



# Rockbridge Underwriting Agency Limited

## APPLICATION FOR PHYSICIAN/SURGEON MEDICAL PROFESSIONAL LIABILITY INSURANCE

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

### I. IDENTIFYING INFORMATION

Full Name:

Mailing Address

Street:

City:

County:

State:

Zip:

Telephone: Area Code ( )

Social Security No.

Date of Birth:

### II. COVERAGE REQUESTED

Effective Date:

Retroactive Date:

Deductible:

Limits of Liability:

\$100,000/\$300,000

\$200,000/\$600,000

\$250,000/\$750,000

\$500,000/\$1,000,000

\$500,000/\$1,500,000

\$1,000,000/\$3,000,000

A "tail" policy is generally available as an option of your expiring Claims Made Policy. Are you purchasing a tail?  Yes  No

If you are requesting prior acts coverage, complete Section XIII. and attach a completed Prior Acts Supplement and a copy of your current Declarations page.

### III. LICENSURE

STATE:

LICENSE #:

EXPIRATION DATE:

STATE:

LICENSE #:

EXPIRATION DATE:

STATE:

LICENSE #:

EXPIRATION DATE:

NARCOTICS LICENSE NO.:

### CHRONOLOGY OF PROFESSIONAL CAREER

LIST ALL PAST AND PRESENT AFFILIATIONS. ATTACH SEPARATE SHEET IF NECESSARY.

	LOCATION, CITY, STATE	SPECIALTY	DATES
A.			
B.			
C.			
D.			
E.			

**IV. EDUCATION**

SCHOOL AND LOCATION	DATE ADMITTED	DATE COMPLETED	DEGREE
UNDERGRADUATE:			
GRADUATE:			
MEDICAL SCHOOL:			

If graduated from a foreign medical school, are you ECFMG Certified?

Yes  No

Certification # \_\_\_\_\_

If NO, please attach explanation.

**INTERNSHIPS**

(Non-Consecutive Training-Please attach explanation)

FACILITY AND LOCATION:	DATE ADMITTED	DATE COMPLETED	SPECIALTY

**RESIDENCIES**

(Non-Consecutive Training-Please attach explanation)

FACILITY AND LOCATION:	DATE ADMITTED	DATE COMPLETED	SPECIALTY

NAME OF RESIDENCY PROGRAM DIRECTOR:

**FELLOWSHIPS**

FACILITY AND LOCATION	DATE ADMITTED	DATE COMPLETED	SPECIALTY

Are you presently participating in an internship, residency or fellowship training program?

Yes  No

If "YES," indicate type of program and location.

**V. CERTIFICATION**

BOARD CERTIFIED BY:

BOARD ELIGIBLE - DATE OF EXAM:

BOARD QUALIFIED (completed required training)

NEITHER BOARD CERTIFIED NOR BOARD QUALIFIED (Explain

IF BOARD ELIGIBLE FOR OVER FIVE YEARS, BUT NOT BOARD CERTIFIED, PLEASE EXPLAIN:

**OTHER CERTIFICATION (List) or TRAINING (preceptorships, etc.)**

<input type="checkbox"/> ACLS Expiration Date:	<input type="checkbox"/> ATLS Expiration Date:
--	--

OTHER (Specify): \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**VI. CURRENT PRACTICE**

MEDICAL SPECIALTY:	SUB-SPECIALTY:	% OF PRACTICE:
Average weekly patient load:	% Of Practice Out Of State	% Locum Tenens:

A. Number of years at current office location: \_\_\_\_\_

B. Have there been any significant changes in your practice during the past 5 years, i.e., change of Specialty, addition or deletion of procedures, etc.  Yes  No  
 If "YES," please explain: \_\_\_\_\_

C. TYPE OF PRACTICE:  
 Are you:

1. Self-employed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. An employee of another physician? If "Yes," explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. An employee of an organization, other than a hospital, engaged in the delivery of medical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. An independent contractor to an organization, other than a hospital, engaged in the delivery of medical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

D. 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:  
 Name \_\_\_\_\_  
 Type of entity:  Medical Partnership  Professional Association  Professional Services Corporation  
 List all stockholders, partners and associates: \_\_\_\_\_

Are you requesting that the legal entity be named on your policy?  Yes  No  
 (If the carrier does not insure all the members, the coverage extended to the corporation would respond only to liability arising out of the acts of the insured physician).

E. Do you practice medicine, in whole or in part, as an employee or consultant to a commercial enterprise, governmental body, military service, educational facility or professional sports organization  Yes  No  
 For Whom: \_\_\_\_\_

F. Are you contracted by or employed in an Emergency Department? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float:right">No. of EDs _____</span>	% of Practice: # Hours/Month: _____
Name of Contract Group or Hospital: _____	Duties: _____

Total emergency procedures performed per year: \_\_\_\_\_

## VII. MEDICAL STAFF

A. Do you personally employ any of the following support personnel? Include number of employees by category:

<input type="checkbox"/> Med Lab Tech	<input type="checkbox"/> LPN/LVN	<input type="checkbox"/> X-Ray Tech
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> RN	<input type="checkbox"/> Physiotherapist
<input type="checkbox"/> Scrub Nurse	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Med Assistant	<input type="checkbox"/> Optician	<input type="checkbox"/> Other:

B. Indicate the number employed by you or your group:

Midwife	Physician/Surgeon Assistant	Paramedic
CRNA	Nurse Practitioner	Or Tech

Are any of the above independent contractors?  Yes  No

If independent contractors, do they have individual coverage, independent of you?  Yes  No

## VIII. MEDICAL PROCEDURES

Check the appropriate box, indicating the extent of surgery you perform:

No surgery except incision of boils, cysts, other superficial abscesses or suturing of minor lacerations.

Assisting in surgery on your own patients. No. Annually \_\_\_\_\_

Assisting in surgery on patients other than your own. No. Annually \_\_\_\_\_

Minor Surgery. No. Annually \_\_\_\_\_

Normal obstetrical deliveries. No. Annually \_\_\_\_\_ Percent Cesarean Sections \_\_\_\_\_

Major Surgery -- includes all procedures done under general, spinal or caudal anesthesia. No. Annually \_\_\_\_\_

Check the following procedures which you perform. If none, check here:

Primary/Assisting	Primary/Assisting	Primary/Assisting
<input type="checkbox"/> <input type="checkbox"/> Abortions No. per year: _____	<input type="checkbox"/> <input type="checkbox"/> Hair growing or transplants	<input type="checkbox"/> <input type="checkbox"/> Shock therapy (E.C.T.)
<input type="checkbox"/> <input type="checkbox"/> Acupuncture or acupressure	<input type="checkbox"/> <input type="checkbox"/> Banding hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Spinal anesthesia
<input type="checkbox"/> <input type="checkbox"/> Anesthesia	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> <input type="checkbox"/> Suction assisted lipectomy/ liposuction
<input type="checkbox"/> <input type="checkbox"/> Angiography	<input type="checkbox"/> <input type="checkbox"/> Hernias	<input type="checkbox"/> <input type="checkbox"/> T & A's
<input type="checkbox"/> <input type="checkbox"/> Appendectomies	<input type="checkbox"/> <input type="checkbox"/> Hysterectomies	<input type="checkbox"/> <input type="checkbox"/> Thoracic surgery
<input type="checkbox"/> <input type="checkbox"/> Cesarean sections	<input type="checkbox"/> <input type="checkbox"/> Injection or implants in breasts	<input type="checkbox"/> <input type="checkbox"/> Tubal ligations
<input type="checkbox"/> <input type="checkbox"/> Chemobrasion	<input type="checkbox"/> <input type="checkbox"/> Insertion of intrauterine contraceptive devices	<input type="checkbox"/> <input type="checkbox"/> Vascular surgery (other than peripheral vascular)
<input type="checkbox"/> <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> <input type="checkbox"/> Laparoscopy	<input type="checkbox"/> <input type="checkbox"/> Vasectomies
<input type="checkbox"/> <input type="checkbox"/> Cosmetic plastic surgery (elective)	<input type="checkbox"/> <input type="checkbox"/> Lasers-used in therapy or surgery	<input type="checkbox"/> <input type="checkbox"/> Weight control-other than by diet
<input type="checkbox"/> <input type="checkbox"/> Cosmetic plastic surgery (traumatic)	<input type="checkbox"/> <input type="checkbox"/> Needle biopsy	<input type="checkbox"/> <input type="checkbox"/> Any procedure not usual or customary to the specialty
<input type="checkbox"/> <input type="checkbox"/> Cryosurgery	<input type="checkbox"/> <input type="checkbox"/> Obstetrical deliveries	<input type="checkbox"/> <input type="checkbox"/> Any procedure disapproved by AMA for FDA
<input type="checkbox"/> <input type="checkbox"/> D & C 's	<input type="checkbox"/> <input type="checkbox"/> OB deliveries at other than a licensed acute care hospital	<input type="checkbox"/> <input type="checkbox"/> Any experimental procedures
<input type="checkbox"/> <input type="checkbox"/> Dermabrasion	<input type="checkbox"/> <input type="checkbox"/> Office x-rays	
<input type="checkbox"/> <input type="checkbox"/> Endoscopic procedures	<input type="checkbox"/> <input type="checkbox"/> Open reductions of fractures	
<input type="checkbox"/> <input type="checkbox"/> Gastric by-pass surgery	<input type="checkbox"/> <input type="checkbox"/> Radial keratotomy	
<input type="checkbox"/> <input type="checkbox"/> Gastric stapling	<input type="checkbox"/> <input type="checkbox"/> Radiation therapy	
<input type="checkbox"/> <input type="checkbox"/> General anesthesia	<input type="checkbox"/> <input type="checkbox"/> Shock therapy (E.C.T.)	

<b>IX. ADDITIONAL PROFESSIONAL INFORMATION (Please give a complete explanation of "Yes" answers)</b>	
a. Has membership in any professional association or society ever been revoked or refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has any hospital suspended, restricted or refused your staff privileges, or have you voluntarily or involuntarily surrendered or limited your privileges anytime while under peer investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you ever had a grievance filed against you with your County or State Medical Society, or have you been censured or received a private reprimand from any such organization or hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have you ever voluntarily surrendered or had a narcotics license refused, suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have you ever been treated for alcoholism, narcotic addiction, or mental illness? If "yes," provide details of rehabilitation program, including dates of treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Have you ever suffered from or been treated for any chronic illness or physical defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Have you ever had any professional liability insurance refused, canceled or non-renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Do you work as an emergency room physician? If "yes," how many hours per week: If "yes," is this required for hospital staff privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Do you work in an industrial clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Do you work in any free-standing Emergency Center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Do you work in any free-standing "Birthing Center" or similar facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer of any of the following? Hospital, Sanitarium, Nursing Home, Surgi-Center, Clinic with bed and board facilities, Laboratory (Independent or outside), Blood Band, Prepaid Health Plan or Health Maintenance Organization, Other medical facility. If you have answered "Yes" to any of the following, please list the names of the facilities and your affiliation with them in the space provided:  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you practice medicine at this/these institution(s)? Please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Do you maintain any overnight patient facilities in your own office?	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Do you render patients unconscious for treatment in your office or other non-hospital facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
q. Do you ever enter into arbitration or similar agreements with your patients? If "yes," submit copies and describe circumstances in which they are used.	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>X. HOSPITAL PRIVILEGES</b>	
Hospital in which you have staff membership or privileges:	Nature of Privileges (active, courtesy, etc.):

Have your hospital privileges been expanded during the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or your Board Specialty?  No  Yes-Explain:

**XI. PREVIOUS INSURANCE**

Current Carrier:	Effective Date: Expiration Date:	Limits of Liability:
Premium:	<input type="checkbox"/> Claims Made Retroactive Date:	<input type="checkbox"/> Occurrence
Prior Carrier:	Effective Date: Expiration Date:	Limits of Liability:
Premium:	<input type="checkbox"/> Claims Made Retroactive Date:	<input type="checkbox"/> Occurrence
Prior Carrier:	Effective Date: Expiration Date:	Limits of Liability:
Premium:	<input type="checkbox"/> Claims Made Retroactive Date:	<input type="checkbox"/> Occurrence

Have you ever had Professional Liability Insurance provided by National Fire & Marine Insurance Company?  Yes  No

If YES, Policy No.:

Have you ever been without insurance?  Yes  No

To your knowledge have you ever been insured with an insolvent carrier?  Yes  No

If "Yes," explain:

**XII. CLAIM INFORMATION**

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit?  No  Yes If yes, complete a claims supplement for each claim.

Total Number of Claims	Open	Closed
------------------------	------	--------

**XIII. PRIOR ACTS COVERAGE**

You are not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Prior Acts Coverage period. You must provide a complete copy of your expiring professional liability policy (including the declarations and endorsements).

**NOTE: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting coverage from your current carrier until you are specifically notified in writing that your request for Prior Acts Coverage has been approved.**

REQUESTED RETROACTIVE DATE: \_\_\_\_\_

NOTE: Since you wish to obtain coverage for PROFESSIONAL MEDICAL SERVICES that took place prior to the Requested Effective Date shown under section II, you must indicate the date that you wish coverage to begin. This date is the Requested Retroactive Date. The period between the Requested Retroactive Date and Requested Effective Date defines the Prior Acts period.

**PRACTICE HISTORY**

Did you practice with other physicians in an employer-employee relationship, ostensible or formal partnership, medical association or medical corporation during the period for which you are requesting Prior Acts Coverage?..... Yes  No

If "yes," list the full name(s) of the entity(ies) and physician(s) with whom you practiced and the period of each such association. Attach additional pages as needed.

NAME OF ENTITY	NAME OF PHYSICIAN	DATES	
		FROM	TO

**NON-PHYSICIAN HEALTH CARE PROVIDERS**

Did you employ, contract with or supervise any non-physician health-care providers (i.e., physician's assistants, nurse practitioners, LPN's, RN's, etc.) during the period for which you are requesting Prior Acts Coverage?..... Yes  No

**CHANGES IN PRACTICE**

Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this application for Medical Professional Liability Claims-Made Coverage. For instance, did your practice formerly include obstetrical care or emergency room services that you are no longer providing or did you ever perform silicone implants of any kind?..... Yes  No

Did any of your policies contain any coverage restrictions?..... Yes  No

If "Yes," please describe the changes in your practice, including all applicable dates. Attach additional pages as needed.

**NOTE: Adequate Prior Acts Coverage is contingent upon your description of your former practice.**

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 1 of this application to (PRESENT DATE) \_\_\_\_\_ have been reported to my current insurance carrier:

(CARRIER): \_\_\_\_\_

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to National Fire & Marine Insurance Company prior to the effective date of such coverage and are listed below:

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations.

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

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which 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 the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains by my background, competence and qualifications, and I incurred in connection therewith.

**ACKNOWLEDGED AND AGREED:**

APPLICANT (Signature Required)

DATE:

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.