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

Office Address

Mailing Address (If Different)

Billing Address (If Different)

Office Phone | Office Fax | Email Address
Used to share Conventus related communication

Practice Contact Person | Practice Contact Person's Title

Practice Contact Phone | Practice Contact Fax | Practice Contact Email Address

Section II – Insurance Coverage Information

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

Policy type requested (check one) Claims-Made Policy ***Tail Coverage is not included*** Modified Claims-Made Policy -"Occurrence Type" ***Tail Coverage is included***

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

If you choose this option, your coverage will be changed. An endorsement will be attached to your policy giving the company the sole right to settle any claim they deem appropriate.

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

Requested effective date: _____ Requested retroactive date: _____

Is Coverage required for your practice entity name? Yes No

If yes, please complete the Supplemental Corporate Entity Application

Section III – Insurance Information: Current and Previous

Name of present insurance carrier: _____ Expiration Date: _____

Type of present policy (*Attach copy of declarations page from present policy*)

Occurrence Type (Modified Claims-made) Occurrence

Claims-made Tail Purchased? Yes No

List all carriers that have ever provided insurance: **This section must be completed**

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

Section IV - Medical Education and Training

Primary Specialty (please list all that apply): _____ % of practice _____

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

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

Are you Board Certified? Yes No

Have you ever been denied Board certification? Yes No

If yes, please provide details:_____

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 Education Council for Foreign Medical Graduates? Yes No

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

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:		

Section V – Scope and Nature of Practice or Employment

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

List all locations you currently work or will be working which will be covered under this policy.

Employer/Facility Name	Address	City	State	Phone	Hours worked per week*

*Including actual patient care and recording keeping, administrative duties, surgeries or assists, house calls, nursing home visits, utilization review and teaching

Do you practice anywhere that is covered by other insurance? Yes No

If yes, where? _____ *Please provide a copy of your COI*

Have there been any changes in your specialty classification, or practice activity within the past ten years? Yes No

Have you discontinued minor or major surgical procedures within the past ten years? Yes No

If yes, please describe: _____

If you indicated that your practice includes **Major Surgery**, please indicate the **percentage of procedures** that are applicable.
Total must equal 100%

%	Procedure	%	Procedure	%	Procedure
	Abdominal		Hand		Plastic – Cosmetic
	Bariatric		Head and Neck		Plastic – Reconstructive
	Cardiac		Neurosurgical		Thoracic
	Colon/Rectal		Ophthalmological		Traumatic/Emergency
	General		Orthopedic - including spinal surgery		Urologic
	Gynecologic		Orthopedic- without spinal surgery		Vascular

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

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

* *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.

Section VI – Medical Procedures

Do you perform any of the following services/procedures as a part of your practice?	Yes	No	If Yes, please describe
Procedures for which you did not receive training in your residency or that are outside the customary scope of practice for your specialty			
Perform surgery in your office?			
If Yes, is general anesthesia or IV conscious sedation administered for these (or any) office procedures?			
If Yes, by whom, and with what training?			
Do you (or your staff) perform any aesthetic and/or cosmetic procedures or employ or contract with anyone who does?			Complete the *Cosmetic Procedures Supplemental Application*
Provide Weight Control Medication services (e.g., GLP-1 Agonist, Semaglutide etc.)?			
Own, operate or have any legal affiliation with a Medi-Spa?			
Perform Bariatric Surgery?			Complete the *Bariatric Surgery Supplemental Application*
Practice Pain Management?			Complete the *Pain Management Supplemental Application*
Provide services via telemedicine/virtual care?			Complete the *Virtual Care Supplemental Application*

Please indicate if <u>you or your staff</u> perform the following procedures. **If You Do Not Perform Any of These Procedures, Initial Here _____**

Please indicate which of the following procedures, techniques or practices you perform or are contemplating performing for which you are requesting coverage.

	Addiction Medicine		Circumcision (Adult)		IV Hydration Therapy/Infusions		PRP Treatments
	- Suboxone Therapy		Circumcision (Pediatric)		Ketamine Administration (treat depression)		Sclerotherapy
	Angiograms		Closed reduction of fracture		Laparoscopy		Tendon repair
	Adenoidectomy		Cryotherapy and LEEPs		Myringotomy		Tonsillectomy
	Analgesia, IV Conscious Sedation		Endoscopic Procedures		Nasal polypectomy		Trigger Point injections
	Anesthesia (Spinal)		Hemorrhoidectomy		Non-Surgical Fat Reduction		Vein Stripping

CARDIOLOGY **If You Do Not Perform Any of These Procedures, Initial Here _____**

	Cardiac Catheterization		Coronary Angiography		Coronary Angioplasty/Stents		Other

OBSTETRICS AND GYNECOLOGY **If You Do Not Perform Any of These Procedures, Initial Here _____**

Do you limit practice to gynecology?		If yes, Is your practice strictly hospital-based?	
How many deliveries do you perform annually?			
Do you perform Pregnancy Terminations		If yes, how many annually?	

OPHTHALMOLOGY **If You Do Not Perform Any of These Procedures, Initial Here _____**

	Medical Treatment Only		All Surgical Procedures
	Limited Surgical procedures – including: Assisting in Surgery; Laser Irdoplasty or Iridtomy; Laser Trabeculoplasty; Laser Ablation; Laser Capsulotomy; Laser Punctal Closure; Other		

List any procedures you perform in an office setting, which you are not privileged to perform in a hospital:

_____

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

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

Do you admit patients to any of the above hospitals? Yes No

If no, please explain your protocols on admitting patients to a hospital if the circumstances would arise?

Explanation:_____

Section VII – Practice and Procedures: General Questions

Yes	No	Do you:
		Work in an emergency room (ER) and/or are you on call at the hospital or ER?
		– If Yes, how many hours on average per week
		Serve as a collaborating physician with a qualified nursing professional?
		– If yes, please describe the extent of this practice, including number of nurses involved, and if the nurses are working within your practice location. – Attach copies of the Joint Protocols that you have in place with these individuals.
		Practice or provide care in a nursing home facility?
		– If yes where? – And what % of your practice is devoted to this activity
		Practice as a Medical Director?
		– If yes, where and do you have separate coverage for this activity?
		Participate as a principal investigator for clinical trials?
		– If yes, do you follow FDA approval protocols?

Section VIII – Professional History

If you answer Yes to any of the questions below, please explain on a separate sheet, and provide full documentation from any agency involved.

Yes	No	
		Are you in military service or employed full-time by the federal government?
		Has any health care facility ever denied, restricted, suspended, or revoked privileges or has probation been invoked?
		Has any state ever refused you a license to practice medicine?
		Has any state ever restricted, suspended, or revoked your license to practice medicine?
		Have you ever voluntarily surrendered a license to practice medicine?
		Has any state ever placed you on probation or restricted your practice?
		To your knowledge, has your license to practice ever been under investigation?
		Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended, or revoked, voluntarily or otherwise?
		Are you currently registered with the New Jersey Prescription Monitoring Program pursuant to NJAC 13:45A-35.9.
		If no, explain why you are not registered.
		If yes, do you have authorized staff for which you have delegatory authority?
		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?
		Are you currently or have you ever been treated for, alcoholism or substance abuse?
		Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?
		Has your professional liability coverage ever been cancelled, restricted, non-renewed, or have you withdrawn an application for insurance to avoid declination?
		Have you ever practiced without insurance?
		Has coverage for professional liability ever been refused, or accepted under special terms?
		Has a complaint against you ever been submitted to the Board of Medical Examiners or Regulatory authority?
		Have you ever been accused of sexual misconduct of any kind?
		Have you ever been indited for, charged with or convicted of any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?

Section IX – Claims Loss Information

For any **Yes** answers, please complete the supplemental claim information form or provide details.

Yes	No	
		In the last 10 years, have you ever been involved in a claim or suit arising out of the rendering or failure to render professional services?
		Are you aware of any complication, incident, or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes, but is not limited to the following: Amputation, Death, Loss of Major Organ Function, Loss of Vision, Permanent Neurological Injury
		In the last 12 months, have you received a written request from an attorney for the treatment records concerning any current or former patient(s) that might reasonably result in a claim or suit?
		Have all claims, suits, written requests, and incidents that would qualify in the questions above, been reported to your current insurance carrier?

Section X- 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.