Washington State Medical Malpractice

PHYSICIANS & SURGEONS
APPLICATION FOR
PROFESSIONAL LIABILITY INSURANCE

CLAIMS - MADE
IMPORTANT

**GENERAL INSTRUCTIONS:** It is essential that all statements be completed and all questions answered that apply to you or your specialty. If the answer to any question is “No,” be certain to check “No” on the application. **DO NOT LEAVE ANY QUESTION UNANSWERED.** IF ADDITIONAL SPACE IS REQUIRED, PLEASE USE THE “REMARKS” SECTION AT THE END OF THE APPLICATION. Please print or type your answers. To expedite the processing of your application, please attach the results of your self query of your National Practitioner Data Bank profile, your curriculum vitae, and a current loss run from your current and prior insurer(s).

**PRIOR ACTS COVERAGE:** If you currently have a Claims-Made policy and want Prior Acts Coverage, the retroactive date is the date you first became insured under a Claims-Made policy. To apply for this coverage, please complete Section III, Prior Acts, of the application.

Prior Acts Coverage does **not** cover claims, suits, incidents or potential claims of which you are, or have reason to be, aware. These matters **must** be reported to your current carrier. You should always request confirmation in writing from that carrier that it will cover claims arising out of these reports.

It is important that you realize that the coverage afforded under Prior Acts Coverage with an insurance carrier that may be selected, if granted, might differ from the coverage afforded by your current carrier. Any claims reported under an insurance carrier that may be selected policy will be subject to the policy terms in effect at the time the claim is reported.

**CONFIRMATION OF PROFESSIONAL LIABILITY COVERAGE TO HOSPITALS:** Under question #19 (page 3), you may request that we automatically send a Confirmation of Coverage Statement to the hospitals you list.
### SECTION I – APPLICANT INFORMATION

**Agent Name/Number (if applicable):**

**Desired Effective Date:** ________________  **Desired Retroactive Date (if applicable):** ________________

**DESIRED LIMITS OF LIABILITY:**
- $1,000,000/5,000,000
- $2,000,000/6,000,000
- $3,000,000/7,000,000
- $4,000,000/8,000,000
- $5,000,000/9,000,000

**Your practice is:**
- [ ] Full-time
- [ ] Part-time, total number of practice hours per week (incl. hospital rounds, charting, patient visits/consults, phone contact) and on call hours involving patient contact: ________________

**1. Name:** __________________________________________  **2. DOB:** ________________  **3. □ M □ F**

**4. Principal medical specialty or subspecialty in which you practice:** ______________________________________

**5. SS #:** __________________________________________  **6. State in which your primary practice is/will be located:** ______________________________________

**7. Are you licensed to practice in any other state(s)?**
- [ ] Yes
- [ ] No

- a. State license number __________________________________________
- b. State license number __________________________________________

**8. Desired policy mailing address:**

<table>
<thead>
<tr>
<th>street address</th>
<th>city</th>
<th>state</th>
<th>zip code</th>
</tr>
</thead>
</table>

**9. Home address:**

<table>
<thead>
<tr>
<th>street address</th>
<th>city</th>
<th>state</th>
<th>zip code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>area code</th>
<th>telephone</th>
<th>fax</th>
<th>Home E-mail address</th>
</tr>
</thead>
</table>

**10. Office practice location(s):**

**Clinic name:** ______________________________________

- a. Street address: __________________________________________

<table>
<thead>
<tr>
<th>street address</th>
<th>city</th>
<th>state</th>
<th>zip code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>area code</th>
<th>telephone</th>
<th>Average weekly practice time at this location:</th>
<th>Business E-Mail Address</th>
</tr>
</thead>
</table>

**Do you perform surgical procedures at this location?**
- [ ] Yes
- [ ] No

**If “Yes,” list all procedures in the “REMARKS” section.**

- b. Street address: __________________________________________

<table>
<thead>
<tr>
<th>street address</th>
<th>city</th>
<th>state</th>
<th>zip code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>area code</th>
<th>telephone</th>
<th>Average weekly practice time at this location:</th>
<th>Business E-Mail Address</th>
</tr>
</thead>
</table>

**Do you perform surgical procedures at this location?**
- [ ] Yes
- [ ] No

**If “Yes,” list all procedures in the “REMARKS” section.**

**NOTE:** If you have more than two office practice locations, please use the “REMARKS” section.
11. Where have you practiced medicine in the past 10 years? Include military and any public service organizations.

PLEASE INCLUDE A CURRICULUM VITAE (CV) WITH YOUR APPLICATION. Please provide evidence of purchase of the Extended Reporting Endorsement Coverage (“Tail”) if not requesting Prior Acts. If you have not practiced medicine continuously, please explain/document those time periods in the “REMARKS” section.

a. 

facility name

street address
city state dates

professional liability insurance carrier

Policy #

b. 

facility name

street address
city state dates

professional liability insurance carrier

Policy #

Have you practiced without insurance at any time? ☐ Yes ☐ No

If “Yes,” please explain in the “REMARKS” section.

12. Are you a member of your state medical association? ☐ Yes ☐ No

State: If applying, check here: ☐

Are you a member of any other professional society or association? ☐ Yes ☐ No

If “Yes,” please list.

13. Medical School:

Name of Medical School

city state/country yr graduated Degree

If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates? ☐ Yes ☐ No

Have you passed the FLEX? ☐ Yes ☐ No

14. Residency:

name of hospital

street address
city state zip
type of residency
dates attended

Was residency completed? ☐ Yes ☐ No

If “No,” please explain:

15. Additional training (Internship/Fellowship/Second Residency):

name of facility (hospital)

street address
city state zip
type of training /type of residency
dates attended

Was residency completed? ☐ Yes ☐ No

If “No,” please explain:

16. Board Certification:

name of board date certified Recertified

17. If you are not Board Certified, have you taken and failed board exams? ☐ Yes ☐ No

Are you Board eligible? ☐ Yes ☐ No

Date eligibility expires: month / year

If not Board Certified and/or Board eligible, please explain in the “REMARKS” section.
18. Principal medical specialty or subspecialty in which you practice and for which you are seeking professional liability insurance:

19. Hospital privileges:

   Primary Hospital:
   
   name of hospital
   
   city
   
   Average number of hours per week at this hospital:
   
   Category of privileges (active, consulting, courtesy, etc.):
   
   Department of:

   Send Confirmation of coverage?  □ Yes  □ No

   Do you staff the E.R. at this hospital other than to maintain hospital privileges?  □ Yes  □ No  If “Yes,” number of hours per week: ___________

   Please list any other hospitals at which you hold privileges: __________________________________________________________________________________________

20. If you do not currently have hospital privileges, explain the referral method you use if a patient requires hospital admission: Please explain why you do not maintain hospital privileges.

21. Your practice is (check all that apply):

   □ Individual (solo unincorporated)
   □ Sole shareholder of a medical corporation
     Name of corporation: __________________________
   □ Employee of*: ___________________________________________________________________
   □ Independent contractor for*: ___________________________________________________________________
   □ Partner of a partnership*
     Name of partnership: __________________________
   □ Shareholder of a multi-shareholder corporation*
     Name of multi-shareholder corporation: __________________________

22. Are you a member of a PHO, IPA, MSO, PHCO, IPO, or similar physician organization?  □ Yes  □ No

   Name of physician organization: __________________________

* Please provide names of all physicians or attach a copy of letterhead of the organization.

23. Do you employ other physicians?  □ Yes  □ No

Please list names in “REMARKS” section.
24. If you are a **solo practitioner**, indicate the extent of your professional relationship with any physician(s) with whom you are associated:

- Not applicable
- Share professional employees
- Share office space only
- See each other’s patients (other than on-call)
- Common billing and/or letterhead
- Name(s) of physicians with whom you are associated:

25. How many of the following ancillary personnel do you employ, contract, supervise or sponsor:

(If you are a member of a partnership/corporation, this does not apply.)

- _____ RN/LPN
- _____ Nurse Practitioner*
- _____ Licensed Surgical Assistant*
- _____ Lab/X-ray technician
- _____ CRNA*
- _____ Certified Nurse Midwife*
- _____ Paramedic*
- _____ Registered Physician Assistant*
- _____Licensed Midwife*
- _____Alternative Health Care Provider* (Please describe)

*If you employ, contract, supervise, or sponsor any of the above, please describe their relationship and duties in the “REMARKS” section, and attach copies of their credentials.

26. Do you have a practice activity or position for which you do not require coverage?  
Yes   No  
If “Yes,” please provide details in the “REMARKS” Section.

27. Do you use an office surgical suite?  
Yes   No

28. Are you associated (except by medical staff appointment) with the following:

- Health care facility having bed and board accommodations?  
Yes   No
- Health care foundation, blood bank, or freestanding laboratory?  
Yes   No
- Medical service facility maintained by an industrial firm?  
Yes   No
- State, federal, or local public entity?  
Yes   No
- Urgent Care facility?  
Yes   No
- In an administrative capacity for/with PPOs, HMOs, IPAs?  
Yes   No

How many hours per week do you spend in the capacity(ies) above?  

If the answer to any of the above is “Yes,” please provide the full legal name and location of the facility(ies) and the department in which you serve:

Is insurance coverage provided by the entity or organization for the activities listed above?  
Yes   No

Name of insurance company:

NOTE: IF ANY ANSWER TO QUESTIONS 29 THROUGH 37 IS “YES,” USE THE “REMARKS” SECTION TO PROVIDE DETAILS. PROVIDING ADEQUATE DETAIL AND DOCUMENTATION WILL ASSIST US IN EXPEDITING OUR UNDERWRITING REVIEW.

29. Has your license to practice medicine or dispense narcotics in any jurisdiction **ever** been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you? 

- Medical License  
Yes   No
- DEA License  
Yes   No

30. Have you been denied membership or renewal thereof or been subject to any disciplinary action in any national, state, or local medical organization, independent practice association, or professional society, or have proceedings towards any of those ends been instituted against you?  
Yes   No

31. Have you **ever** been subject to governmental agency, medical, or professional society disciplinary proceedings resulting in reprimand, censure, sanction, or modification of your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by any such agency or society?  
Yes   No
32. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?
   ☐ Yes ☐ No
   NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.

33. Have you had an application for membership or privileges at a hospital, health maintenance organization, independent practice association, or other health care facility denied, granted with limitations, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have any such actions been recommended by a standing medical staff committee or governing board of a hospital or other health care facility? ☐ Yes ☐ No

34. Has your professional liability insurance ever been declined, cancelled, refused renewal, or issued on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature?
   ☐ Yes ☐ No

35. Have you ever incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (alcoholism, convulsive disorders, mental illness, multiple sclerosis, narcotics addiction, HIV, etc.)? ☐ Yes ☐ No
   If “yes,” in the “REMARKS” section, state illness or disability with date(s), and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession.

36. Has any claim or suit for alleged malpractice ever been brought against you or your professional corporation?
   ☐ Yes ☐ No
   If “Yes,” give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.

37. Has the threat or avoidance of disciplinary action ever caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration? ☐ Yes ☐ No
   If “Yes,” give full details on the Claim Information Supplement, which is attached as part of this application.
SECTION III – PRIOR ACTS INFORMATION (to be completed by all applicants requesting Prior Acts Coverage)

NOTE: Include current copy of the declarations page from your current or previous insurer.
Retroactive date: __________________________

38. Have you been continuously covered by an individual Claims-Made policy for your primary practice from the retroactive date stated on page 1 to the requested effective date of your coverage with the insurance carrier which may be selected?  
   - Yes  
   - No  
If “No,” please explain in the “REMARKS” section.

39. During the period for which you are requesting Prior Acts Coverage, did you practice with other physicians:
   - In an employer-employee relationship?  
     - Yes  
     - No
   - Locum tenens relationship?  
     - Yes  
     - No
   - Formal partnership or informal association?  
     - Yes  
     - No
   - Corporation?  
     - Yes  
     - No
If “Yes,” list the full names of all physicians with whom you have been associated during this period:

40. Indicate below the health care providers you employed, contracted, or supervised during the period for which you are requesting Prior Acts Coverage and please describe the nature of your relationship. If none, please indicate.
   - Physician Assistant  
     - Yes  
     - No  
     - Dates ______________
   - Nurse Practitioner  
     - Yes  
     - No  
     - Dates ______________
   - Nurse Midwife  
     - Yes  
     - No  
     - Dates ______________
   - Nurse Anesthetist  
     - Yes  
     - No  
     - Dates ______________
   - Licensed Surgical Assistant  
     - Yes  
     - No  
     - Dates ______________

41. Indicate all practice locations during the period for which you are requesting Prior Acts Coverage.

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

42. During the period for which you are requesting Prior Acts Coverage, was your practice different from your practice as described in Section II of this application? For example, did your practice formerly include obstetrical care or emergency medicine services which you are no longer providing?  
   - Yes  
   - No  
If “Yes,” describe below the changes in your practice, including all applicable dates. Attach additional pages as needed.

43. Are you aware 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?
   a. Patient or attorney request for records related to an adverse outcome?  
      - Yes  
      - No
   b. A letter from an attorney regarding your medical treatment of a patient?  
      - Yes  
      - No
   c. Intra-operative or postoperative complications or other complications resulting in death, paralysis, or other significant disabilities?  
      - Yes  
      - No
   d. Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis?  
      - Yes  
      - No
   e. A patient who is suing another physician or hospital for the same treatment at issue?  
      - Yes  
      - No
   f. Any other circumstance that might reasonably lead to a claim or suit?  
      - Yes  
      - No

   Explain any “Yes” answer on the attached Claim Information Supplement.

44. Have you reported to your current insurance company all the above circumstances of which you are aware that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit)?  
   - Yes  
   - Please attach documentation of all such reports.
   - No  
   - Please explain in the “REMARKS” section.
   - None to report
### SECTION IV – SPECIALTY QUESTIONS

Please be certain to answer all questions applicable to your specialty or procedure. If the answer is “No,” be certain to check “No.”

#### ANESTHESIOLOGY

1. Do you practice in other than a hospital setting (office surgical suite, surgery center, etc.)? □ Yes □ No

2. Please indicate type of anesthesia used outside of hospital setting: __________________________________________

3. If yes, is the suite/center certified by the American Association for Accreditation of Ambulatory Surgery Facilities? □ Yes □ No

4. Do you practice in the field of pain management? □ Yes □ No  Acupuncture? □ Yes □ No

   If “Yes,” are you board certified in Pain Management by the American Board of Anesthesia? □ Yes □ No

   If “Yes” to either of the above, please provide details of practice including methods used, pain-management training, and patient selection criteria:

   Percent of practice ______ %

   Please list procedures and medications you use for pain medication: __________________________________________

   __________________________________________

5. What types of narcotics do you prescribe for relief of pain? __________________________________________

   Do you use a dictated record for pain patients? □ Yes □ No

6. What portion of your practice consists of the following:

<table>
<thead>
<tr>
<th>Pediatrics</th>
<th>OB</th>
<th>Cardiac</th>
<th>Pain Management</th>
<th>Operative Anesthesia</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ %</td>
<td>_____ %</td>
<td>_____ %</td>
<td>_____ %</td>
<td>_____ %</td>
<td>_____ %</td>
</tr>
</tbody>
</table>

7. Please indicate the type of monitoring you utilize during the administration of sedation, spinal, caudal, epidural, major nerve blocks or general anesthesia:

   □ Continuous electrocardiographic display
   □ Continual blood pressure monitoring either by use of an intra-arterial and electronic monitor or by use of standard blood pressure cuff with periodic checks at regular intervals
   □ Use of precordial, esophageal, or peritracheal stethoscope
   □ Continuous peripheral blood flow monitoring (pulse monitor)
   □ Pulse Oximeter
   □ End tidal CO₂ monitor
   □ Other: __________________________________________

8. Do you perform hypotensive anesthesia? □ Yes □ No

   If yes, □ in a hospital □ in a surgery center

9. Do you supervise CRNAs? □ Yes □ No

   Maximum number of CRNAs you will supervise at any one time: ________

   Are the CRNAs you supervise: □ hospital employees? □ your own employees? □ other: __________________
1. Are you required to supervise emergency medical technicians via radio? □ Yes □ No

2. Are you required to perform: □ Obstetrics/Emergency deliveries □ Surgery

3. Please describe the extent of surgery you perform: ________________________________________________________________

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**GENERAL, CARDIAC, NEUROLOGICAL, THORACIC, UROLOGICAL AND VASCULAR SURGERY**

1. Do you perform organ transplants? □ Yes □ No If “Yes,” what types? ________________________________

2. Do you perform bariatric surgery? □ Yes □ No If “Yes,” please describe types of procedures performed and patient selection criteria: ________________________________
   Percent of practice ________ %

3. Do you subspecialize? □ Yes □ No If “Yes,” subspecialty: ________________________________
   Percent of practice ________ %

4. Do you perform any surgery that is not categorized as part of your specialty? □ Yes □ No
   If “Yes,” please list procedures performed: ________________________________

5. Do you perform video surgeries (endoscopic, laparoscopic, arthroscopic, etc.?) □ Yes □ No
   If “Yes,” please specify: ________________________________

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**GENERAL/FAMILY PRACTICE, DERMATOLOGY, RADIOLOGY & OTHER NONSURGICAL SPECIALTIES**

(Except Pediatrics & Emergency Medicine)

1. Do you assist in surgery on your own patients only? □ Yes □ No
   Do you assist in surgery on other than your own patients? □ Yes □ No

2. Do you perform induced, non-spontaneous abortions? □ Yes □ No
   First Trimester, less than 12 weeks ________ (number/month)
   Second Trimester, 12-16 weeks ________ (number/month)
   Second Trimester, over 16 weeks ________ (number/month)
   List hospitals, clinics, or other facilities where performed: ________________________________________________________________

3. Do you provide obstetrical care? □ Yes □ No
   Uncomplicated prenatal care, labor, and delivery? ________ Number of deliveries performed per year: ________
   High-risk pregnancies, including but not limited to cesarean section, VBAC, or identifiable prospects of multiple births, preeclampsia, insulin-dependent diabetes, cardiac disease, renal disease, morbid obesity, or other life-threatening conditions? ________ Number of deliveries performed per year: ________
   Are deliveries undertaken in other than a licensed hospital (except in an emergency)? □ Yes □ No
   If “Yes,” please explain in “REMARKS” section.
4. Do you ever administer any spinal, caudal, epidural, or general anesthesia?  ☐ Yes  ☐ No

5. Do you perform in-office anesthesia?  ☐ Yes  ☐ No  If “Yes,” please indicate level:  ☐ Minimal Sedation  ☐ Moderate Sedation/Analgesia  ☐ Deep Sedation, Major Conduction Analgesia  ☐ General Anesthesia

6. Please check surgical procedures and medical techniques you perform:

☐ Acupuncture for analgesia  _____ % of practice
☐ Acupuncture, other:  ____________________________  _____ % of practice
☐ Alternative or Complementary Medicine
☐ Angiography
☐ Appendectomies
☐ Body Imaging
☐ Chemical Peels (Baker or Phenol)
☐ Chemotherapy
☐ Deep Radiation/X-Ray Therapy (over 120 k.v.)
☐ Diagnostic Embolization
☐ Dilation and Curettage
☐ Endoscopy
  ☐ Therapeutic  _______ #
  ☐ Diagnostic  _______ #
☐ Hair Transplants
☐ Hemorrhoidectomies
  ☐ External  _______ #
  ☐ Internal  _______ #
☐ Herniorrhaphies
☐ Hysterectomies
☐ Injection of Radiopaque Dye (other than IVP, CAT scans, and MRI)
☐ Laparoscopy
☐ Laser Procedures, please describe:
  ____________________________
  ____________________________
☐ Left Heart Catheterization
☐ Liposuction  _______ cc of fat removed
☐ MOHS technique
☐ Open Reduction of Fractures
☐ Other Visualization of Internal Organs
☐ Pain Management, please describe:  _________
  ____________________________
☐ Plastic Surgery Procedures, please describe:
  ____________________________
  ____________________________
☐ Right Heart Catheterization (other than Swan-Granz)
☐ Scalp Reduction
☐ Shock Therapy
☐ Transluminal Angioplasty
☐ T&As
☐ Tubal Ligation
☐ Urgent Care  _______ % of practice
☐ Percent of return patients  _______ %
☐ Vasectomies
☐ Weight Reduction Drugs
☐ Name of medication  ____________________________
☐ Percentage of patients  _______ %
☐ Telemedicine
☐ Virtual Medicine

7. Does your practice include videoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.)?  ☐ Yes  ☐ No

8. If you are NOT a radiologist, do you read your own X rays?  ☐ Yes  ☐ No  If “yes,” do you have them over read by a radiologist?  ☐ Yes  ☐ No

9. Are you responsible for the primary management of critical care or intensive care patients?  ☐ Yes  ☐ No
OBSTETRICS AND GYNECOLOGY

1. Do you limit your practice to Gynecology only? □ Yes □ No
   If “Yes,” are you:
   a. obligated to cover for a colleague doing OB? □ Yes □ No
   b. required to be available for OB consultations and deliveries as a part of your hospital staff privileges?
      □ Yes □ No

2. Do you provide obstetrical services? □ Yes □ No
   If “Yes,” please provide:
   _______ Number of vaginal deliveries per year
   _______ Number of cesarean sections per year

3. Do you perform induced, non-spontaneous abortions? □ Yes □ No
   First Trimester, less than 12 weeks _________ (number/year)
   Second Trimester, 12-16 weeks _________ (number/year)
   Second Trimester, over 16 weeks _________ (number/year)

4. Do you perform deliveries or abortions in a non-hospital facility? □ Yes □ No
   If “Yes,” please list facility name(s):

5. Does your practice include infertility patients? □ Yes □ No
   If “Yes,” please elaborate on this activity and procedures performed:

6. Do you follow ACOG guidelines for genetic screening? □ Yes □ No
   If “No,” please explain: _____________________

OPHTHALMOLOGY

1. Do you perform the following procedures?
   Laser procedures □ Yes □ No ______ (number/month)
   Radial Keratotomy* □ Yes □ No ______ (number/month)
   Keratomileusis (LASIK)* □ Yes □ No ______ (number/month)
   Photorefractive Keratectomy* □ Yes □ No ______ (number/month)

2. Do you perform any ophthalmologic plastic surgery procedures? □ Yes □ No
   If “Yes,” please specify types(s) of procedures performed: ______________________________________________________
ORTHOPEDIC SURGERY

1. Do you perform laminectomies?  □ Yes  □ No

2. Do you perform videoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.)?  □ Yes  □ No
   If “Yes,” please specify: ____________________________________________________________

3. Do you subspecialize within your orthopedic practice?  □ Yes  □ No
   Subspeciality: ________________________________________  Percent of practice _________ %

OTORHINOLARYNGOLOGY

1. Please check the surgical procedures and medical techniques you perform:
   □ Traumatic/pathologic plastic surgery  □ Cosmetic plastic surgery  □ Neuro-otological surgery
   □ Liposuction __________ cc of fat removed

2. Do you perform videoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.)?  □ Yes  □ No
   If “Yes,” please specify: ________________________________

PEDIATRICS

1. Do you provide care in a Level III neonatal intensive care nursery?  □ Yes  □ No

2. If your practice includes neonatology, please indicate percentage: _________ %

PLASTIC SURGERY

1. Do you perform silicone implant procedures?  □ Yes  □ No

2. Do you perform liposuction?  □ Yes  □ No  If “Yes,” _________ cc of fat removed

3. Do you perform any laser treatments or procedures?  □ Yes  □ No

SECTION V - REMARKS

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
1. Name of Patient: ________________________________  
2. DOB: _________  
3. Sex: ____  
4. Allegation: ____________________________________  
   ____________________________________  
   ____________________________________  
   ____________________________________  
5. Date of Incident: ________________  
6. Date Reported: ____________________  
7. Insurance Carrier: ________________________________  
   Was a lawsuit filed?  
   Yes  
   No  
8. Additional Defendants: ________________________________  
9. Location of Occurrence: ________________________________  
10. Disposition of Claim: ________________________________  
11. Amount of Settlement or Judgment: ________________________________  
   If claim is still open, reserve amount: ________________________________  
   The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient’s charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.  
12. Condition and Diagnosis at Time of Incident: ________________________________  
13. Dates and Description of Treatment Rendered: ________________________________  
14. Condition of Patient Subsequent to Treatment: ________________________________  
I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.  

____________________________________  
Signature  

____________________________________  
Date
APPLICANT’S AUTHORIZATION AND RELEASE OF CLAIMS INFORMATION (PLEASE READ CAREFULLY)

I authorize and consent to the release of claims information by an insurance carrier that may be selected and its authorized representatives to my employer or to any clinic of which I am an employee, partner, member, or shareholder. I hereby release an insurance carrier that may be selected and its authorized representatives from any liability for the release of said claims information, provided that such release is done in a good faith belief that the receiving party is my employer or a clinic of which I am an employee, partner, member, or shareholder.

This release shall remain in effect until revoked by me in writing.

APPLICANT’S REPRESENTATION (PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of an insurance carrier that may be selected in considering this application have been omitted. I agree that this shall be the basis of the policy of insurance requested and that I will notify an insurance carrier that may be selected of any changes contained herein.

APPLICANT’S AUTHORIZATION AND RELEASE (PLEASE READ CAREFULLY)

I acknowledge as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by an insurance carrier that may be selected or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had a application for staff privileges denied, any state licensing agency, any of my attending or treating physicians, the Washington Physicians Health Program, any prior insurance carriers, prior employers or professional associates and an insurance carrier that may be selected or it duly authorized representatives. I hereby release and discharge the providers of committees from any and all legal liabilities which might otherwise incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by an insurance carrier that may be selected or its duly authorized representatives.

Applicant’s Signature  Date

(A photocopy of this Authorization shall be considered as effective and valid as the original.)

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THIS INSURANCE.
Application checklist:

Before submitting your application, please review this checklist to ensure all necessary information has been provided. Missing information could delay the approval of your application.

- Sign and date the application (pages 12 and 13)
- Include a copy of your current Curriculum Vitae (CV)
- Include a copy of your most recent declarations page if applying for prior acts coverage
- Include evidence of Extended Reporting (tail) Coverage if not applying for prior acts coverage (not applicable for new graduates just completing residency programs)
- Complete the “REMARKS” section for any questions requiring additional details (page 11)
- Provide a copy of the results of your self query of the National Practitioner Data Bank profile
- Include an insurer-produced summary of your prior claims experience
- Complete the appropriate portion of Section IV – Specialty Questions relating to your specialty