Physicians and Surgeons
Professional Liability Insurance Application

Section I – General Information. Please print legibly. If a question is not applicable, state "N/A."

First Name | Middle Name/Initial | Last Name | Former Name/Alias, if applicable

Credentials (MD/DO) | Suffix | Date of Birth MM/DD/YYYY | Gender

License # | State | NPI #

Practice Name/Employer

Practice Address (include city, state and zip)

Office Phone | Office Fax

Email Address

Practice Contact Person: _____

Phone: _____ Fax: _____

Email: _____

7. Type of practice (check all that apply):

Employee Sole proprietor/unincorporated

Solo corporation (Name)_____

Professional association Independent contractor Principal in a professional corporation

Partnership Limited Liability Corporation

Other (describe)_____

Section II- Medical Education and Training

8. Primary Specialty (please list all that apply): _____ %of practice_____

Sub-specialty (please list all that apply): _____ %of practice_____

9. Does your practice include (mark one): Major Surgery Minor Surgery No Surgery

10. Do one or more boards of the American Board of Medical Specialties currently certify you?
Please list: _____

If not, are you Board eligible? Yes No

11. Have you ever been denied Board certification? Yes (provide details below) No

Details:

12. Name(s) of medical school(s):

Medical School	*City*	*State/Country*	*Graduation Date*

If you attended a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates? Yes No

If Yes, date certified: _____ If No, please explain: _____

13. All internship/residency training undertaken and dates, whether completed or not:

Location	*Specialty*	*Month/Year Completed*
Served internship at:		
Served residency at:		
Served residency at:		
Served fellowship at:		

14. Have you participated in any risk management or professional liability claims prevention courses over the past 24 months? Yes No

If Yes, please specify topic and date:

15. Has your staff participated in any risk management or professional liability claims prevention courses over the past 24 months? Yes No

If Yes, please specify topic and date: _____

Section III – Insurance Coverage Information

16. Limits of Liability requested (Check one)

$1,000,000/$3,000,000 $2,000,000/$4,000,000 $3,000,000/$5,000,000

$4,000,000/$6,000,000 $5,000,000/$7,000,000

16a. Policy type requested (check one) Claims-Made Policy Modified Claims-Made Policy

16b. Do you want to waive your Consent to Settle provision for a 1% discount on your medical professional liability premium? Yes No

17. Is Prior Acts coverage requested? Yes No

(If Yes, please attach a copy of your current policy's declaration page and complete the Supplemental Prior Acts Application)

18. Requested effective date: _____

Requested retroactive date: _____

Section IV – Insurance Information: Current and Previous

19. Name of present insurance carrier: _____ Expiration Date: _____

19a. Type of present policy (Attach copy of declarations page from present policy)

Occurrence Plus (Modified Claims-made) Occurrence

Claims-made Tail Purchased? Yes No

20. List all carriers that have ever provided insurance: **Must Be Completed**

Name of Insurance Carrier	Coverage Dates		Occurrence/Occurrence Plus/Claims-Made	Retro Date (If applicable)	Policy #
	Effective	Expire			

Section V – Scope and Nature of Practice or Employment

21. List **all** locations where you work.

Employer/Facility Name	Address	City	State	Phone	Position to be covered by Conventus Policy? Yes or No*

If No, please provide proof of coverage

22. Do you have ownership in any medical facility other than your office practice, such as, a surgicenter, urgent care, nursing home, etc.? Yes No

(If Yes, and it is not covered by this insurance, please provide evidence of insurance)

23.

	Please indicate total hours worked per week at each office location for the following:	Location #1 Hours per week	Location #2 Hours per week	Location #3 Hours per week
A	Actual patient care, including record keeping and hospital rounds			
B	Administrative duties			
C	Surgeries and assists			
D	House calls and nursing home visits			
E	Utilization review			
F	Teaching			

23a. _____ % of patients seen through managed care contracts.

_____ % of patients 'fee for service' or indemnity insurance.

Section V – Scope and Nature of Practice or Employment (continued)

24. If Major Surgery is indicated, please complete the **percentage** of your surgical practice applicable to the following: **Total must equal 100%**

%	Procedure
	Abdominal
	Bariatric
	Cardiac
	Colon/Rectal
	General/IM/FP
	Gynecologic

%	Procedure
	Hand
	Head and Neck
	Neurosurgical
	Ophthalmological
	Orthopedic - including spinal surgery
	Orthopedic- without spinal surgery

%	Procedure
	Plastic – Cosmetic
	Plastic – Reconstructive
	Thoracic
	Traumatic
	Urologic
	Vascular

25. Please indicate below your best estimate of the number of the following procedures you expect to perform, or in which you will participate, in the next 12 months, beginning with the date of your requested coverage (use additional sheet for description).

If You Do Not Perform Any Of These Procedures Initial Here

# of Procedures	Procedures
	Abortion - first trimester
	• Hospital
	• Clinic
	• Office
	Abortion -after first trimester
	• Hospital
	• Clinic
	• Office
	Acupuncture
	Adenoidectomy
	"Alternative medicine" or "complementary medicine" procedures (as viewed by most physicians) Please describe:
	Anesthesia - obstetrical
	• General
	• Spinal
	• Epidural
	Anesthesia- non-obstetrical
	• General
	• Spinal

# of Procedures	Procedures
	• Anesthesia- non-obstetrical - Epidural
	• Anesthesia- non-obstetrical Other- Please describe:
	Angiography
	Angioplasty
	Anteriography
	Assisting in major surgery - own patients
	Assisting in major surgery - other than own patients
	Bariatric
	Breast implants
	Breast reduction
	Catheterization
	• Cardiac
	• Arterial
	• Other - Please describe:
	Chelation therapy
	Chemabrasion
	Chemical Peel
	Chemotherapy

Section V – Scope and Nature of Practice or Employment (continued)

If You Do Not Perform Any Of These Procedures Initial Here

# of Procedures	Procedures
	Colonoscopy
	Cosmetic implantation or injection of silicone or other materials - Please describe:
	Cryosurgery - Please describe:
	D &C's
	Deliveries
	• Cesarean
	• Vaginal after Cesarean
	Discograms
	Electromyography
	Endoscopy (other than proctoscopy or sigmoidoscopy). Please describe:
	Experimental or investigative procedures (Attach protocol used and state whether or not you follow FDA guidelines in administering this)
	Eyeliner pigmentation
	Fracture reductions - closed
	Fracture reductions - open
	Hair transplants, or other hair growing or replacement techniques
	Hemorrhoidectomy
	• Internal
	• External
	Herniorrhaphy
	Laparoscopy:
	• Diagnostic - Please describe
	• Surgical - Please indicate type of surgery:
	Laser Surgery- Please indicate type of surgery:

# of Procedures	Procedures
	Lasik
	Liposuction
	Lumbar puncture
	Manipulation therapy
	Mesotherapy
	Myelography
	Needle aspirations
	Needle biopsy
	Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts Please indicate type of surgery:
	Pacemaker insertion
	Pre-natal care
	Radical keratotomy
	Radiation
	• Diagnostic
	• Therapeutic
	Sclerotherapy
	Shock therapy
	Spinal surgery
	Tattoo removal
	Teleradiologist
	Thoracentesis
	Tonsillectomy
	Total joint replacements
	Tubal ligations

Section V – Scope and Nature of Practice or Employment (continued)

If You Do Not Perform Any Of These Procedures Initial Here

# of Procedures	Procedures
	Vasectomy
	Venography
	Weight control by bariatric surgery
	Any other procedure you reasonably believe will be of interest to a medical professional liability

26. Have you made any changes to your practice in the past 10 years, such as change in **specialty** or **services** offered? Yes No

    If yes, please describe: _____

27. List all facilities and hospitals where you have staff or courtesy privileges.

Facility Name and Location	Department	Type of Privileges	Dates From/To

28. List all locations where you have practiced since formal training. Please explain any period(s) of inactivity. Attach explanatory sheet if necessary. Please attach your CV.

Location (city and state)	Dates From/To

29. List all states in which you are licensed or have been licensed and information on that state license if available.

State	License #	DEA #	Active? Yes/No	% of Patients	% of Office Hours

30. If you are a sole proprietor/unincorporated, please complete this section. Please indicate the number of people you have working your practice in each position.

# of People	Role/Credential		# of people	Role/Credential
	Lab or X-Ray Technicians			Nurse Practitioners*
	Medical Assistants			Physicians or Surgeons **
	Nurses			Physician Assistants*
	Nurse Anesthetists*			Surgical Assistants*
	Nurse Midwives*			All other Licensed Health Care Providers (Specify)

* *Non-Physician Health Care Provider Application* must be completed for each person in this category.

** *Physicians and Surgeons Application* must be completed for each person in this category.

31. How many employees have left your practice in the past 3 years? _____

Section VI – Practice and Procedures: General Questions

32a. Do you perform surgery in your office? Yes No

If Yes, please list the specific procedures: _____

32b. Is general anesthesia or IV conscious sedation administered for these (or any) office procedures? Yes No

If Yes, by whom, and with what training? _____

33. What specific emergency equipment do you have available? _____

34. How far is this location from the nearest hospital with emergency services? _____

35. Do you own, or operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office? Yes No

36. Do you work in an emergency room? Yes No

If Yes, how many hours on average per week: _____

37. Do you perform any cosmetic procedures in your practice? Yes No

If so, please complete the Cosmetic Procedures Supplemental Application.
Also, please attach a copy of all advertising materials related to cosmetic procedures.

38. Do you provide any services over the internet or through a telemedicine program? Yes No

39. Regarding collection procedures:

a. Do you have written protocol for handling collection problems with your patients? Yes No

b. If you utilize collection agencies, have you specified, in writing, the specific circumstances under which legal action may be taken against your patients? Yes No

c. Are your patients clearly informed, in writing, of your billing procedures and collection policies, and do they understand their rights if they choose to dispute a charge? Yes No

40. Have you introduced any new technology into your office practice during the past 3 years such as computerized medical records, voice data recording, computerized order entry technology, or any other automation surrounding patient care and record keeping? Yes No

41. Do you participate in any patient satisfaction surveys or studies conducted by any managed care provider or do it on your own? Yes No

Section VII – Professional History

If you answer Yes to questions 42 through 54, please explain on a separate sheet, and provide full documentation from any agency involved.

42.	Are you in military service or employed full-time by the federal government?	Yes	No
43.	Do you work for a correctional facility (jail)?	Yes	No
44.	Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked?	Yes	No
45.	a. Has any state ever refused you a license to practice medicine?	Yes	No
	b. Has any state ever restricted, suspended or revoked your license to practice medicine?	Yes	No
	c. Have you ever voluntarily surrendered a license to practice medicine?	Yes	No
	d. Has any state ever placed you on probation or restricted your practice?	Yes	No
	e. To your knowledge, has your license to practice ever been under investigation?	Yes	No
46.	Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise?	Yes	No
47.	Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine?	Yes	No
48.	Are you currently or have you ever been treated for a psychiatric condition, alcoholism or substance abuse?	Yes	No
49.	Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?	Yes	No
50.	Has your professional liability coverage ever been cancelled, restricted, non-renewed, or have you withdrawn an application for insurance to avoid declination?	Yes	No
51.	Have you ever practiced without insurance?	Yes	No
52.	Has coverage for professional liability ever been refused, or accepted under special terms?	Yes	No
53.	Has a complaint against you ever been submitted to the Board of Medical Examiners or Regulatory authority?	Yes	No
54.	Have you ever served as an expert witness in any professional liability lawsuit?	Yes	No

Section VIII – Claims

55.	a. Has anyone ever filed a claim against you regardless of whether the claim was dismissed or a judgment was rendered? *(If Yes, you MUST provide details on claims information sheet for each claim.)*	Yes	No
	If Yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage?	Yes	No
	b. Do you know of any circumstance, act, error, or omission that could possibly result in a professional liability claim against you?	Yes	No
	If Yes, has this incident(s) been reported to a prior insurer?	Yes	No

Must provide complete details for each incident on the Supplemental Claims Information Sheet and attach to this application. The name of the patient, date of incident, medical incident details, insurance carrier which handled claim and disposition, including loss paid or reserve.

Section IX- Signature

I understand that no coverage will be bound until after *Conventus* Inter-Insurance Exchange has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of *Conventus'* intent to provide coverage. If coverage is declined by *Conventus*, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage by *Conventus*, no insurance will be provided for any claim (or incident that the insured has reason to believe might result in a claim) known to the insured at the effective date that has, or has not, been reported to another insurance carrier prior to the effective date.

The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the underwriter's risk.

I authorize the release of any underwriting, credentialing and/or claim information from (and release from any and all liability for the provision of information) all prior and current insurers, all professional societies or associations, any state licensing authority, any hospitals, or any credentialing agency to *Conventus* and its subsidiaries, or agents, or Attorney-in-Fact.

Signature of Applicant: _____ Date: _____

Conventus reserves the right to reject any application that does not meet its underwriting standards.

NOTICE TO NEW JERSEY APPLICANTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALITIES.

APPENDIX A
ASSIGNEMENT OF UNEARNED PREMIUM, DIVIDEND & VOTING RIGHTS

1. If the premium payer is any party other than the named insured, is all right, title, and interest to unearned premium, potential dividends and voting rights in the *Conventus Inter-Insurance Exchange* (the "Exchange") irrevocably assigned to the payer? Yes No

2. _____, hereinafter referred to as the Group Practice and,

   _____ the named insured, hereinafter referred to as the Medical Practitioner ("MCP"), hereby enter into this agreement.

   Whereas the Group Practice has paid the premium for the MCP to obtain membership in the Exchange.

   Now, therefore, the parties hereto agree to the following:

In consideration for the Group Practice paying the premium for said insurance, the MCP hereby:

3. Assigns and gives a security interest to the Group Practice for any and all unearned premiums which may become payable from the professional liability policies paid for by the Group Practice.

4. Irrevocably appoints the Group Practice as the MCP's Attorney-in-Fact with full authority to cancel the MCP's professional liability policies purchased by the Group Practice, receive all sums assigned to the Group Practice or in which the MCP has granted the Group Practice a security interest in furtherance of this agreement.

5. Assigns to the Group Practice the right to receive any dividends which may become payable to the MCP under the MCP's professional liability policies purchased by the Group Practice.

6. Irrevocably appoints the Group Practice as MCP's Attorney-in-Fact with full authority to exercise the MCP's voting rights as a member of the Exchange.

7. All legal rights given to the Group Practice under this Assignment shall benefit the Group Practice's successors and assigns.

8. The MCP agrees not to further assign any interest in said professional liability policies without the Group Practice's written consent

Date _____

_____ _____
Medical Practitioner – Print Name Medical Practitioner – Signature

Date _____

_____ _____
Group Practice – Print Name Group Practice – Address

_____ _____s
Officer – Print Name & Title Officer – Signature

_____
Witness to Medical Care Practitioner's Signature

(Rev 1/1/14)

CONVENTUS
MEDICAL PROFESSIONAL LIABILITY INSURANCE

Supplemental Claims Information Sheet

Complete for all closed, pending, or potential claims(s)

Claimant's/plaintiff's name: _____

Date care rendered: _____ Date claim reported: _____

Status: Open Closed Date closed: _____

If closed, was any indemnity payment or award made? Yes No If Yes, amount: _____

If open, what is the amount of loss reserve or damages sought? _____

Name of insurance company defending you: _____

Are you the primary target of the complaint? Yes No If No, who is? _____

Description of claim (Include type of treatment, result of treatment, your involvement):

Claimant's/plaintiff's name: _____

Date care rendered: _____ Date claim reported: _____

Status: Open Closed Date closed: _____

If closed, was any indemnity payment or award made? Yes No If Yes, amount: _____

If open, what is the amount of loss reserve or damages sought? _____

Name of insurance company defending you: _____

Are you the primary target of the complaint? Yes No If No, who is? _____

Description of claim (Include type of treatment, result of treatment, your involvement):

CONVENTUS INTER-INSURANCE EXCHANGE
SUPPLEMENTAL PRIOR ACTS APPLICATION FOR PROFESSIONAL LIABILITY

IMPORTANT: Please read all of the following information carefully.
Should you have any questions, please contact Conventus or your agent prior to completing any information on this page.

- It is not the intent of *Conventus* Inter-Insurance Exchange to cover any incident. circumstance, act, error or omission of which you are currently aware which may reasonably be expected to result in a claim or suit.
- This information must be completed in its entirety before you can be considered for Prior Acts Coverage.
- A complete copy of all professional liability Declaration Pages and Endorsements for professional liability policies you maintained during the period for which you are requesting Prior Acts Coverage must accompany your application for coverage.
- In addition, you are eligible for Prior Acts Coverage only if you maintained continuous Claims Made Professional Liability Insurance, with your own limits of liability, during the entire requested Prior Acts Coverage Period.
- Prior Acts Coverage is optional and subject to separate underwriting approval. For your own protection, unless you are specifically notified by *Conventus* that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Reporting Endorsement Coverage ("tail" coverage) from your current carrier. Your agent is not authorized to bind prior acts coverage.

1. Name of Applicant: _____
2. Agent: _____
3. Name of Prior Carrier: _____
4. Retroactive date used by your prior carrier: _____
5. Did any previous policy(ies) carry any kind of deductible or self-insurance retention? Yes No

   If Yes, please describe and indicate amounts:
6. List all states where you have practiced or taught, and the years associated with these states since your earliest retroactive date (use separate sheet if necessary): _____
7. Please check all types of practices that applied during the period for which you are requesting prior acts:

   Sole Proprietor/unincorporated | Partnership | Employed Physician

   Professional Association/Corporation | Independent Contractor | Limited Liability Corp.

   a. Professional Association/Professional Corporation Prior Acts coverage desired? Yes No

   b. If so, was your PA/PC insured during the period you had prior acts? Yes No
8. In what specialties have you practiced during the period that you have requested prior acts? _____
9. Have you changed, added or deleted any aspects of your practice after your requested retroactive date? Yes No

   If Yes, please describe and indicate date(s): _____
10. Has coverage been continuously in force since the retroactive date you are requesting? Yes No
11. Any incident, circumstance, act, error, or omission, including a request for records, of which you are aware, must be reported to your current carrier.

All of the above information is true and correct to the best of my knowledge and belief. Any and all acts, incidents, and/or circumstances of which I am aware, and which might reasonably be expected to result in a claim, have been disclosed on this application.

NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT:_____