

Physicians and Surgeons Professional Liability BRIDGE Application

A. APPLICANT INFORMATION

Name: _____
First Name Middle Last Name

Male Female Social Security No: _____ Date of Birth: _____

Contact Person/Insured's Representative: _____

B. COVERAGE INFORMATION

- Desired effective date: _____ (policy issued annually)
MO/DAY/YR
- Select Requested coverage:
 Claims Made Coverage with Prior Acts Claims Made Coverage without Prior Acts
 Claims Made Coverage with Pre-Paid Tail (MI and OK only)
 Desired Retroactive Date: _____
MO/DAY/YR
 Occurrence
- Please indicate limits of liability requested for coverage or a quote *(not all limits may be available in all states)*
 _____ Per Claim/ _____ Annual Aggregate

C. PRACTICE ACTIVITIES

- Primary medical specialty: _____ % of practice: _____
- Do you have a secondary medical specialty? Yes No
If yes, please list: _____ % of practice: _____
- 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 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
- Are you now, or have you ever practiced without professional liability insurance? Yes No
- 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
- Has your medical license ever been investigated, denied, restricted, suspended, voluntarily surrendered or revoked in any state?..... Yes No

C. PRACTICE ACTIVITIES (continued)

- 7. Has your DEA certification ever been restricted/put on probation, suspended or voluntarily surrendered?..... Yes No
- 8. Have any complaints or actions been brought against you by any hospital?
(This includes restriction, suspension, revocation of privileges or probation.)..... Yes No
- 9. 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
- 10. Have any complaints or claims been brought against you for sexual misconduct? Yes No
- 11. Have you ever been accused of or been found to have altered healthcare records?..... Yes No
- 12. 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
- 13. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol,
narcotics, or any other substance abuse? Yes No
- 14. 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? **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..... Yes No
- 15. 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 ABOVE QUESTIONS, PROVIDE DETAILS ON THE LAST PAGE.

D. 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.

IF YOU ANSWERED “YES” TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.

E. 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 changes 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



Mail to:
14001 University Avenue
Clive, Iowa 50325-8258

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

Email: submissions@psicinsurance.com