

PROFESSIONAL LIABILITY INSURANCE

(PA Physicians and Surgeons Application)



**PHYSICIANS INSURANCE CONSULTANTS
1540 BETHLEHEM PIKE
FLOURTOWN, PA 19031
215-233-4410 800-466-6906
FAX: 215-233-4409**

To help us expedite the processing of this application, please be sure to:

- Print or type your responses.
- Answer every question or mark it with N/A (not applicable).
- Complete a claims information form for each claim or suit in the past ten years.
 - Enclose a copy of your present declarations page.
 - Mail or fax application back to our office.

A. GENERAL INFORMATION (Please type or print clearly in ink)

If my application is approved, make coverage effective on _____ (if possible) otherwise on any other date set by the Company.

1. Name: _____ MD DO (Check One)
First Middle Last

2. Date of Birth: _____ 3. Male Female

4. Social Security Number: _____ 5. License Number: _____

6. Home Address: _____ () _____
Number Street Telephone
_____ () _____
City County State Zip Fax

7. Primary Office Address: _____ () _____
Number Street Telephone
_____ () _____
City County State Zip Fax

This address is a (check one): Private Office Hospital Clinic Other _____
Number of years at current location: _____ Number of hours per week you are at this location: _____
Number of patients you see per week at this location: _____

8. Do you provide professional services at any other location/facility? Yes No
(If yes, please provide the name(s), address(es), phone & fax numbers for each location/facility)

9. Mailing Address: Home Primary Office Other: _____

B. TRAINING

10. Specialty:
a. Medical Specialty Currently Practiced: _____ Board Certified? Yes No
Sub-Specialty: _____ Board Certified? Yes No
b. Specialty for which you want coverage for: _____
c. Name(s) of any professional medical association(s) to which you belong: _____

11. Medical Education: _____
M.D./D.O. School Country Degree/Dates Attended

12. Postgraduate Medical Training:
Name Location From/To Completed Y/N Degree
Internship Served: _____
Residency(ies): _____
Fellowship(s): _____

C. COVERAGE OPTION

13. Do you want a Claims-Made policy?
14. Prior Acts
a. Is this to replace an existing Claims-made policy? Yes No
b. Do you wish prior acts coverage (nose) beginning on the initial issue date of your Claims-Made Policy? Yes No
c. If YES, please advise the retroactive or initial covering date: _____
d. The attached Prior Acts warranty statement must be completed in full and signed by the insured.

D. PRACTICE ASSOCIATIONS

REMINDER: Answers to the questions in this section should reflect your intended practice as of the date you wish this policy to become effective.

15. Practice Situation

a. Indicate all practice situations that apply to you:

- "Solo" Physician
- "Solo" Medical Corporation
- Medical Corporation with more than one shareholder
- Medical Partnership
- Independent Contractor/Contractee
- Use of Assumed name (DBA)
- Employed by another physician
- Employ another physician
- Other: _____

If you check any boxes above other than "Solo" Physician or "Solo" Medical Corporation, list below the name of the applicable entity(ies) and/or any physician(s).

Name of Entity	Name of Physician Employer or Shareholders	Professional Liability Insurance Carrier
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Do you wish coverage for any of the above entities? Yes No

PLEASE SUBMIT A COPY OF ARTICLE OF INCORPORATION/PARTNERSHIP AND FILING RECEIPT

E. INSURANCE

16. Prior Insurance

Provide name(s) of professional liability carrier(s), policy number(s), and coverage period(s) of all professional liability insurance policies under which you have been insured in the past ten (10) years. If you are applying for Prior Acts Coverage, please complete the following for the entire Prior Acts Coverage Period. Attach additional pages as needed.

Coverage Period	Insurance Carrier	Policy #	Medical Specialty	Limits of Liability	Type of Policy CM/OCC	No. of Claims
From/to						
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

17. Have you ever had professional liability insurance refused, declined, cancelled or accepted on special terms? (If yes, explain in Remarks).

Yes No

F. MEDICAL CONDUCT INFORMATION

18. Governmental Action

- a. Has any governmental agency ever investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice? (If YES, explain in Remarks) Yes No
- b. Have you ever been convicted of a crime? (If YES, explain in Remarks) Yes No

19. Hospital Privileges

Have you ever privileges at any hospital or other institution reduced, revoked, restricted, or suspended? (If Yes, explain in Remarks) Yes No

20. Health

Do you have any health problems, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? (If Yes, explain in Remarks) Yes No

21. Claims or Suits

Have you ever been named as a defendant in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten (10) years, or are you presently involved in malpractice litigation? Yes No

(If YES, submit a separate form for each case in the last ten (10) years, see page) Yes No

G. PRACTICE AND PROCEDURES: GENERAL QUESTIONS

22. Please check the category that most closely describes your practice.

- Major Surgery:** Performing any operative procedure done under general, spinal or caudal anesthesia or assisting in “Major Surgery” on other than your own patients.
- Minor Surgery*:** Performing any operative procedure other than as included in “Major Surgery” or assisting in “Major Surgery” on your own patients
- No Surgery*:** NOT performing any operative procedure including “Major Surgery” or “Minor Surgery”.
*Note: Incising of boils and superficial fascia, suturing of minor lacerations and removal of superficial skin lesions are not considered operative procedures for the purpose of this application.

23. Indicate percentage of time devoted to the following activities commonly associated with the following surgical specialties:

Percentage	Specialty	Percentage	Specialty	Percentage	Specialty
_____ %	Abdominal	_____ %	Hand	_____ %	Plastic
_____ %	Cardiac	_____ %	Head & Neck	_____ %	Thoracic
_____ %	Cardiovascular	_____ %	Laryngology	_____ %	Traumatic
_____ %	Colon&Rectal	_____ %	Neoplastic	_____ %	Urological
_____ %	Gastroenterology	_____ %	Otology	_____ %	Vascular
_____ %	Gynecology	_____ %	Otorhinolaryngology	_____ %	Other _____

24. Check any of the following applicable to you practice for which Clarendon Coverage is required:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Abortions: Trimester: _____
Where Performed: _____ <input type="checkbox"/> Administration of General, Spinal or Caudal Anesthesia <input type="checkbox"/> Acupuncture (please submit copy of certification) <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Angiograms <input type="checkbox"/> Angioplasty <input type="checkbox"/> Coronary <input type="checkbox"/> Other _____ <input type="checkbox"/> Aspiration of Cyst of Breast <input type="checkbox"/> Assisting in Major Surgery
List Procedures: _____ <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Cardiac Catheterization <ul style="list-style-type: none"> <input type="checkbox"/> Left Heart <input type="checkbox"/> Swan Ganz <input type="checkbox"/> Cataract Surgery <input type="checkbox"/> Cervical Cautery <input type="checkbox"/> Chelation Therapy (other than for treatment of heavy metal poisoning) <input type="checkbox"/> Chemabrasion/Dermabrasion <input type="checkbox"/> Chemical Peel: Type: _____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chorionic Villi Sampling <input type="checkbox"/> Circumcision of Newborn/Adult <input type="checkbox"/> Closed Reduction of Fractures <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cosmetic Surgery of Breast <input type="checkbox"/> Cryosurgery: Compound _____ <input type="checkbox"/> Culdocentesis <input type="checkbox"/> D & C <input type="checkbox"/> Deep Radiation/X-Ray Therapy | <ul style="list-style-type: none"> <input type="checkbox"/> Duodenoscopy <input type="checkbox"/> Endometrial Biopsy <input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography <input type="checkbox"/> Esophagoscopy <input type="checkbox"/> Excisional Punch Biopsy <input type="checkbox"/> Foreign body removal from Eye <input type="checkbox"/> Gastric Bubble <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hair Transplants: Type _____ <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hydrocelectomy <input type="checkbox"/> Injection of Radiopaque Dye <input type="checkbox"/> Interventional Radiology Procedures _____ <input type="checkbox"/> Insertion of IUD <input type="checkbox"/> Intestinal Surgery for Obesity <input type="checkbox"/> Liposuction <input type="checkbox"/> Laser Surgery: _____ <input type="checkbox"/> Nasal Polypectomy <input type="checkbox"/> Needle Biopsy: Type _____ <input type="checkbox"/> Peripheral Nerve Block Anesthesia <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Permanent Pacemakers <input type="checkbox"/> Polypectomy by Endoscopy <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Proctoscopy <input type="checkbox"/> Radial Keratotomy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Stress Testing <input type="checkbox"/> Telemedicine <input type="checkbox"/> Temporary Pacemaker <input type="checkbox"/> Vein Stripping <input type="checkbox"/> Other: _____ |
|---|---|

I do hereby represent that any statements and answers mentioned herein are true, and that I have not misrepresented or withheld any information which is calculated to influence the judgement of the Company in considering this application for professional liability insurance.

The application duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature form does not bind the applicant or the Company to issue coverage.

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 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 PENALTIES.

I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company underwriter, and insurance agent to furnish any information concerning me or my medical practice which the Company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction together with agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

SIGNATURE: _____

Date: _____

CONSENT OPTION

The Company will provide a 5% premium reduction for policyholders who opt to forego the customary consent to settle any claim.

Please indicate by checking the appropriate box below, the option that you wish.

“NO CONSENT” OPTION

I hereby authorize the Company to act on my behalf to settle any claims reported without first obtaining my written consent.

“CONSENT” OPTION

I wish to maintain the terms of the policy which, under Part 4, currently requires the Company to obtain my written consent prior to settling any claim on my behalf.

Signed: _____

Date: _____

Please make additional copies of this page as necessary. If you have had claims or suits filed against you, please complete this form for each claim or suit in the past ten (10) years. Provide information on all claims that have also been resolved (closed, tried or settled) within the past ten (10) years. Also include all "incidents".

CLAIM INFORMATION

- 1. Name of Patient _____ 2. Age _____ 3. Sex _____
- 4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
- 5. Allegation _____
- 6. Date of incident _____ 7. Report date _____
- 8. Insurance carrier _____
- 9. Other defendants _____
- 10. Present Status: Open Claim Closed claim Date closed _____ Settlement or Judgment Amount _____
- 11. Location of incident _____
- 12. Condition and diagnosis at time of incident _____

- 13. Dates and description of treatment rendered _____

- 14. Condition of patient subsequent to treatment and dates of follow-up treatment _____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: _____ Date Signed: _____

CLAIM INFORMATION

- 1. Name of Patient _____ 2. Age _____ 3. Sex _____
- 4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
- 5. Allegation _____
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- 13. Dates and description of treatment rendered _____

- 14. Condition of patient subsequent to treatment and dates of follow-up treatment _____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: _____ Date Signed: _____

APPENDIX A

SUBSCRIBERS AGREEMENT

The undersigned subscriber to Pennsylvania Physicians' Reciprocal Insurers (the "Exchange"), a Pennsylvania reciprocal insurance exchange, agrees together with all other subscribers to the Exchange, and with Physicians Reciprocal Managers, Inc. (the "Company"), a Pennsylvania corporation, as the Attorney-in-Fact for the Exchange, as follows:

1. The undersigned agrees to pay its policy premiums and to exchange with the other subscribers to the Exchange policies providing insurance for any insured loss as stated in those insurance policies at the offices of the Company in Harrisburg, Pennsylvania.

2. The undersigned appoints the Company as Attorney-in-Fact with the power to (a) exchange insurance policies with other subscribers to the Exchange, (b) take any action necessary for the exchange of such insurance policies, (c) issue, change, non-renew or cancel insurance policies, (d) obtain reinsurance, (e) collect premiums, (f) invest and reinvest funds, (g) receive notices and proofs of loss, (h) appear for, compromise, prosecute, defend, adjust and settle losses and claims under the insurance policies of subscriber, (i) accept service of process on behalf of the Exchange as insurer and (j) conduct the business and affairs of the Exchange as set forth herein, in the Declaration of Organization and the Attorney-in-Fact Agreement between the Exchange and the Company. This power of attorney is limited to the purposes described in this Subscribers Agreement.

3. The undersigned agrees that the compensation to the Company for the Company (a) becoming and serving as Attorney-in-Fact for the subscribers to the Exchange, (b) managing the business and affairs of the Exchange as provided herein and (c) paying the general administrative expenses of serving as Attorney-in-Fact for the Exchange, including sales commissions, salaries and employee benefits, taxes other than premium taxes, rent, depreciation, supplies, and data processing, shall not exceed 21% of all premiums written or assumed by the Exchange. The remainder of all premiums written or assumed by the Exchange shall be used for losses, loss adjustment expenses, investment expense, damages, legal expenses, court costs, premiums taxes, assessments, licenses, fees, any other governmental fees and charges, establishment of reserves and surplus and reinsurance, and may be used for dividends and other purposes the Company decides are to the advantage of the subscribers to the Exchange.

4. The undersigned agrees that this Subscribers Agreement, including the power of attorney set forth herein, shall apply to all insurance policies for which the undersigned applies at the Exchange, including changes in any of the undersigned's coverages.

5. The undersigned agrees to sign and deliver to the Company all papers required to carry out this subscribers agreement.

6. This Subscribers Agreement, including the power of attorney set forth herein, shall not be affected by your subsequent disability or incapacity.

7. The subscribers Agreement and the Declaration of Organization of the Exchange are and shall be binding upon the Company and the undersigned and all of their respective executors, administrators, personal representatives, successors, and assigns.

IN WITNESS WHEREOF, the undersigned subscriber hereto sets his hand and seal.

Signature of Subscriber

Date

Name of the Subscriber (please print)

In the event that an Insured chooses to purchase Prior Acts Coverage then the following warranty statement must be completed, dated and signed by the Insured before any such Prior Acts Coverage can become effective. The signing of this statement alone does not guarantee that Pennsylvania Physicians' Reciprocal Insurers will be bound to offer the Prior Acts Coverage to the Insured.

Prior Acts Coverage - Warranty Statement

In consideration of the premiums charged under the above policy, the undersigned warrants that as of ____/____/____ all known claims or suits or medical incidents which occurred during the retroactive (effective date)

period ____/____/____ to ____/____/____ have been reported to our previous insurance carrier, (retroactive date) (effective date)

(current insurance carrier)

It is also warranted that any and all acts, medical incidents and/or circumstances, of which any director, shareholder, officer, or employee of _____ is aware, and which might reasonably (applicant name) be expected to result in a claim under the proposed coverage afforded by this policy, were disclosed on the application prior to binding of such coverage effective ____/____/____ and are listed below: (effective date)

These warranties are material to the acceptance of coverage by the Insurer, and the warranties are made a part of the insurance policy. This policy would not be offered or placed in the absence of such warranties.

Further, I acknowledge and agree that any claims resulting from medical incidents committed prior to the binding of coverage, and of which **I am aware**, are specifically excluded from coverage under this policy. I acknowledge and agree that such excluded claims would not have coverage under the policy of any other carrier, unless properly reported to such insurance carrier under the terms and conditions of such policy.

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 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 PENALTIES.

ACKNOWLEDGED AND AGREED:

Signature

BY:

TITLE: