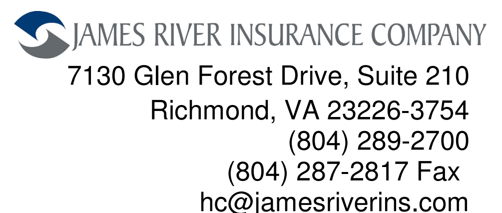
# PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION – CLAIMS-MADE FORM

**The following documentation must be submitted with the fully completed application:**

1. **Copy of your curriculum vitae.**
2. **Copy of your current policy declarations page. (Claims-Made policies must reflect retroactive date.)**
3. **Copy of all licenses and board certifications.**
4. **Copy of all prior reporting endorsements issued to you.**
5. **Currently valued 5-year claims/loss history from prior companies.**
6. **Copy of your business letterhead**
7. **Copy of all advertising that you use.**

**NOTE: Submission of a completed application confers no obligation upon the company to bind coverage.**




7130 Glen Forest Drive, Suite 210
Richmond, VA 23226-3754
(804) 289-2700
(804) 287-2817 Fax
hc@jamesriverins.com

| JAMES RIVER GROUP | **James River Insurance Company**<br>7130 Glen Forest Drive, Suite 210<br>Richmond, VA 23226<br>804-289-2700 | **Physicians and Surgeons Professional Liability Application – Claims-Made Form**<br><br>**HEALTHCARE Division**<br>Email to HC@jamesriverins.com or,<br>Fax to 804-287-2817 |
|---|---|---|

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

# PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION CLAIMS-MADE FORM

## PLEASE TYPE OR PRINT IN INK

**(If more space is needed to answer any questions, use page 10 or a separate sheet.)**

## I. GENERAL INFORMATION

1. A. Full Name of Applicant________________________________________Degree ____________

B. Practice Address:______________________________________________________________
Street County
______________________________________________________________
City State Zip Code

C. Mailing Address:______________________________________________________________
Street County
______________________________________________________________
City State Zip Code

D. Phone: ______________________________ E. Fax: ______________________________

F. E-Mail Address:__________________________ G. Website Address: ______________________

H. Secondary Practice Locations______________________________________________________
______________________________________________________________

I. Social Security No. ______________________ J. Date of Birth ______________________

2. Are you a U. S. Citizen? ☐ Yes ☐ No If no, please indicate your status and date of entry into USA on page 10.

3. A. Are you a Foreign Medical School Graduate? ☐ Yes ☐ No B. Date of ECFMG Certification: ________________

4. Provide the following information for all the states in which you are licensed to practice:

| State | % of Practice | License No. | Active | Inactive | Temporary | Pending |
|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |

5. Federal DEA License Number and status______________________________________________

6. List all locations and dates where you have practiced in the last ten (10) years.

| Practice Name | City/State | Specialty Practiced | From | To |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

7. Current Practice Specialty: ________________________________________ Percentage of Practice: __________________
8. Subspecialty: ____________________________________________________Percentage of Practice: _________________
9. Board Certification:

☐ Board Certified By: __________________________________ ☐ Board Eligible – Date of Exam:______________________

☐ Neither Board Certified Nor Board Qualified (please explain) ☐ Board Qualified (completed required training)

If Board Eligible for Over Five Years, But Not Board Certified, Please Explain:

______________________________________________________________________________________________

______________________________________________________________________________________________

## II. MEDICAL EDUCATION AND TRAINING

10. Medical Education – please complete the following:

| | Name of Institution | Degree/ Specialty | Location | From | To | Completed (Yes/No) |
|---|---|---|---|---|---|---|
| Medical School | | | | | | |
| Internship | | | | | | |
| Residency | | | | | | |
| Residency | | | | | | |
| Fellowship | | | | | | |

11. How many hours of continuing medical education have you completed within the past three (3) years? _________________

## III. PRACTICE INFORMATION

12. A. Type of Practice:

Are You:

1. Self Employed? ☐ Yes ☐ No
2. An employee of another physician? If yes please explain on page 10 ☐ Yes ☐ No
3. An employee of an organization, other than a hospital, engaged in the delivery of medical services? ☐ Yes ☐ No
4. An independent contractor to an organization, other than a hospital, engaged in the delivery of medical services? ☐ Yes ☐ No

Type of Practice: (continued)

5. Are you a partner, stockholder or employee in a Medical partnership, Professional Association or professional services corporation? ☐ Yes ☐ No

If yes, are you a ☐ Partner ☐ Stockholder ☐ Employee

If yes, please give the following details:

a. Type of Entity: ☐ Medical Partnership ☐ Professional Association ☐ Professional Services Corporation

b. List all stockholders, partners and associates: ____________________________________________________________

____________________________________________________________________________________________

c. Are you requesting that the legal entity be named on your policy? If yes, please forward the articles of incorporation. ☐ Yes ☐ No

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B. Do you practice with any physician(s) not named in Item 12.B. above? ☐ Yes ☐ No

If yes, provide the name of each physician and the practice relationship:__________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

C. Do you employ, contract with or supervise any physician(s) or surgeon(s)? ☐ Yes ☐ No

If yes, provide the number and attach a current certificate of insurance for each. Number: ___________

D. Do you have any office or expense sharing arrangement with any other physician(s) or surgeons(s) other than those named in 12.B. or 12.C. above? ☐ Yes ☐ No

If yes, provide the number and attach a current certificate of insurance for each. Number: ___________

E. Do you employ, contract with or supervise any non-physician health care extenders? ☐ Yes ☐ No

If yes, enter the information below:

| | # Employed | Is Coverage Desired? | # of Independent Contractors | **Are they insured?** |
|---|---|---|---|---|
| Nurse Practitioner | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Physician Assistant | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| CRNA* | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Nurse Midwife* | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Surgeon Assistant | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Physical Therapist | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Nurses (RN, LPN, LVN) | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Medical Assistants | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Other: | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Other: | | ☐ Yes ☐ No | | ☐ Yes ☐ No |

* If coverage is desired, please complete an Allied Personnel application for each.

13. Are you employed full-time or part-time by the federal, state, or local government, or are you on active military duty? ☐ Yes ☐ No

If yes, please explain: ____________________________________________________________________________

14. Provide the following information for all hospitals or surgery-centers where you are currently on staff:

| Name | City | State | % of Work | Type of Privileges |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

15. Are you currently a hospital chief of staff or head of any hospital department? ☐ Yes ☐ No

    If yes, please describe: ______________________________________________

16. Do you or any entity named in 12.A. above own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgery-center, abortion clinic, walk-in clinic, or birthing center? ☐ Yes ☐ No

    If yes, attach a detailed explanation and include the location name, size, and number of beds.

17. Do you serve as a medical director of a nursing home, clinic, commercial enterprise or any other organization? ☐ Yes ☐ No

    If yes, provide a detailed explanation and attach a copy of any contract or other agreement that describes your position: ______________________________________________

    ______________________________________________

18. Average weekly patient load: ______ Average weekly practice hours: _______ Percentage of Locum Tenens work: _______

19. Do you work in an Emergency Room, other than to maintain hospital privileges? ☐ Yes ☐ No

    If yes, provide the average number of hours you work in the Emergency Room each month: __________

20. Are you ACLS certified? ☐ Yes ☐ No Are you ATLS certified? ☐ Yes ☐ No

21. Do you work for any locum-tenens companies as an ☐ employee or ☐ independent contractor? ☐ Yes ☐ No

    If yes, number of hours each month in which you work in locum-tenens positions: __________

    If yes, does each company provide you with Professional Liability insurance for locum positions? ☐ Yes ☐ No

    If Yes, attach a copy of your Certificate(s) of Insurance.

22. Do you now or have you ever provided services to any state, local or federal correctional facility, jail, or prison? ☐ Yes ☐ No

    If yes, please describe: ______________________________________________

23. Have there been any changes in your specialty or practice activities within the past ten (10) years? ☐ Yes ☐ No

    If yes, describe the changes: ______________________________________________

24. Do you anticipate any changes in your specialty or practice in the next year? ☐ Yes ☐ No

    If yes, describe the anticipated changes: ______________________________________________

25. Do you perform any procedure not routinely performed by other persons practicing your specialty or subspecialty? ☐ Yes ☐ No

    If yes, please provide complete details: ______________________________________________

26. Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering medical services? ☐ Yes ☐ No

    If yes, indicate all states where the patients being treated reside: ______________________________________________

    If yes, what percentage of your practice does this outside state activity constitute? __________

27. Do you read or interpret films, slides or specimens of patients who reside in states other than your indicated practice states? ☐ Yes ☐ No

    If yes, indicate all states in which the patients reside and indicate the percentage of your practice corresponding to each state: ______________________________________________

28. Do you read your own x-rays? ☐ Yes ☐ No

    If yes, will they subsequently be read by a radiologist? ☐ Yes ☐ No

    If yes, within how many hours? __________

29. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? ☐ Yes ☐ No

30. Do you perform surgical procedures at a same day surgery center other than your own office? ☐ Yes ☐ No

31. Do you perform surgery in your office or private suite using anesthesia other than local or topical? ☐ Yes ☐ No

If yes, complete the following information: (Use supplemental sheet if more space is needed.)

| Procedure | Anesthetic or Parenteral Sedation | Emergency Equipment and/or Emergency Procedures in Place in Case of Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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

33. Do you practice any forms of "Alternative Medicine" including but not limited to Ayurvedic Medicine, Chinese Medicine, Homeopathic Medicine, Chiropractic Medicine, Holistic Medicine or Naturopathic Medicine? ☐ Yes ☐ No

If yes, please describe your practice: ___________________________________________

34. Are you engaged in any "moonlighting" activities? ☐ Yes ☐ No

If yes, do you desire coverage for "moonlighting" activities? ☐ Yes ☐ No

If yes, describe the activities: ___________________________________________

35. Do you treat patients in a nursing home or similar facility? ☐ Yes ☐ No

If yes, how many patients do you treat there per month, on average? ______________________

36. Do you now or have you ever performed experimental or investigational procedures or prescribed or dispensed experimental drugs? ☐ Yes ☐ No

If yes, please explain on page 10 or on a separate sheet.

37. A. With the exception of surgery for obesity, does your practice include weight reduction or control other than by diet or exercise? ☐ Yes ☐ No

B. Percentage of your patient that are weight control patients: _______________%

C. Do you dispense any drugs? ☐ Yes ☐ No

If yes, provide the names of the drug(s) dispensed: ___________________________________________

38. Check All Procedures/Treatments That You Perform. Indicate In Appropriate Column, Where Performed.

| Office | Hospital | Other | Procedure |
|---|---|---|---|
| | | | Abortion (Do you perform non-therapeutic abortions? Yes [ ] No [ ]) Which Trimester?___ No. per yr. ___ |
| | | | Acupuncture |
| | | | Anesthesia – Non-Obstetrical |
| | | | Anesthesia – Obstetrical |
| | | | Angiography |
| | | | Angioplasty |
| | | | Assisting In Surgery – (Own Patients; Patients of Others) Circle those that apply. |
| | | | Bariatric Surgery:<br>☐Gastric Banding ☐Gastric Bubble ☐Gastric Bypass ☐Gastric Stapling ☐ Other (please indicate below) |
| | | | Blepharoplasty |
| | | | Breast Enhancement - Silicone |
| | | | Breast Enhancement – Saline |
| | | | Breast Enhancement – Trans-Umbilical |
| | | | Breast Reduction |
| | | | Cardiac Catheterization |
| | | | Cervical Biopsy |
| | | | Chelation Therapy (Lead Removal/Arteriosclerotic Heart Disease) Circle those that apply. |
| | | | Chemonucleolysis |
| | | | Chemotherapy |
| | | | Cryosurgery (other than use on benign, malignant or pre-malignant dermatological lesions) |
| | | | Cosmetic Procedures:<br>Botox Injection |
| | | | Chemical Peels |
| | | | Chemobrasion |
| | | | Collagen Injection |

| | | | |
|---|---|---|---|
| | | | Dermabrasion |
| | | | Fat Transfer |
| | | | Hair Transplant |
| | | | Laser Hair Removal |
| | | | Laser Skin Resurfacing |
| | | | Any other laser procedure or treatment (please specify): |
| | | | Lippodissolve |
| | | | Mesotherapy |
| | | | Microdermabrasion |
| | | | Silicone Injection |
| | | | Other (Describe here or on supplemental sheet): |
| | | | Dilation & Curettage |
| | | | Echocardiography |
| | | | Electroconvulsive Therapy |
| | | | Endoscopic Procedures |
| | | | Facial Plastic Surgery (Elective Cosmetic/Reconstructive) Circle those that apply. |
| | | | Fracture Reduction (Closed/Open) Circle those that apply. |
| | | | Hyperbaric Medicine |
| | | | Hysterectomy |
| | | | Intensive Care For Newborns |
| | | | Intensive Care Medicine For Adults |
| | | | Laparoscopy |
| | | | Liposuction (Tumescent/Other) Circle those that apply. |
| | | | Lymphangiography |
| | | | MOHS Micrographic Surgery |
| | | | Myelography |
| | | | Needle Biopsy (including lung, prostate, liver and kidney) |
| | | | Obstetrics<br>Prenatal Care ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester |
| | | | Normal Deliveries (Provide annual number: ) |
| | | | C-Sections (Provide annual number: ) |
| | | | VBAC Deliveries (Provide annual number: ) |
| | | | Organ Transplantation |
| | | | Orthopedic Surgery (including spinal/without spinal) Circle those that apply. |
| | | | Osteopathic Manipulative Medicine |
| | | | Pain Management (if other than medication only, please complete supplement) |
| | | | Penile Prosthetic Implants |
| | | | Phalloplasty |
| | | | Permanent Pacemaker Insertion |
| | | | Pneumoencephalography |
| | | | Prolotherapy |
| | | | Radiation Therapy |
| | | | Radiopaque Dye Injections |
| | | | Refractive Surgery (LASIK, PRK, AK, PTK, ICR) Circle those that apply. |
| | | | Rhinoplasty |
| | | | Sclerotherapy |
| | | | Thoracic Surgery _________% |
| | | | Tonsillectomy/Adenoidectomy |
| | | | Transgender Surgery or Hormonal Gender Conversion. Circle those that apply |
| | | | Tubal Ligation |
| | | | Vascular Surgery _________% |
| | | | Vasectomy |
| | | | Vertebroplasty |
| | | | Other Procedures not listed above (please list)<br>______________________________<br>______________________________<br>______________________________ |
| | | | I do not perform any of the above procedures/treatments. Initial__________ |

**If you answer "yes" to questions 39 through 45, please provide details on page 10.**

39. Has any licensing authority or hospital ever reprimanded you or ever denied, revoked, suspended, or restricted your medical license, narcotics license or practice privileges or put you on probation? ☐ Yes ☐ No
40. Has any licensing authority or hospital conducted (or are they currently conducting) an investigation relating to the nature of your practice privileges, or to the restriction or limitation of your license or privileges? ☐ Yes ☐ No
41. Have you ever been indicted, charged, arrested (other than for motor vehicle violations) or convicted of any offense, crime, or misdemeanor in any state or any federal jurisdiction? ☐ Yes ☐ No
42. Have you ever been evaluated, diagnosed, or treated for any disease or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency? ☐ Yes ☐ No
43. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No
44. Do you have a physical handicap or any chronic disease? ☐ Yes ☐ No
45. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health payors, or public health payors, including but not limited to Medicare or Medicaid? ☐ Yes ☐ No

## IV. CLAIM INFORMATION

**IMPORTANT INFORMATION REGARDING QUESTIONS 46A, 46B, 46C AND 46D (INCLUDING SUB-QUESTIONS)**

1. The word "claim" as used in questions 46A, 46B, 46C and 46D as follows refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional services and brought against you or any partner, associate, employee, or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or legal representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer yes to any parts of questions 46A, 46B or 46C, please complete the Supplementary Claims Information Form on page 11 for all such claims.

46. A. Have you ever been involved in a malpractice suit or claim, either directly or indirectly? ☐ Yes ☐ No

    If yes, how many? __________ (Provide details for each on page 11.)

    B. Other than the claims/suits indicated in 46.A. above, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

    1. A request for records from a patient and/or attorney related to an adverse outcome? ☐ Yes ☐ No
    2. A letter from an attorney regarding your medical treatment of a patient? ☐ Yes ☐ No
    3. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability, or the need for follow-up surgery? ☐ Yes ☐ No
    4. Patient or family members dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No
    5. Knowledge or information relating to service or services on a Board which might result in a claim? ☐ Yes ☐ No
    6. Any other circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No

    C. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability company? ☐ Yes ☐ No

    If yes, how many? __________ (Provide documentation of all such reports.)

    If no, please explain details on page 11.

    **For the purposes of this question, check the following box if you are aware of no circumstances that might reasonably lead to a claim or suit ……………………………………………………………..…..Not Applicable** ☐

    D. Has any prior professional liability company refused coverage for, or declined to accept a report of a medical incident, threat of a claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No

    If yes, please explain details on page 10.

## V. PROFESSIONAL LIABILITY INSURANCE HISTORY

47. Provide details of Professional Liability Insurance for the past seven (7) years, including coverage for "moonlighting" positions:

| Company Name | Each Claim Limit | Aggregate Limit | Policy Dates From | Policy Dates To | Claims Made or Occurrence? | Retroactive Date |
|---|---|---|---|---|---|---|
| | | | | | | |
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48. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium or issued coverage with any restrictions or exclusions? ☐ Yes ☐ No

    If yes, provide explanation on supplemental page 10.

49. Have you ever been without professional liability coverage since beginning practice? ☐ Yes ☐ No

    If yes, provide explanation on supplemental page 10.

50. Do you have professional liability insurance for work you do elsewhere? ☐ Yes ☐ No

    If yes, provide explanation on supplemental page 10.

51. If prior coverage is Claims-Made, has a Reporting Endorsement ("tail" coverage) been purchased? ☐ Yes ☐ No

    If yes, provide copy of the Reporting Endorsement.

    If no, provide explanation on supplemental page 10.

## VI. COVERAGE REQUEST

52. Effective Date Desired: ________________________ Retroactive Date Desired: ______________________________

    ***(NOTE: THE COMPANY MAY NOT PROVIDE DESIRED DATES)***

53. Policy Limits Desired: ☐$100,000/$300,000 ☐$200,000/$600,000 ☐$250,000/$750,000 ☐$500,000/$1,500,000 ☐$1,000,000/$3,000,000 ☐Other: ____________________________________________________

54. A deductible of at least $5,000 is required. Please select any optional deductibles that you desire. No aggregate limit will apply to the deductible. ☐$10,000 ☐$25,000 ☐$50,000 (approved LOC required)

## SUPPLEMENTAL INFORMATION

***Please use this form to provide additional information or to answer any questions.***

| Question No. | |
|---|---|
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**DECLARATION**

I understand the submission of this application does not bind the Company to issue or me to purchase this insurance. By signing below, I grant permission (1) to the Company to contact third parties and (2) for third parties to release to the Company information which relates to the issuance and continuation of this insurance. I also understand that knowingly providing false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company may constitute a crime punishable by imprisonment, fines and/or a denial of insurance benefits.

I represent that the information provided in this application (and attachments) is true. I understand (1) that this application and any previous applications are the basis of and will become a part of the insurance contract with the Company; (2) that the application information I provided is material to the Company; (3) that the Company is relying on this information in determining whether to issue an insurance contract and in establishing the premium to charge for the insurance contract; and (4) that the Company may rescind or void the insurance contract if this application or any previous application contains any misrepresentations or omissions. Furthermore, I understand that my failure to disclose to the Company any material fact that I become aware of subsequent to the completion of this application but prior to the effective date of the policy may also void the contract.

| **Signature of Applicant** | **Date** |
|---|---|
| | |

## SUPPLEMENTAL CLAIM INFORMATION

**If reporting more than one claim, please photocopy this form, and complete a separate form for each claim.**

**If space is insufficient to answer any question fully, please attach a separate sheet. All questions must be answered or marked not applicable (N/A).**

1. Patient's Name:_______________________________________________Age________Sex_________
2. Date reported to insurance company: _______________
3. Date of incident and your treatment: ________________
4. Name of insurance company:____________________________________________________________
5. Allegations:__________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
6. What is the present condition of the patient?__________________________________________
   ______________________________________________________________________________________
7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No
8. Status of claim (check applicable answer):

| | | |
|---|---|---|
| ☐ Suit threatened, no action take<br>☐ Suit filed but dropped by claimant<br>☐ Summary judgment in your favor | Court outcome in your favor:<br>☐ Jury verdict<br>☐ Directed verdict | Unresolved/Open Claim:<br>☐ Awaiting mediation<br>☐ Awaiting court action |
| ☐ Suit settled out of court<br>a. Date claim paid:____________<br>b. Amount paid: $ _____________<br>c. Did you want to settle this claim? ☐ Yes ☐ No | Court outcome in favor of plaintiff:<br>☐ Jury verdict<br>☐ Directed verdict<br>Amount of loss payment:<br>$ ________________ | Reserve Amount:<br>$___________________ |

9. Name and address of the attorney assigned to your case:___________________________________
   ______________________________________________________________________________________
10. To your knowledge, was any settlement paid by another party involved (your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No

    If yes, what was the amount of the settlement? _______________________________
11. Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:_________________
    ______________________________________________________________________________________
    ______________________________________________________________________________________
    ______________________________________________________________________________________

Applicant's Signature ____________________________________________ Date: ________________________

Name (Printed) ____________________________________________