THE DOCTORS COMPANY
American Physicians

THE DOCTORS COMPANY/AMERICAN PHYSICIANS

Michigan Office: 1301 N. Hagadorn Road, P.O. Box 1471, East Lansing, MI 48826-1471, 1-800-748-0465
New Mexico Office: 7770 Jefferson St., NE, Suite 410, Albuquerque, NM 87109-4368, 1-800-880-9485

Application for Physicians and Surgeons Professional Liability Insurance

American Physicians Policy No.:_____
(Leave blank if you do not currently have your professional liability insurance with American Physicians.)

FOR AMERICAN PHYSICIANS USE ONLY
CLIENT NO: **APP ID:**
ACN NO:

Agency Name: _____ **Agency Code:** _____

Address: _____

Agency Phone: (____)_____ **Agent or Representative:** _____

Please type or legibly print your responses in full. Supplement this application with responses to questions requiring more room than contained in this form and submit copies of all documents requested on the last page of this application.

1. Name (First, Middle, Last):		2. ☐ MD ☐ DO
3. Social Security Number (Last 4 digits only):	4. Date of Birth:	5. ☐ Male ☐ Female
6a. Physician's E-mail Address:	6b. Website Address:	

7a. Current Medical Specialty: _____
Board Certified? ☐ Yes ☐ No Certification Date: _____ Board Eligible? ☐ Yes ☐ No

7b. Name of Certification Board: _____
If not Board Certified or Board Eligible please explain on a separate sheet and attach to this application.

8a. Medical Subspecialty: _____
Board Certified? ☐ Yes ☐ No Certification Date: _____ Board Eligible? ☐ Yes ☐ No

8b. Name of Certification Board: _____
If not Board Certified or Board Eligible please explain on a separate sheet and attach to this application.

9a. **Mailing Address**:

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )
Business manager/contact person:		Telephone: ( )

9b. **Principal Office Address:** (If different than mailing address)

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )
Kentucky residents only: Is this address within city limits? ☐ Yes ☐ No		

9c. **Residence Address:** (If different than mailing address)

Street:		
City/State/Zip:		
County:	Residence Telephone: ( )	Residence Fax: ( )

9d. **Additional Offices: (Please attach a separate sheet for additional office locations.)**

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )

10. Type of coverage requested: **TO AVOID ANY GAPS IN THIS IMPORTANT INSURANCE COVERAGE, PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE ABOUT THE DIFFERENCES IN THESE INSURANCE FORMS.**

☐ Claims-made **(Not available in all states)** Covers incidents that take place and are reported during the policy period, which begins with the retroactive date.	☐ Occurrence **(Not available in all states)** Covers incidents that take place during the policy period regardless of when reported as a claim.
☐ TailGard® **(Not available in all states)** Claims-made coverage with a pre-paid reporting period extension.	

11. Requested limits of insurance: **NOT ALL OF THE LIMITS LISTED BELOW ARE AVAILABLE IN ALL STATES. PLEASE CONSULT YOUR AMERICAN PHYSICANS AGENT OR OTHER REPRESENTATIVE FOR DETAILS.**

☐ $100,000 per incident/$300,000 policy aggregate
☐ $200,000 per incident/$600,000 policy aggregate
☐ $250,000 per incident/$750,000 policy aggregate
☐ $300,000 per incident/$900,000 policy aggregate
☐ $500,000 per incident/$1,000,000 policy aggregate
☐ $500,000 per incident/$1,500,000 policy aggregate
☐ $1,000,000 per incident/$3,000,000 policy aggregate
☐ Other: $_____ per incident
$_____ policy aggregate

12. Requested effective date (12:01 a.m.): _____

Requested retroactive date (12:01 a.m.): _____

A "retroactive date" is applicable for "Claims-made" coverage only. Claims-made coverage is limited to claims which are first made while the insurance is in force and which arise out of professional incidents that first occur on or after the retroactive date.

13. List all states where you are licensed (attach a sheet of paper if additional space is needed):

State	License Number	Average number of hours per week per state

14. Narcotics Drug Enforcement Agency Number: _____

15. List all hospitals and surgicenters where you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each. If none, please explain on a separate sheet of paper and attach it to this application.

Name	City	County	State	% of Admissions

16. List all medical societies, medical associations, or other related professional societies, to which you belong:

17. Name of medical school(s):

Medical School	City	State/Country	Graduation Date

If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates?
☐ Yes – Date Certified: _____ ☐ No – Explain on a separate sheet.

18. List all internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Mo./Yr. Completed
Served internship at:		
Served residency at:		
Served fellowship at:		

19. Please indicate below your best estimate of the **NUMBER** of the following procedures you expect to perform, or in which you will participate, within the next year, beginning with the date of your requested coverage:

_____ Abortion – first trimester
_____ Abortion – after first trimester
_____ Acupuncture
_____ "Alternative medicine" or "complementary medicine" procedures (as viewed by most physicians) Please describe:_____
_____
_____
_____ Amniocentesis
Anesthesia:
_____ General
_____ Epidural
_____ Spinal
_____ Other – Please describe:_____
_____
_____ Angiography/Angioplasty
_____ Arteriography
_____ Assisting in major surgery – own patients
_____ Assisting in major surgery – other than own patients
Bariatric procedures:
_____ Gastric banding
_____ Gastric bypass
_____ Gastric stapling
_____ Breast implants and/or reduction
_____ Bronchoscopy
_____ Blepharoplasty
_____ Brachytherapy
Catheterization:
_____ Cardiac ☐ Right Heart ☐ Left Heart
_____ Arterial
_____ Urinary
_____ Other – Please describe:_____
_____
_____ Chelation therapy
_____ Cholangiogram
_____ Cholecystectomy
_____ Circumcision
_____ Colonoscopy
_____ Cryosurgery – Please describe:
_____
_____ Cystoscopy
_____ D & Cs
_____ Deliveries: Home_____ Hospital_____
_____ Deliveries - Vaginal
_____ Deliveries - Cesarean
_____ Deliveries - Vaginal Birth after Cesarean (VBAC)
Dermatological procedures
_____ Botox injection
_____ Chemical peels
_____ Chemabrasion
_____ MOHS surgery
_____ Dermabrasion
_____ Fat transfer
_____ Hair transplant
_____ Laser hair removal
_____ Laser skin resurfacing
_____ Microdermabrasion
_____ Silicone injection
_____ Tattoo removal

_____ Discograms
_____ Electromyography
_____ Endoscopy (other than proctoscopy or sigmoidoscopy)
Please describe: _____
_____
_____ Endoscopic Retrograde Cholangiopancreatography-ERCP
_____ Eyeliner pigmentation
_____ Fluoroscopy
_____ Fracture reductions – closed
_____ Fracture reductions – open
_____ Gastroscopy
Hemorrhoidectomy:
_____ Internal Hemorrhoidectomy
_____ External Hemorrhoidectomy
_____ Hysterectomy
_____ Intravenous Pyelogram (IVP)
_____ Laparoscopy- Please describe: _____
_____
_____ Laser surgery – Other – Please describe:_____
_____
_____ Liposuction
_____ Lumbar puncture
_____ Mesotherapy
_____ Myelography
_____ Ophthalmology – Invasive procedures involving the eye
_____ Pacemaker insertion
Pain management:
_____ Cordotomy
_____ Dorsal root gangliotomy
_____ Facet blocks
_____ Medication only
_____ Nerve root blocks
_____ Pump implantation
_____ Sphenopalatine lesioning
_____ Spinal injections
_____ Thoracic sympathectomy
_____ Trigeminal lesioning
_____ Penile implants
_____ Polyp removal
_____ Pre-natal care:
☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester
_____ Prolotherapy
_____ Radial keratotomy (Lasik Surgery)
_____ Radiation oncology
_____ Sclerotherapy: ☐ Surface veins ☐ Deep veins
_____ Shock therapy (ECT)
_____ Thoracentesis
_____ Threadlifts
_____ Tonsillectomy
_____ Total joint replacement
_____ Tubal ligations
_____ Vasectomy
_____ Venography
_____ Weight control by means other than diet or exercise
Please describe:_____

_____ **I DO NOT PERFORM ANY OF THESE PROCEDURES**

20. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of surgery:

_____ Abdominal	_____ Neurosurgical
_____ Bariatric	_____ Obstetrical
_____ Cardiac	_____ Ophthalmological
_____ Cardiovascular disease	_____ Orthopedic – including spinal surgery
_____ Colon/rectal	_____ Orthopedic – without spinal surgery
_____ Emergency Medicine	_____ Otolaryngological
_____ Gastroenterology	_____ Plastic – cosmetic
_____ General	_____ Plastic – reconstructive
_____ Gynecologic	_____ Thoracic
_____ Hand	_____ Traumatic
_____ Head and Neck	_____ Urologic
_____ Neonatology / Pediatrics	_____ Vascular

21. Please describe and provide dates for any major changes in your practice in the last ten years (such as changes of specialty or significant procedures initiated or no longer performed):

22a. List all practice locations within the ten years prior to this application, with the current or most recent first:

Name	City/State	Dates at Location	Type of Practice

22b. Do you practice as a hospitalist? ☐ Yes ☐ No

If yes, please explain: _____

_____

In responding to questions 23 through 44c, please explain any "yes" response and/or provide any required explanation or details on supplementary pages and attach to this application.

23. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society? ☐ Yes ☐ No

24a. Has any licensing authority ever refused you a license to practice medicine? ☐ Yes ☐ No

24b. Has any licensing authority ever restricted, suspended or revoked your license to practice medicine? ☐ Yes ☐ No

24c. Have you ever voluntarily surrendered a license to practice medicine? ☐ Yes ☐ No

24d. Has any licensing authority ever placed you on probation or restricted your practice? ☐ Yes ☐ No

24e. To your knowledge, is your license to practice currently under investigation? ☐ Yes ☐ No

25. Has any hospital or health care institution ever denied, restricted, reduced, or suspended your privileges or invoked probation? ☐ Yes ☐ No

26. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? ☐ Yes ☐ No

27. Are you now being, or have you ever been, treated for or suffered from, alcoholism, chemical dependency or a mental disorder or mental illness? ☐ Yes ☐ No

28. 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

29. Have you ever been convicted of, or are you currently under investigation for, a crime other than a routine civil traffic offense? ☐ Yes ☐ No

30. Have you ever been refused board certification? ☐ Yes ☐ No

31a. Have you ever had medical professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or has renewal been refused or not offered? ☐ Yes ☐ No

31b. To your knowledge has any medical professional liability insurer ever considered such an action against you or is any such action against you currently being considered? ☐ Yes ☐ No

32. Do you intend to carry or do you currently carry any other medical professional liability insurance from any other insurer while this insurance is in effect? ☐ Yes ☐ No

If yes, please attach proof of coverage from the other insurer and explain.

33a. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office? If yes, attach explanation. ☐ Yes ☐ No

33b. Are you a medical director of any nursing home, health care facility or business enterprise providing medical services? If so, indicate name: _____ ☐ Yes ☐ No

33c. Do you treat nursing home patients? ☐ Yes ☐ No

33d. Do you treat other than your own patients at the nursing home? ☐ Yes ☐ No

33e. How many nursing home patients, on average, do you treat per month? _____

34. Are you an employee of, or do you perform contract work for, any government agency? ☐ Yes ☐ No

35. Are you a sports team physician for any college, university or professional team? ☐ Yes ☐ No

36. Do you participate in any pharmaceutical testing programs? ☐ Yes ☐ No
If yes, is it (are they) FDA-approved? ☐ Yes ☐ No

37. Do you treat or review treatment for jail or prison inmates? ☐ Yes ☐ No
If yes, provide details on a separate sheet as to where and how often inmates are treated.
If coverage is currently provided by another carrier, please provide evidence of that coverage.

38. Do you engage in any "moonlighting" activity apart from your practice? ☐ Yes ☐ No
If yes, explain on a separate sheet of paper and attach to this application.

39. Do you work in an emergency room? ☐ Yes ☐ No
If yes, how many hours on average per week: _____
If yes, for what institution? _____
If yes, are you covered by other insurance for the emergency room work? ☐ Yes ☐ No
If coverage is currently provided by another carrier, please provide evidence of that coverage.

40. If you are not a radiologist:
a. Do you take and/or interpret your own X-rays or perform other imaging procedures? ☐ Yes ☐ No
b. If yes, estimated number per year: _____
c. Does a radiologist over-read your X-rays? ☐ Yes ☐ No

41a. Do you perform surgery in your office? ☐ Yes ☐ No
(Surgery other than incision of boils and superficial abscesses or suturing of skin or superficial fascia.)
If yes, please list the specific procedures: _____
_____

41b. Is general anesthesia administered for these (or any) office procedures (i.e. MRI, etc.)? ☐ Yes ☐ No
If yes, by whom: _____
With what training/qualifications? _____
_____

41c. What specific emergency equipment do you have available in your office? _____

_____

41d. How far is this office location from the nearest hospital with emergency services? _____

41e. Do you have privileges at the nearest hospital with emergency services? ☐ Yes ☐ No

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42a. Do you perform invasive pain management procedures? ☐ Yes ☐ No
If yes, please list the procedures you perform:

In your office: _____

In a hospital: _____

42b. If you are not an anesthesiologist, attach evidence of training, seminars and/or continuing education on those procedures you perform.

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43. Do you practice medicine in any internet or telemedicine program? ☐ Yes ☐ No

If yes, for what state(s)? _____

Do you hold a current medical license for each state? ☐ Yes ☐ No

Attach a copy of your license for each state.

44a. Does your practice have:

- A formal procedure of contacting patients if they are "no shows" or cancellations? ☐ Yes ☐ No
- A system to track that patients are informed of test results? ☐ Yes ☐ No
- A system for monitoring patient compliance/non-compliance? ☐ Yes ☐ No
- A system to ensure patient follow-up with consultations and referrals to other health care practitioners? ☐ Yes ☐ No
- A written policy delineating necessary documentation for dispensing sample medication? ☐ Yes ☐ No
- A policy to ensure that clinical advice is given **only** by physicians, nurse practitioners and/or physician assistants? ☐ Yes ☐ No
- A policy to document all telephone calls in the medical record? ☐ Yes ☐ No

44b. Is (are) the physician(s) involved in the informed consent discussion with patients regarding the risks and benefits of procedures and treatment options? ☐ Yes ☐ No

If yes, are consent discussions documented in the medical record? ☐ Yes ☐ No

44c. Are after-hours calls documented in the medical record? ☐ Yes ☐ No

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45. Average number of patients per week:

46. Average number of hours practiced per week: (Including on call, charting, teaching, phone consultations, etc.)

47a. Please advise your relationship with a Medical Corporation / Professional Organization as one of the following:

☐ Solo Practitioner (Incorporated) ☐ Employee ☐ Other _____

☐ Solo Practitioner (**NOT** Incorporated) ☐ Independent Contractor

47b. Please give COMPLETE CORPORATION / PROFESSIONAL ORGANIZATION NAME and **attach a copy of the Articles of Incorporation and Office Letterhead**.

Name:_____ Federal ID Number:_____

47c. Number of physicians working at this Corporation / Professional Organization:_____

47d. List all physicians at the Corporation / Professional Organization:_____

_____

_____

_____

_____

47e. Does this Corporation / Professional Organization currently carry separate medical professional liability insurance? ☐ Yes ☐ No

If yes, please attach a copy of the current declarations page.

If no, a professional organization application is required. **Please consult your American Physicians agent or other representative for details.**

47f. Do you as an individual, or your solo professional organization or medical corporation, practice under any other name, such as an "assumed name" (AKA) or "Doing Business As" (DBA)? Attach a sheet of paper if additional space is needed. ☐ Yes ☐ No

Dates Used	Name

48a. Indicate number of the following healthcare providers that you employ (include independent contractors): ☐ None

Specialty

_____ Chiropractor
_____ Nurse Anesthetist
_____ Nurse Midwife
_____ Nurse Practitioner
_____ Perfusionist
_____ Physician Assistant
_____ Podiatrist – Including Surgery
_____ Podiatrist – No Surgery
_____ Psychologist
_____ Surgical Assistant

48b. Do you want to share your limit of liability with the healthcare providers listed in 48a above? ☐ Yes ☐ No

If yes, an additional shared limits charge will be made. **Shared limits are not available in IN, NM, or WI.**

If no, an additional vicarious charge will be made. Please attach a copy of the healthcare providers' separate insurance declarations sheet. If proof of current coverage is not provided a shared limits charge will be made.

48c. Do any of the healthcare providers above want a separate limit of liability? ☐ Yes ☐ No
If yes, a separate Healthcare Providers application must be submitted.

49. Indicate number of the following healthcare providers that you employ (include independent contractors): ☐ None

Specialty

_____ Athletic Trainer
_____ EMT - Paramedic
_____ Nurse
_____ Operating Room Assistant
_____ Ophthalmology Assistant
_____ Optician
_____ Optometrist
_____ Pathology Assistant
_____ Physical Therapist
_____ Physical Therapist Assistant
_____ Social Worker
_____ X-Ray Technician
_____ Other – Please describe:_____

PLEASE NOTE: Separate limits are ONLY available in IN and MI for healthcare providers listed in question 49 above. A separate Healthcare Providers application must be submitted in IN and MI for Healthcare Providers wanting a separate limit of liability. The healthcare provider must have the same coverage form and the limit of liability must be the same or higher than the professional organization.

50. Do you supervise any healthcare providers other than those employed at your practice? ☐ Yes ☐ No

If yes, please list facility, specialty and number supervised:_____

_____

51. Do you supervise any residents or interns in your office? ☐ Yes ☐ No

If yes, please describe: _____

_____

52. Beginning with your most recent or current insurer, please list **ALL** current and prior medical professional liability insurers. Please explain any gaps in the continuity of your professional liability coverage. Attach a sheet of paper if additional space is needed.

Name of Insurer	Coverage Type (Claims-made or Occurrence)	Policy Number	Policy Period

53. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer? ☐ Yes ☐ No

Please provide a copy of the declarations page of your current coverage and any reporting period extension ("tail").

54. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation, or partnership to which you currently belong or have belonged to in the past? ☐ Yes ☐ No

If yes, has such incident(s) been reported to a prior professional liability insurer and has that insurer acknowledged coverage for the incident(s)? ☐ Yes ☐ No

Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.

55. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or persons for whom you are responsible, or any professional association, corporation, or partnership to which you currently belong or have belonged to in the past, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim? ☐ Yes ☐ No

If yes, has this (these) incident(s) been reported to a prior insurer? ☐ Yes ☐ No

Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OF A MATERIAL NATURE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO IMPRISONMENT, FINES, AND DENIAL OF INSURANCE.

APPLICANT'S REPRESENTATIONS, WARRANTIES AND AUTHORIZATION

I understand that no coverage will be bound until after American Physicians Assurance Corporation has reviewed this completed application and formally bound the requested coverage. Acceptance of payment is not an expression of American Physicians Assurance Corporation's intent to provide coverage. If coverage is declined by American Physicians Assurance Corporation, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage or retroactive coverage on my professional liability policy, such coverage will apply only to liability arising out of an occurrence which happened prior to the effective date of the policy and subsequent to the retroactive date of the policy for which I am applying.

It is agreed that no insurance will be provided for:

1. any claim which has been reported to another insurance carrier prior to the effective date;
2. any claim known to the insured at the effective date which has not been reported to a prior carrier;
3. any claim that may arise out of an incident which has been reported to another insurance carrier prior to the effective date;
4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.

I specifically represent and warrant to the insurer that 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 acceptance of the risks described to the underwriter in this application. I understand and acknowledge that this completed application shall be considered an integral part of any insurance policy issued to me by the insurer. I further agree that any false or misleading statement(s) in this application shall be grounds for the insurer to cancel and void coverage at its sole and absolute discretion.

I authorize the release of any underwriting and/or claim information (and release from any and all liability for the provision of information) from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals or health care institutions, to American Physicians Assurance Corporation and its subsidiaries or agents.

I agree to cooperate with the Risk Management Department of American Physicians Assurance Corporation, and its subsidiaries or agents, and to support their efforts to enhance quality of patient care.

_____ _____

Signature Title Date

ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer, _____, both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to: American Physicians Assurance Corporation

Initial Here: ☐

Please attach:

- ☐ Copy of current/most relevant medical license(s)
- ☐ Copy of board certification
- ☐ Curriculum vitae
- ☐ Copy of current declarations page
- ☐ Supplemental Claim Information Form for each claim, regardless of outcome
- ☐ Copy of letterhead or sample billing statement
- ☐ Current loss runs from previous carrier(s)
- ☐ Communication Skills Assessment, if applicable
- ☐ Articles of Incorporation
- ☐ Radiological Supplement, if applicable
- ☐ Supplemental Information Form for VBAC's, if applicable