



HEALTHCARE PROVIDERS INSURANCE EXCHANGE

Physicians
Insurance
Consultants
800-466-6906

APPLICATION FOR HPIX MEMBERSHIP AND INSURANCE

Name (First, Middle Initial, Last)

Home Address (Include City, State, Zip)

MD DO Social Security Number: Gender: M F
Home Phone: E-mail Address: Date of Birth:
Business Phone: Business Fax:

PREFERRED MAILING ADDRESS: Home Principal Office Other

Street Address

City, State, Zip

PROFESSIONAL EDUCATION

Medical School Name City State Country Year Completed

Residency (list all resident training locations)

1. Hospital Name State Country From (MM/DD/YY) To (MM/DD/YY) Type Completed
2. Hospital Name State Country From (MM/DD/YY) To (MM/DD/YY) Type Completed
3. Hospital Name State Country From (MM/DD/YY) To (MM/DD/YY) Type Completed

Fellowship

Hospital Name State Country From (MM/DD/YY) To (MM/DD/YY) Type Completed

Date you entered private practice for the first time:

LICENSURE

States in which you hold a license to practice medicine. Indicate what percentage of your total practice is spent in each. For surgeons and obstetricians, base your percentages on surgeries or deliveries.

Table with 4 columns: State, License Number, Date of License, % of Total Practice. Row 1: Pennsylvania

- 1. Has your medical license in any state ever been suspended, revoked or restricted?
2. Are you currently under investigation by any state licensing board or agency?
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited?

Fully explain any yes answer:

COVERAGE HISTORY

Previous professional liability insurers. List current insurer first.

Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date

1. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement (tail coverage)? Yes No
2. Has your application for professional liability insurance ever been declined, or has your policy premium ever been surcharged, canceled or nonrenewed by the insurer? Yes No
If yes, explain: _____

MEMBERSHIP COVERAGE SELECTION

Desired coverage effective date: _____ 12:01 a.m.

Desired coverage type:

CLAIMS-MADE **With Prior Acts Coverage.** Retroactive date used by your existing carrier: _____ 12:01 a.m.
A copy of your current declarations page verifying retroactive date must be attached.

CLAIMS-MADE **Without Prior Acts Coverage** (decline or do not need retroactive coverage). The retroactive date on the policy applied for will be the same as the effective date of coverage.

Under the *claims-made policy type*, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force. A reporting endorsement or equivalent coverage must be secured upon policy termination or nonrenewal.

OCCURRENCE

Under the *occurrence policy type*, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is reported.

PRACTICE INFORMATION

1. What is your medical specialty? _____ Subspecialty ? _____
2. Are you board certified? Yes No
 If no, are you board eligible? Yes No
 If yes, when do you plan on taking your boards? _____
 Specialty Board _____ Date Certified _____
- Have you ever failed a specialty/subspecialty exam? _____
 Yes No
 Subspecialty Certificate _____ Date Certified _____

Describe the practice for which you need insurance:	PRACTICE HOURS PER WEEK	
	Average hours (not just patient contact)	
	Patient visits (in office, hospital, etc.)	
	Surgeries (major in hospital)	
	Obstetrical deliveries	

Practice and hospital locations where you will practice subsequent to your desired date of coverage. List principal location first. Total of percentage of practice at all locations should equal 100%.

PRACTICE LOCATIONS

1. _____
 Suite Number & Street City State Zip Code County % of Practice
2. _____
 Suite Number & Street City State Zip Code County % of Practice
3. _____
 Suite Number & Street City State Zip Code County % of Practice

HOSPITAL LOCATIONS

1. _____
 Hospital Name City State County Privilege Type % of Practice
2. _____
 Hospital Name City State County Privilege Type % of Practice
3. _____
 Hospital Name City State County Privilege Type % of Practice

1. Do you serve in a hospital emergency room for which you require HPIX coverage? Yes No
 If yes, number of hours per week: 8 hours or fewer per week Greater than 8 hours per week
2. Do you serve in a prison environment for which you require HPIX coverage? Yes No
 If yes, number of hours per week: 8 hours or fewer per week Greater than 8 hours per week

Locations (other than present) where you have practiced since completion of formal training (include military or public service organizations):

Practice Name and Location	From	To

PRACTICE ORGANIZATION

Check the boxes that best describe your practice affiliation(s):

Employment Status

- Employee
- Shareholder/Partner
- Solo Unincorporated
- Solo Corporation
- Independent Contractor for

Entity Type

- Multi-shareholder Corporation, Partnership, Limited
- Liability Corporation
- Government
- Hospital
- Industrial

Corporation, Partnership or Employer Name _____

Primary Office Contact Person: and Telephone Number _____

If this entity is not currently insured with HPIX, do you wish coverage? Yes No
 If Yes, complete the Entity Liability Application

How many physicians and/or surgeons are in your group? _____ How many are applying to HPIX? _____

Do you (or does your entity) employ any paraprofessionals? Yes No
 If yes, complete Section 1 below.

If you wish to purchase a separate set of basic limits of liability for any of these employees (referred to as Designated Employee Coverage), complete Section 2 below and attach a copy of employee's license and/or certification.

SECTION 1	
<i>Specialty</i>	<i>Number</i>
Nurses (RN and LPN)	
CRNAs	
Nurse Practitioners	
Nurse Midwives	
Physician Assistants	
Surgical Assistants	
Physical Therapists	
Medical or Lab Technicians	
Medical Assistants	
Other (specify)	

SECTION 2		
<i>Name and Specialty</i>	<i>Current Insurer</i>	<i>Retroactive Date</i>

Have any of your paraprofessional employees ever been named in a claim or suit? Yes No

Have any of your paraprofessional employees ever had any action taken against licensure? Yes No

If yes to either answer, complete the following (if additional space is required, photocopy this form as needed).

Employee Name: _____ Insurer: _____

Allegation: _____

Action Taken: _____

Status: Open Reserves: Closed without Payment Closed with Payment - Amount: _____

MEDICAL PROCEDURES

1. Check any of the following procedures applicable to your practice for which you require HPIX coverage:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortions | <input type="checkbox"/> Hair Transplants | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Scalp Excision | <input type="checkbox"/> Phenol Facial Peels |
| <input type="checkbox"/> Therapeutic | <input type="checkbox"/> Plug Technique | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> In-Vitro Fertilization | <input type="checkbox"/> Prenatal Care (other than first trimester) |
| <input type="checkbox"/> Anesthesia (General/Spinal/Caudal) | <input type="checkbox"/> Interventional Radiology | <input type="checkbox"/> During second trimester |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Angiography | <input type="checkbox"/> To term but do not deliver |
| <input type="checkbox"/> Assist in Major Surgery | <input type="checkbox"/> Arteriography | <input type="checkbox"/> To term and deliver |
| <input type="checkbox"/> Own patients only | <input type="checkbox"/> Phlebography | <input type="checkbox"/> Radiation or X-Ray Therapy |
| <input type="checkbox"/> Other than own patients | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Radiopaque Dye Injection |
| <input type="checkbox"/> Biopsy by Aspiration | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Shock Therapy |
| <input type="checkbox"/> Other Biopsy | <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Sigmoidoscopy |
| Location _____ | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Less than 50 cm |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Laser | <input type="checkbox"/> Greater than 50 cm |
| <input type="checkbox"/> Cosmetic _____ % of practice | <input type="checkbox"/> Treatment | <input type="checkbox"/> Skin Flaps/Grafts |
| <input type="checkbox"/> Reconstruction _____ % of practice | <input type="checkbox"/> Surgery | <input type="checkbox"/> Cosmetic |
| <input type="checkbox"/> Bone Fractures (closed treatment) | <input type="checkbox"/> Lasik | <input type="checkbox"/> Reconstruction |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Telemedicine |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Catheterization | <input type="checkbox"/> Myelography | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Swan-Ganz | <input type="checkbox"/> Nerve Blocks | <input type="checkbox"/> Weight Control Medication |
| <input type="checkbox"/> Right Heart (other than CVP lines) | <input type="checkbox"/> Facet | <input type="checkbox"/> C-Sections: How many annually? _____ |
| <input type="checkbox"/> Left Heart | <input type="checkbox"/> Lumbar | <input type="checkbox"/> Normal Obstetrical Deliveries |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Myofascial | How many annually? _____ |
| <input type="checkbox"/> Cryosurgery (other than external lesions) | <input type="checkbox"/> Occipital | <input type="checkbox"/> Other Medical Techniques |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Paravertebral | List Procedures _____ |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Triggerpoint Injection | _____ |
| <input type="checkbox"/> ERCP | | |

2. Do you perform any procedure not typical to the specialty in which you received your residency or fellowship training? Yes No
 If yes, describe those activities. _____

3. Do you teach, supervise or proctor medical students, residents or fellows? Yes No
 If yes, provide the number of hours per week. _____

4. Do you participate in clinical trials for any pharmaceutical or for any organization acting on behalf of a pharmaceutical? Yes No
 If yes, describe. _____

5. SURGICAL ACTIVITIES. Check any of the following surgical activities applicable to your practice for which you require HPIX coverage and indicate the percentage of practice devoted to that activity:

- | | | |
|--|--------------------------------|--|
| _____ % Bariatric including Gastric Stapling | _____ % Orthopedic With Spine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ % Colorectal | _____ % Plastic Cosmetic | _____ % Cardiac |
| _____ % Gynecology | _____ % Plastic Reconstruction | _____ % Thoracic |
| _____ % Obstetric including C-Sections | _____ % Hand | _____ % Vascular |
| | _____ % Neurosurgery | _____ % Transplants |

REMARKS. Use the space below for any comments that you feel will help HPIX better understand your practice.

ADDITIONAL INFORMATION

Fully explain any yes answer in the space provided below.

1. Will you be performing activities which will be covered by another professional liability policy? Yes No
If yes, indicate who will provide this coverage and what professional services it will cover.
2. Have you ever suffered from or been treated for any substance abuse, disability, mental illness or serious physical injury or illness that has or might affect your ability to practice medicine or surgery? Yes No
If yes, state the illness or disability and the date it occurred.
3. Have you ever been arrested for, charged with or convicted of a crime other than a minor traffic violation? Yes No
If yes, provide details.
4. Do you own, operate or serve as an executive, administrative officer, medical director or department head for any hospital, nursing home, nonhospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization? Yes No
If yes, indicate its name and describe your duties.
5. Do you hold any positions outside of your principal medical or surgical practice (e.g., working in a hospital emergency room or part time at a clinic or nursing home, working for an HMO or other managed care or insurance company, serving as a Medical Director, etc.)? Yes No
If yes, indicate for whom you provide these services.
6. Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges on your application or reapplication for medical staff privileges? Yes No
7. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? Yes No

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-
-
8. Have you changed medical specialties within the past five years? Yes No
If yes, complete the following chart.

Specialty	Insurance Carrier	Hours per Week	From	To

CLAIMS HISTORY

1. In the past ten years, has any malpractice claim or suit been made against you? Yes No
If yes, how many? _____
2. Do you have knowledge of any incident, adverse outcome or other circumstances of clinical care of a patient that might reasonably lead to such a claim or suit? Yes No
If yes, how many? _____ Have they been reported to your previous insurers? Yes No
Physician self-reporting obligation: Have they been reported to the State Board of Medicine? Yes No

Complete a Claims Supplement Form for each claim, suit or potential claim.

ASSIGNMENT OF RIGHTS 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 (e.g., termination of coverage, classification change, etc.). 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 HPIX, 305 North Front Street, Fifth Floor, Harrisburg, PA 17101-1216.

Initial Here:

CERTIFICATION AUTHORIZATION AND SIGNATURE

CONDITIONS OF MEMBERSHIP

There are several conditions to the undersigned's membership and continued membership with HPIX. Failure to comply with any of these conditions is grounds for non-renewal of the undersigned's membership and insurance policy. These conditions include, but are not limited to, that the undersigned hereby agrees to:

- (1) Accept and cooperate with coordinated defense to the extent ethically permissible.
- (2) Participate in and cooperate with programs that promote intensive risk management whenever requested by HPIX or its attorney-in-fact. Whenever requested by HPIX or its attorney-in-fact, the undersigned hereby agrees to undergo and cooperate with a practice audit to review various administrative and clinical patterns of practice.
- (3) Report incidents at the time they become known to the undersigned.

The undersigned agrees to fully comply with HPIX's conditions of membership, including those listed above, and agrees that the undersigned's membership in HPIX and insurance policy may be non-renewed by HPIX if the undersigned fails to comply.

The undersigned certifies that the information in this application is true and correct and authorizes the release and exchange of any information regarding the undersigned's medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which the undersigned is or has been a member and HPIX.

The undersigned further agrees to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

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 penalties.

Applicant's signature: _____ Date: _____