

Physicians and Surgeons Professional Liability Application

Please remember to attach a copy of the following with the application:

- Your current Declarations Page
- A current curriculum vitae (CV) for each physician
- Loss runs from all carriers for the previous 5 years or since the start of the practice, whichever is greater, if losses were noted in Section J.
- A list of all past claims. Please complete PSIC Claim Information Form as necessary
- Additional Supplements as indicated throughout the application

A. APPLICANT INFORMATION

Name: _____
First Name Middle Last Name

Male Female Social Security No: _____ Date of Birth: _____
MO/DAY/YR

Contact Person/Insured's Representative: _____
First Name Middle Last Name

Office Phone: _____ Office Fax: _____

Email Address: _____ Website Address: _____
Your email address will never be sold. It will be used to send you important messages.

Primary Practice Location: _____ % of Practice
Street City State Zip County (all locations must total 100%)

Do you have additional Practice Location(s)? Yes No

If yes: _____ % of Practice
Street City State Zip County (all locations must total 100%)

Mailing/Billing: Primary Practice Location
 Address Other: _____
Street City State Zip

IF MORE ROOM IS NEEDED FOR PRACTICE LOCATIONS, PLEASE USE THE LAST PAGE OF THIS APPLICATION.

B. COVERAGE INFORMATION

1. Desired effective date: _____ (policy issued annually)
MO/DAY/YR

2. Select requested coverage:

Claims Made Coverage **with** Prior Acts
 Desired Retroactive Date: _____
MO/DAY/YR

The retroactive date is the date first continuously insured under a Claims Made policy. Please contact your agent should you have any questions pertaining to Claims Made coverage or the need for Prior Acts coverage.

Occurrence
*I realize that if I switch from a Claims Made to an Occurrence policy, my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of **professional services** rendered while insured by my current carrier's claims made policy. I understand the policy I am purchasing will not provide prior acts coverage.*

Claims Made Coverage without Prior Acts

Claims Made Coverage with Pre-Paid Tail (OK and MI only):

(If you choose Claims Made Coverage without Prior Acts or Claims Made Coverage with Pre-Paid tail select one below.)

Prior coverage written on an Occurrence basis
 Prior coverage written on a Pre-Paid Tail basis
 An extended reporting endorsement **has** been purchased
*I realize that my failure to purchase an extended reporting endorsement from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of **professional services** rendered while insured by my current carrier's claims-made policy. I understand the policy I am purchasing will not provide prior acts coverage. By checking this box, I verify the above:*

D. PRACTICE LOCATION(S) (continued)

2. Do you perform surgical procedures at a surgical center, office-based suite, or similar facility? Yes No
3. Do you have a full ACLS Resuscitation cart in your office? Yes No
4. Do you use an electronic health recordkeeping system? Yes No
5. Do you staff an emergency room? Yes No
If yes, is this to maintain hospital privileges? Yes No
How many hours in emergency medicine per month? _____ Hours
6. Do you have medical staff or courtesy privileges at any healthcare facilities? Yes No
If yes, provide the following information:

Facility Name	City	State	County	Activities at this location	%
Facility Name	City	State	County	Activities at this location	%

If no, please provide details regarding your patients who require hospital care including the names and practice locations of all physicians who will follow them while hospitalized. If extra space is needed, please attach additional sheets.

E. PRACTICE INFORMATION

1. Employment Status: Employee Independent Contractor Solo Unincorporated/Sole Proprietor
 Shareholder/Partner Other: _____
- If Employee or Independent Contractor, complete this section:*
Name of Employer: _____ *Name of Contractee:* _____
2. Entity Type: Solo Incorporated – No employee or contracted physicians Partnership/LLC
 Multi-Shareholder Corporation Other: _____
- Name of Partnership or Solo/Multi-Shareholder Corporation:* _____
If Partnership, Multi-Shareholder Corporation or other, complete this section:
Name of partner(s) or other members: _____
3. Do you desire coverage for this entity? Yes No
If yes, do you desire shared or separate limits of liability? Shared Separate
If separate, please complete and submit the Corporate and Partnership Professional Liability Application (PSIC-MDAPP-02).
4. Does your entity include a surgicenter, laboratory or other freestanding facility? _____ Yes No
If yes, explain: _____
5. What percentage of your revenue is from the following sources?:
 _____ % Government Programs (Medicaid, Medicare, Health Exchanges)
 _____ % Indemnity/Private Insurance Plans

F. MEDICAL PERSONNEL

1. Do you as an individual employ any physicians or surgeons? Yes No
If yes, please complete the following:

Name	Specialty	Surgery Performed (check one)	Independent Contractor?
		<input type="checkbox"/> None <input type="checkbox"/> Minor <input type="checkbox"/> Major	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> None <input type="checkbox"/> Minor <input type="checkbox"/> Major	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> None <input type="checkbox"/> Minor <input type="checkbox"/> Major	<input type="checkbox"/> Yes <input type="checkbox"/> No

F. MEDICAL PERSONNEL (continued)

2. Do you employ or contract with any mid-level providers (PA, NP, CRNA, CNM, CNS, etc.)? Yes No
 If yes, please complete the following:

Name	Designation/ Specialty	Supervision	Independent Contractor?	Coverage Desired?	FT/PT
		<input type="checkbox"/> Direct <input type="checkbox"/> Indirect*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> FT <input type="checkbox"/> PT
		<input type="checkbox"/> Direct <input type="checkbox"/> Indirect*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> FT <input type="checkbox"/> PT
		<input type="checkbox"/> Direct <input type="checkbox"/> Indirect*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> FT <input type="checkbox"/> PT

*If indirect supervision, please submit a copy of protocols and physician supervision agreement.

If coverage is desired, please complete and submit either the **CRNA/AA Roster Addendum (PSIC-MDAPP-06)** or the **Nurse Practitioner/Physician Assistant Supplemental Questionnaire (NFL 9688)**.

3. Do you employ any ancillary healthcare providers? (RN, LPN, Medical Assistant, etc.) Yes No

G. PRACTICE ACTIVITIES

1. Primary medical specialty: _____ % of practice: _____
2. Do you have a secondary medical specialty? Yes No
 If yes, please list: _____ % of practice: _____

3. Select one of the following as applicable:

- No Surgery** – This does include incision of boils and superficial abscesses, suturing of skin or superficial fascia, as well as the removal of superficial growths.
- Minor Surgery** – Activities not considered major surgery, but which surgically penetrate the body cavity and/or surgically penetrate beneath the epidermis. (Catheterizations, tonsillectomies and vasectomies are considered minor surgery.)
- Major Surgery** – Includes operations in or upon any body cavity such as the cranium, thorax, abdomen or pelvis. Also includes other operations that present a distinct hazard to life, due to the condition of the patient, length of the operation or the circumstances involved. Also includes removal of tumors, open bone fractures and operations done under general anesthesia.
- Assisting in Major Surgery** – Average hours per month assisting on own patients: _____ hours
 Average hours per month assisting on patients of others: _____ hours

4. Are you a Surgeon? Yes No
 If yes, please provide the percentage of time devoted to the following surgical activities per year:

Abdominal _____	Hand _____	Otorhinolaryngology (incl. plastic) _____
Bariatrics* _____	Head and Neck _____	Otorhinolaryngology (no plastic) _____
Bariatrics (Assist) _____	Neurology _____	Plastic _____
Cardiac _____	Ophthalmology _____	Thoracic _____
Colon and rectal _____	Organ Transplant _____	Traumatic _____
General _____	Orthopedic (incl. spinal) _____	Urology _____
Gynecology _____	Orthopedic (no spinal) _____	Vascular _____

*If performing Bariatrics, please complete and submit the **Bariatrics Supplemental Application (NFL 9630-182206)**.

5. Identify the medical activities/procedures that you perform by indicating the number per month:

Elective Abortions _____	D&C _____	Cordotomies _____
Acupuncture _____	Dermatopathology _____	Dorsal Root Gangliotomies _____
Anesthesia: _____	Echocardiography _____	Facet Blocks _____
Spinal _____	Electrocardiography _____	Implantation/Removal of _____
Caudal _____	Endoscopic Laser Therapy _____	Drug Infusion Pumps _____
General _____	Endoscopy (other than Proctoscopy, _____	Rhizotomy _____
Local _____	Sigmoidoscopy, Colposcopy _____	Select Nerve Root Blocks _____
Angiography _____	and Cystoscopy) _____	Sphenopalatine Lesioning _____
Angioplasty _____	ERCP/EGD/ERC _____	Spinal Cord Stimulators _____
Appendectomy _____		Spinal Injections _____

G. PRACTICE ACTIVITIES (continued)

Arteriography _____	Exchange Transfusions _____	Osteopathic Manipulative _____
Arthroscopy _____	In Newborns _____	Medicine _____
Biopsies: _____	Fertility Treatment _____	Thoracic _____
Breast _____	Fluoroscopy _____	Sympathectomies _____
Core Needle _____	Fracture Reductions: _____	Trigeminal Lesioning _____
Endoscopic/Punch _____	Open _____	Trigger Point Injections _____
Excisional _____	Closed _____	Pedicle Screws for _____
Blepharoplasty _____	Gastroscopy _____	Spinal Surgery _____
Breast Implants: _____	Hemorrhoidectomy _____	Percutaneous _____
Cosmetic _____	Hernia Repair _____	Vertebroplasty _____
Reconstructive _____	Hip Nailings _____	Permanent Pacemaker _____
Bronchoscopy _____	Hospitalist Activities _____	Polypectomy _____
Cardiac Catheterization _____	Hyperbaric Medicine _____	Prenatal Care _____
Chelation Therapy (other than heavy _____	Hysterectomy _____	Prolotherapy _____
metal poisoning) _____	Hysteroscopy _____	Radiation/X-ray Therapy _____
Chemonucleolysis _____	Intensive Care Activities _____	Radiopaque Dye _____
Cholecystectomy _____	Intensive Care for _____	Roux-en-y _____
Cholecystectomy, _____	Newborns within a _____	Sclerotherapy _____
Laparoscopic _____	Tertiary Care Unit _____	Scoliosis Surgery _____
Circumcision (other than newborns) _____	Laminectomy _____	Sigmoidoscopy >60 cm _____
Colonoscopy _____	Laparoscopy _____	Thyroidectomy _____
Colposcopy _____	Laser Surgery _____	Tonsillectomy/ _____
Cryosurgery (other than _____	Liposuction < 3,500 cc _____	Adenoidectomy _____
external lesions) _____	Liposuction > 3,500 cc _____	Transgender Surgery _____
Botox injections _____	Lithotripsy _____	and/or Hormonal Gender _____
Chemical peels _____	Lumbar Fusion _____	Conversion _____
Chemabrasion _____	Mammography _____	Tubal Ligation _____
Collagen Injections _____	Maternal Fetal Medicine _____	Vasectomy _____
Cryosurgery (superficial only) _____	Activities _____	Bariatric Bypass _____
Dermabrasion _____	Myelography _____	Gastric Bubble _____
Eye liner Pigmentation _____	Myomectomy _____	Gastric Stapling _____
Fat Transfer _____	Neonatology _____	Medications prescribed _____
Hair Transplants _____	Norplant Insertion/ _____	(please list): _____
Laser Hair Removal _____	Extraction _____	_____
Laser Skin Resurfacing _____	Obstetrics _____	_____
Lipodissolve _____	Vaginal deliveries _____	_____
Mesotherapy _____	C-sections _____	Other _____
Microdermabrasion _____	C-sections (Assist) _____	_____
Silicone Injections _____	<input type="checkbox"/> Own Patient or <input type="checkbox"/> Others _____	_____
Tumescent Liposuction _____	VBACs _____	_____
	<input type="checkbox"/> Own Patient or <input type="checkbox"/> Others _____	

6. Do you perform any procedures or practice activities not routinely performed by other physicians in your specialty or subspecialty? Yes No
If yes, explain: _____
7. Have there been any changes in your specialty or practice activities within the past 5 years? Yes No
If yes, explain: _____
8. Are you entering practice for the first time? Yes No
9. How many hours per week do you work? _____ Number of patients seen per week? _____

IF MORE SPACE IS NEEDED FOR EXPLANATIONS, PLEASE USE THE LAST PAGE OF THIS APPLICATION.

H. ANCILLARY PRACTICE ACTIVITIES

1. Do you hold a full-time teaching appointment with regular clinical supervision responsibilities? Yes No
If yes, what percentage of your activities is devoted to clinical supervision? _____%
2. Do you review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? Yes No
If yes, what percentage of your practice is devoted to these activities? _____%
3. Do you practice Home Health Care? Yes No
If yes, please complete and submit the Home Health Care Supplemental Application (NFL 9712).

H. ANCILLARY PRACTICE ACTIVITIES (continued)

4. Do you or your employees provide clinical or administrative services to any nursing home, skilled nursing facility, assisted living center, hospice or similar facility, including any mobile healthcare facilities?..... Yes No
 If yes, what percentage of your practice is devoted to these activities? _____ %
 If yes, do you treat patients other than your own? Yes No
5. Do you provide professional services or review treatment of any professional athletes? Yes No
 If yes, what percentage of your practice is devoted to these activities? _____ %
6. Do you have any medical director responsibilities?..... Yes No
 If yes, please provide the following information related to your medical director activities.
 Facility Name: _____ Location: _____
 Does the above facility provide you with coverage for your administrative responsibilities? Yes No
7. Do you participate in any medical research or clinical trials that are not FDA or IRB approved?..... Yes No
 If yes, please attach copies of any protocols and informed consent documents.
8. Do you engage in telemedicine/telehealth activities? Yes No
If yes, please complete and submit the Telemedicine/Telehealth Supplemental Application (NFL 9734).
9. Do you engage in retainer medicine, such as concierge, direct primary care, etc.?..... Yes No
If yes, please complete and submit the Retainer Practices Supplemental Application (NFL 9707).
10. Are you employed full-time by the federal government or are you serving in the military?..... Yes No
11. Are you engaged in any "moonlighting" activities? Yes No
If yes, please indicate the number of hours per month: _____
12. Do you render patients unconscious for treatment in your office or other non-hospital facility? Yes No
13. Do you perform utilization review services for a fee for others? Yes No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON THE LAST PAGE.

I. HISTORY

1. Please provide information on each professional liability insurer you have had for the last 10 years. *Please provide this information in chronological order.*

Dates	Insurer	Practicing Specialty	Limits of Liability	Coverage Type	Tail Coverage Purchased?	Any Claims?
				<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Are you now, or have you ever, practiced without professional liability insurance? Yes No
3. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? *Missouri residents, skip this question.* Yes No
4. Has your medical license ever been investigated, denied, restricted, suspended, voluntarily surrendered or revoked in any state?..... Yes No
5. Regarding your DEA certification, has it ever been restricted/put on probation, suspended or voluntarily surrendered? Yes No
6. Have any complaints or actions been brought against you by any hospital?
(This includes restriction, suspension, revocation of privileges or probation.) Yes No

I. HISTORY (continued)

- 7. Have you ever been the subject of or are you aware of any future involvement in an investigation by a regulatory or peer review board? Yes No
- 8. Have any complaints or claims been brought against you for sexual misconduct? Yes No
- 9. Have you ever been accused of or been found to have altered health care records? Yes No
- 10. Have you ever had a chronic physical limitation or mental/emotional illness or disorder which impairs or adversely impacts your practice of medicine? Yes No
- 11. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics, or any other substance abuse? Yes No
- 12. Have you ever been charged, indicted or convicted; received a deferred prosecution or a deferred judgment and sentence; entered a guilty plea or a plea of nolo contendere; or been placed on adult diversion for any violation of any law? Yes No

Note: You must answer “yes” even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.

- 13. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? Yes No

If you answered “yes” to any of the questions above, please provide details.

J. LOSS INFORMATION

- 1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services? * Yes No
If yes, please indicate the number of each: Number of pending suits: _____ Number of closed claims: _____
- 2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient? * Yes No
A letter from an attorney regarding your treatment of a patient? Yes No
A patient, family member or a patient representative’s dissatisfaction with the outcome of a procedure, treatment or diagnosis? Yes No
Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes No
- 3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier? ** N/A Yes No

If yes, please attach a current loss run for each carrier, as appropriate.

If no, please explain why these circumstances were not reported: _____

* For the purposes of this section the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.

** For the purposes of this question, “N/A” means that you are aware of no circumstances that might reasonably lead to a claim or suit.

IF YOU ANSWERED “YES” TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON THE LAST PAGE.

K. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the Company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Oklahoma:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Signature of Applicant

Date

Signature of Agent

Date

L. DETAILS

Section/Question	Comments

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE.



Mail to:
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Clive, Iowa 50325-8258

Questions:
Phone: 800-788-8540
Fax: 800-510-6370

Email: submissions@psicinsurance.com