surgery – (Own Patients; Patients of Others) Circle those that apply.
			Bariatric Surgery: <input type="checkbox"/> Gastric Banding <input type="checkbox"/> Gastric Bubble <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Gastric Stapling <input type="checkbox"/> Other (please indicate below)
			Blepharoplasty
			Breast Enhancement - Silicone
			Breast Enhancement – Saline
			Breast Enhancement – Trans-Umbilical
			Breast Reduction
			Cardiac Catheterization
			Cervical Biopsy
			Chelation Therapy (Lead Removal/Arteriosclerotic Heart Disease) Circle those that apply.
			Chemonucleolysis
			Chemotherapy
			Cryosurgery (other than use on benign, malignant or pre-malignant dermatological lesions)
			Cosmetic Procedures: Botox Injection
			Chemical Peels
			Chemobrasion
			Collagen Injection

			Dermabrasion
			Fat Transfer
			Hair Transplant
			Laser Hair Removal
			Laser Skin Resurfacing
			Any other laser procedure or treatment (please specify):
			Lipodissolve
			Mesotherapy
			Microdermabrasion
			Silicone Injection
			Other (Describe here or on supplemental sheet):
			Dilation & Curettage
			Echocardiography
			Electroconvulsive Therapy
			Endoscopic Procedures
			Facial Plastic Surgery (Elective Cosmetic/Reconstructive) Circle those that apply.
			Fracture Reduction (Closed/Open) Circle those that apply.
			Hyperbaric Medicine
			Hysterectomy
			Intensive Care For Newborns
			Intensive Care Medicine For Adults
			Laparoscopy
			Liposuction (Tumescent/Other) Circle those that apply.
			Lymphangiography
			MOHS Micrographic Surgery
			Myelography
			Needle Biopsy (including lung, prostate, liver and kidney)
			Obstetrics
			Prenatal Care <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> 3 rd Trimester
			Normal Deliveries (Provide annual number:)
			C-Sections (Provide annual number:)
			VBAC Deliveries (Provide annual number:)
			Organ Transplantation
			Orthopedic Surgery (including spinal/without spinal) Circle those that apply.
			Osteopathic Manipulative Medicine
			Pain Management (if other than medication only, please complete supplement)
			Penile Prosthetic Implants
			Phalloplasty
			Permanent Pacemaker Insertion
			Pneumoencephalography
			Prolotherapy
			Radiation Therapy
			Radiopaque Dye Injections
			Refractive Surgery (LASIK, PRK, AK, PTK, ICR) Circle those that apply.
			Rhinoplasty
			Sclerotherapy
			Thoracic Surgery _____%
			Tonsillectomy/Adenoidectomy
			Transgender Surgery or Hormonal Gender Conversion. Circle those that apply
			Tubal Ligation
			Vascular Surgery _____%
			Vasectomy
			Vertebroplasty
			Other Procedures not listed above (please list)

			I do not perform any of the above procedures/treatments. Initial_____

If you answer "yes" to questions 39 through 45, please provide details on page 10.

39. Has any licensing authority or hospital ever reprimanded you or ever denied, revoked, suspended, or restricted your medical license, narcotics license or practice privileges or put you on probation? Yes No
40. Has any licensing authority or hospital conducted (or are they currently conducting) an investigation relating to the nature of your practice privileges, or to the restriction or limitation of your license or privileges? Yes No
41. Have you ever been indicted, charged, arrested (other than for motor vehicle violations) or convicted of any offense, crime, or misdemeanor in any state or any federal jurisdiction? Yes No
42. Have you ever been evaluated, diagnosed, or treated for any disease or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency? Yes No
43. Have you ever been accused of sexual misconduct of any kind? Yes No
44. Do you have a physical handicap or any chronic disease? Yes No
45. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health payors, or public health payors, including but not limited to Medicare or Medicaid? Yes No

IV. CLAIM INFORMATION

IMPORTANT INFORMATION REGARDING QUESTIONS 46A, 46B, 46C AND 46D (INCLUDING SUB-QUESTIONS)

1. The word "claim" as used in questions 46A, 46B, 46C and 46D as follows refers to:
- a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional services and brought against you or any partner, associate, employee, or professional corporation or partnership; or
 - b. Circumstances which have been brought to your attention by a patient or legal representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer yes to any parts of questions 46A, 46B or 46C, please complete the Supplementary Claims Information Form on page 11 for all such claims.

46. A. Have you ever been involved in a malpractice suit or claim, either directly or indirectly? Yes No
If yes, how many? _____ (Provide details for each on page 11.)
- B. Other than the claims/suits indicated in 46.A. above, are you aware of any 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:
- 1. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
 - 2. A letter from an attorney regarding your medical treatment of a patient? Yes No
 - 3. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability, or the need for follow-up surgery? Yes No
 - 4. Patient or family members dissatisfied with the outcome of a procedure, treatment or diagnosis? Yes No
 - 5. Knowledge or information relating to service or services on a Board which might result in a claim? Yes No
 - 6. Any other circumstances that might reasonably lead to a claim or suit? Yes No
- C. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability company? Yes No
If yes, how many? _____ (Provide documentation of all such reports.)
If no, please explain details on page 11.
For the purposes of this question, check the following box if you are aware of no circumstances that might reasonably lead to a claim or suitNot Applicable
- D. Has any prior professional liability company refused coverage for, or declined to accept a report of a medical incident, threat of a claim, letter of intent, adverse result notice or attorney contact? Yes No
If yes, please explain details on page 10.

V. PROFESSIONAL LIABILITY INSURANCE HISTORY

47. Provide details of Professional Liability Insurance for the past seven (7) years, including coverage for “moonlighting” positions:

Company Name	Each Claim Limit	Aggregate Limit	Policy Dates		Claims Made or Occurrence?	Retroactive Date
			From	To		

48. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium or issued coverage with any restrictions or exclusions? Yes No
 If yes, provide explanation on supplemental page 10.
49. Have you ever been without professional liability coverage since beginning practice? Yes No
 If yes, provide explanation on supplemental page 10.
50. Do you have professional liability insurance for work you do elsewhere? Yes No
 If yes, provide explanation on supplemental page 10.
51. If prior coverage is Claims-Made, has a Reporting Endorsement (“tail” coverage) been purchased? Yes No
 If yes, provide copy of the Reporting Endorsement.
 If no, provide explanation on supplemental page 10.

VI. COVERAGE REQUEST

52. Effective Date Desired: _____ Retroactive Date Desired: _____

(NOTE: THE COMPANY MAY NOT PROVIDE DESIRED DATES)

53. Policy Limits Desired: \$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000 \$500,000/\$1,500,000
\$1,000,000/\$3,000,000 Other: _____

54. A deductible of at least \$5,000 is required. Please select any optional deductibles that you desire. No aggregate limit will apply to the deductible. \$10,000 \$25,000 \$50,000 (approved LOC required)

SUPPLEMENTAL CLAIM INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each claim. If space is insufficient to answer any question fully, please attach a separate sheet. All questions must be answered or marked not applicable (N/A).

1. Patient's Name: _____ Age _____ Sex _____

2. Date reported to insurance company: _____

3. Date of incident and your treatment: _____

4. Name of insurance company: _____

5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

8. Status of claim (check applicable answer):

- Suit threatened, no action take
- Suit filed but dropped by claimant
- Summary judgment in your favor

- Court outcome in your favor:
- Jury verdict
 - Directed verdict

- Unresolved/Open Claim:
- Awaiting mediation
 - Awaiting court action

- Suit settled out of court
 - a. Date claim paid: _____
 - b. Amount paid: \$ _____
 - c. Did you want to settle this claim? Yes No

- Court outcome in favor of plaintiff:
- Jury verdict
 - Directed verdict
- Amount of loss payment:
\$ _____

Reserve Amount:
\$ _____

9. Name and address of the attorney assigned to your case: _____

10. To your knowledge, was any settlement paid by another party involved (your P.A., P.C., partners, employees, etc.)? Yes No

If yes, what was the amount of the settlement? _____

11. Explain in detail what action(s) you have taken to prevent recurrence of this type of claim: _____

Applicant's Signature _____ Date: _____
Name (Printed) _____