Professional Liability by Physicians for Physicians	**Professional Liability by Physicians for Physicians, Inc.**
	Physicians Professional Liability, Portfolio Insurance Company P.O. Box 1159 Grand Cayman, KY1-1102, Cayman Islands
Application	Physician's and Surgeon's Professional Liability Application

This is an application for a claims-made policy form of professional liability insurance to be issued in connection with an insurance program sponsored by ***Professional Liability by Physicians for Physicians, Inc.*** *("PLPP") of Columbus, Ohio.*

If issued, the policy will apply only to claims first made against an Insured and reported to the Underwriter during the policy period or any extended reporting period.

All insurance coverage is subject to underwriting approval and payment of the premium. No coverage exists until the premium is received and a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

- All questions should be answered. If you do not know the answer to a particular question, please note that in the Remarks Section.
- If you wish to explain any of your answers, please use the Remarks Section. If you need additional space, please attach a supplemental sheet to the application.
- If you are applying for coverage and would like to be added to an existing policy, please note that in the Remarks Section. Include the relationship, name, and policy number of the existing policyholder, and the type of coverage you desire.
- Claims information should be provided for a 10-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current company loss runs.

In addition to the Application documents, please forward a copy of the following:

1. Your letterhead and any advertisements;
2. The Declarations Page from your current policy, showing your existing policy number and policy period, (NB: this is not the same as your Certificate of Insurance);
3. Copy of Curriculum vitae (CV);
4. Copy of Medical License;
5. Copy of Board Certifications(s) / Re-Certification(s);
6. Loss runs from your current and previous professional liability carriers for the past 10 years. (Ask your broker if you're unsure about this.)

If you need additional forms or have any questions about the application process, please call your broker or Professional Liability by Physicians for Physicians (PLPP).

General Information

Desired effective date: (MM/DD/YY)

Current policy expires: (MM/DD/YY)

Limits of liability: $1,000,000/$3,000,000

Indicate any deductible options desired: ☐ $10,000/$30,000 ☐ $25,000/$75,000 ☐ Other :

What is your practice structure? ☐ Individual ☒ Corporation ☐ Partnership ☐ Professional Association ☐ Professional Corporation ☐ d.b.a. or fictitious name ☐ Limited Liability Corporation ☐ Other:

Organization / Entity Information

Name of Organization / Entity:
Midwest Physician Anesthesia Services, Inc.

Retroactive Date :

List partners', owner's or members' names:
See Attached

Do you employ any physicians besides yourself in your practice? ☒ Yes ☐ No If yes, please explain in Remarks Section.

Do you independently contract with any entities or physicians? ☐ Yes ☒ No If yes, please explain in Remarks Section.

If you are an independent contractor, please complete the following statement:

My association with (enter Group/Physician Name below) is that of an independent contractor, and the relationship conforms to the guidelines of the Internal Revenue Service.

If you are an employed physicians/Skip this section

Signature _____ Date _____

Primary Location

Street Address: 5151 Reed Road			Suite / Floor: Suite 225-C
City / Town: Columbus	State: OH	Postal Zip: 43220	% of Practice at this Location: Business Office
Phone Number: (614) 457-2306	Fax Number: (614) 884-0776		Years at this location?
Occupancy: ☐ Owned ☐ Rented ☒ Leased	Name of your GL Insurance carrier at this location (If self-insured, please indicate) : St. Paul's Travelers		
Practice E-mail Address:	May we use this e-mail address to communicate Policy-related information? ☐ Yes ☐ No		
Do you have a Web site address? ☒ Yes ☐ No	Website Address: www.mpasohio.com		

Additional Location

Street Address: 3535 Olentangy River Road			Suite / Floor: Anesthesia Dept.
City / Town: Columbus	State: OH	Postal Zip: 43214	% of Practice at this Location: 90%
Phone Number: (614) 566-4919	Fax Number: (614) 566-6993		Years at this location? 45+ years
Occupancy: ☐ Owned ☐ Rented ☒ Leased	Name of your GL Insurance carrier at this location (If self-insured, please indicate) : St. Paul's Travelers		

Billing Address

Complete ONLY if you require that your premium billing be sent to an address *other than your primary practice address;* if so, please indicate.

Street Address			Suite / Floor:
City / Town	State	Postal Zip	Contact / Phone Number

Individual Information		
Individual Name:		Retroactive Date :
Social Security Number	Corp Tax ID# (if applicable) 31-1039177	Date of Birth

Education				
Medical School Name:				
City / Town:	State:	Country:	Degree:	Dates: to

Additional Education: Complete the information requested below. If you have completed more than two residencies, one fellowship, or another training program, then please provide details in the Remarks Section. Explain any gap or split in training in the Remarks Section.

Internship Hospital:		City / Town:	State:
Dates: to	Type/Specialty:	Completed: ☐ Yes ☐ No	
Residency Hospital		City / Town	State
Dates: to	Type/Specialty:	Completed: ☐ Yes ☐ No	
Residency Hospital		City / Town	State
Dates: to	Type/Specialty:	Completed: ☐ Yes ☐ No	
Fellowship Hospital		City / Town	State
Dates: to	Type/Specialty:	Completed: ☐ Yes ☐ No	

Have you participated in any continuing medical education within the last three years? ☐ Yes ☐ No	If yes, how many credit hours?

If you are a graduate of a non-U.S. medical school, are you certified by the Educational Council for Foreign Medical School Graduates?
☐ Yes ☐ No

Licenses and Affiliations					
Specify state(s) where you are or have been licensed. Use the Remarks Section to list additional locations.					
State:	License #:	☐ Active	☐ Inactive	☐ Restricted	☐ Revoked / Suspended
State:	License #:	☐ Active	☐ Inactive	☐ Restricted	☐ Revoked / Suspended

If any of your licenses are or have been inactive, suspended, restricted, or revoked, please explain in the Remarks Section.

Are you a member of any national, state, or county medical societies? ☐ Yes ☐ No	If yes, list:

Are you entering practice for the first time since completing an internship, residency program, fellowship, or military service?
☐ Yes ☐ No

Specialty		
Primary Specialty Name:		Percentage of Practice:
Are you ABMS or AOA board certified? ☐ Yes ☐ No	Name of Board:	If yes, dates? (MM/DD/YY)
If not board certified, what is the expiration date of eligibility?	If expired, why?	

Secondary Specialty Name:	Percentage of Practice:

Are you ABMS or AOA board certified? ☐ Yes ☐ No	Name of Board:	If yes, dates? (MM/DD/YY)

If not board certified, what is the expiration date of eligibility?	If expired, why?

Procedures

Describe any procedure you or any of your staff perform that is outside the typical practice of your particular specialty.

Do you practice in any office surgical facility in which intravenous analgesia or general anesthetic is administered?
☐ Yes ☐ No

If yes, list facilities:	Is the office certified by AAAASF or AAAHC?
	☐ Yes ☐ No
	☐ Yes ☐ No

Please indicate below the procedures you expect to perform, or in which you will participate in, within the next year, beginning with the date of your requested coverage:

☐ Abortion – first trimester
☐ Abortion – after first trimester
☐ Acupuncture
☐ "Alternative medicine" or "complementary medicine procedures (as viewed by most physicians) Please describe:_____
_____
_____
☐ Amniocentesis
☒ Anesthesia
  ☒ General
  ☒ Caudal
  ☒ Spinal
  ☒ Local
  ☐ Other – Please describe _____
_____
☐ Angiography / Angioplasty
☐ Arteriograph
☐ Assisting in major surgery-own patients
☐ Assisting in major surgery-other than own patients
☐ Bariatric Procedures
  ☐ Gastric banding
  ☐ Gastric bypass
  ☐ Gastric stapling
☐ Blepharoplasty
☐ Breast Biopsy
☐ Breast implants and/or reduction
  ☐ Elective ☐ Reconstructive
☐ Brachy therapy
☐ Bronchoscopy
☐ Catheterization
  ☐ Cardiac ☐ Right Heart ☐ Left Heart
  ☐ Arterial
  ☐ Urinary
☐ Other – Please describe: _____
_____
☐ Chelation therapy
☐ Cholangiogram
☐ Cholecystectomy
☐ Circumcision
☐ Colonoscopy
☐ Cryosurgery – Please Describe: _____
_____
☐ Cystoscopy
☐ D & Cs
☐ Deliveries: Vaginal
☐ Deliveries: Cesarean
☐ Vaginal after Cesarean (VBAC)
☐ Dermatological procedures
  ☐ Botox injection
  ☐ Chemical peels
  ☐ Chemabrasion
  ☐ Dermabrasion
  ☐ Fat transfer
  ☐ Hair transplant
  ☐ Laser hair removal
  ☐ Laser skin resurfacing
  ☐ Mesotheraphy
  ☐ Microdermabrasion
  ☐ Silicone injection
  ☐ Tattoo removal
  ☐ Tumescent Liposuction
☐ Discograms
☐ Elective Plastic Surgery
☐ Electromyography
☐ Endoscopy (other than proctoscopy or signiodoscopy) Please describe: _____
_____
☐ Endoscopic Retrograde Cholangiopancreatomography-ERCP
☐ Eyeliner pigmentation
☐ Fluoroscopy
☐ Fracture reductions – closed
☐ Fracture reductions – open
☐ Gastroscopy
☐ Hemorrhoidectomy
☐ Internal Hemorrhoidectomy
☐ External Hemorrhoidectomy
☐ Hyperbaric Medicine
☐ Hysterectomy
☐ Intravenous Pyelogram (IVP)
☐ Laminectomy
☐ Laparoscopy – Please describe: _____
_____
☐ Laser surgery – Other – Please describe: _____
_____
☐ Liposuction
☐ Lumbar puncture
☐ Myelography
☐ Ophthalmology – Invasive procedures involving the eye
☐ Organ Transplant
☐ Pacemaker insertion
☐ Pain Management
  ☐ Cordotomy
  ☐ Dorsal root gangliotomy
  ☐ Facet blocks
  ☐ Medication only
  ☐ Nerve root blocks
  ☐ Pump implantation and removal
  ☐ Sphenopalatine lesioning
  ☐ Spinal injections
  ☐ Thoracic sympathectomy
  ☐ Trigeminal lesioning
☐ Penile implants
☐ Pre-natal care
  ☐ 1st Trimester
  ☐ 2nd Trimester
  ☐ 3rd Trimester
☐ Prolotherapy
☐ Radial keratotomy (Lasik Surgery)
☐ Radiation oncology
☐ Sclerotherapy
  ☐ Surface veins
  ☐ Deep veins
☐ Shock therapy (ECT)
☐ Spinal surgery
☐ Thoracentesis
☐ Thyroidectomy
☐ Tonsillectomy
☐ Total joint replacement
☐ Tubal ligations
☐ Vasectomy
☐ Venography
☐ Weight control by means other than diet or exercise:
_____
_____

☐ **I DO NOT PERFORM ANY OF THE ABOVE PROCEDURES**

☐ **Other Procedures (Please List)** _____

Work Schedule and Practice History

Please indicate the number of hours you work per week for each of the following. (Include only work to be covered under the Policy.)

Number of hours per week for office and clinical practice (direct patient care, consultation, admin. Activities, etc.):	HOURS
Number of hours per week for being on call:	HOURS
Number of hours per week for hospital rounds:	HOURS
Number of hours per week for scheduled surgery:	HOURS
If you are an anesthesiologist, indicate your number of billable hours per week:	HOURS
Estimate the number of patients you see per week in clinical practice:	Patients

Where have you practiced your profession for the past 10 years other than your current practice locations? Please explain any gaps in your practice. Use the Remarks Section to list additional locations.

Entity Name		Dates: to	
Address	City / Town	State	Postal Zip
Entity Name		Dates: to	
Address	City / Town	State	Postal Zip
Entity Name		Dates: to	
Address	City / Town	State	Postal Zip

Staff Privileges

List all facilities, including non-hospital facilities, where you have staff privileges. List principal location first. Use the Remarks Section, page 8, to list additional facilities. Please list the name of the facilities.

Facility Name	Type (Category)	
City / Town	State	Zip
Department	% of Practice	
Facility Name	Type (Category)	
City / Town	State	Zip
Department	% of Practice	

Do you or any of your staff provide medical services for:

Professional sport organization?	Hotel services?	Spa?	Health Club?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you perform medical legal evaluations? ☐ Yes ☐ No	If yes, with whom?	What percentage of your practice does this entail?

Do you contract with or have you ever contracted with any skilled nursing facility, convalescent hospital, nursing home, or similar facility? ☐ Yes ☐ No

If the answer is yes, please list the name(s) of each facility.

Name of Facility	Name of Facility

If the answer is yes, do you create and maintain a record for each patient under your care or treatment at any of these facilities?
☐ Yes ☐ No

Advertising and Telemedicine

Do you advertise your medical practice? (If yes, provide samples.) ☐ Yes ☐ No

Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunications, video, or information systems? ☐ Yes ☐ No

If yes, please describe:

Office Procedures Information

If x-ray imaging is performed at your office do you have all x-rays read by a Radiologist? ☐ Yes ☐ No ☒ Not Applicable

If no, is there a written report for each x-ray as well as a written policy and procedure for over-reads being done with documentation of results? ☐ Yes ☐ No

Explain:

Do you have a written policy that you follow requiring that the communication of all results of tests ordered by you or your partners, regardless of result, occur within 7 days or less of the latest result being received by the office? ☐ Yes ☐ No

If no, explain.

Do you have a written policy that you follow supporting the commitment to communicate back to all missed appointment patients within 7 days? ☐ Yes ☐ No

If no, explain.

Miscellaneous

If you answer yes to any of the following questions, please give full details in the Remarks Section, page 8. Include dates and copies of related documents.

Are you now being treated for alcoholism, narcotics addiction, or mental illness? ☐ Yes ☐ No

(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.)

Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice medicine? ☐ Yes ☐ No

(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.)

Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible or surcharge assessed against you? ☐ Yes ☐ No

Have you ever been investigated by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended, or limited in any way? ☐ Yes ☐ No

(If yes, please provide copies of complaint and disposition documents.)

Has any hospital ever restricted or revoked your privileges or invoked probation for any cause? ☐ Yes ☐ No

Have you ever been indicted or convicted of a crime other than minor traffic violations? ☐ Yes ☐ No

Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)? ☐ Yes ☐ No

During the preceding 10-year period, has any claim or suit been brought against you, or are you aware of any incident that has taken place in the last 10 years that may lead to a claim or suit? ☐ Yes ☐ No

If yes, how many?	If you answer yes, please provide complete details on the Claim Information Form on page 10. Complete a separate form for each claim.

Signature:	Date:

Group's/Physician's Insurance Carrier Name:
A current Declarations Page or Certificate of Insurance for the above group must be attached.

Do you contract to treat or review treatment at correctional facilities, prisons, or jails? ☐ Yes ☐ No If yes, please explain on page 8.

Are you employed by any physicians or entities? ☐ Yes ☐ No If yes, please explain in the Remarks Section.

Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, please provide proof of coverage, including name and address of entity.

Previous Insurance

To assure that there are no gaps in coverage, please list all previous medical professional liability insurance carried during the past 10 years, beginning with your current carrier. Use the Remarks Section to list additional carriers.
Attach a copy of the Declarations Page from your most recent policy.

Current Carrier:	Policy Period: (MM/DD/YY) to
Limits of Liability:	Type of coverage – Occurrence or Claims-made:
Next Previous Carrier:	Policy Period: (MM/DD/YY) to
Limits of Liability:	Type of coverage – Occurrence or Claims-made:
Second Previous Carrier:	Policy Period: (MM/DD/YY) to
Limits of Liability:	Type of coverage – Occurrence or Claims-made:

Retroactive Coverage

Retroactive coverage, which is also called tail or prior acts coverage, provides insurance for claims arising from incidents that took place while a previous claims-made policy (or policies) was in effect but were reported after the policy (or policies) has terminated. If your current policy is claims-made, you must either a) apply for a policy with a retroactive date back to the first day of your claims-made coverage, or b) purchase an extended reporting endorsement (tail coverage) from that insurance company.

Retroactive coverage does not cover claims that have already been filed against you or that were reported to your previous insurer(s) prior to the effective date of the policy being applied for. Any claims and all conduct, circumstances, or incidents that could reasonably be expected to result in a claim must be reported to your present insurance company prior to the requested effective date of this insurance. Your prior policy may require that such notification be made to the company in writing.

I have read and understand the above statement. I understand that if I do not purchase tail from my current insurance company or obtain prior acts coverage from the Company, I will be uninsured for any claim that arises from my acts prior to the effective date of coverage with the Company.

Applicant's Initials: _____ Date: _____

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier? ☐ Yes ☐ No

If no, do you wish to purchase retroactive coverage from the Company? ☐ Yes ☐ No

If yes, please complete the following:

Desired retroactive date:	(You must attach a copy of the most recent Declarations Page from your present carrier indicating the original effective date of coverage and the current paid-through date.)

Are you, as of this date, aware of any claims against you that have not been reported to your present or prior insurer(s)?
☐ Yes ☐ No

Does your current carrier consider a claim to be a: ☐ Report of a medical incident ☐ Formal demand for money

Are you, as of this date, aware of any conduct, circumstances, or incidents that occurred during the period of coverage listed in the Previous Insurance section that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? ☐ Yes ☐ No

I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier.

Applicant's Initials: _____ Date: _____

Changes in Practice

Have your practice specialties/procedures, etc., changed in the past five years? ☐ Yes ☐ No

If yes, please explain how the specialties/procedures, etc., have changed and give the dates of changes.

Ancillary Responsibilities

Do you have any teaching responsibilities? ☐ Yes ☐ No If yes, complete the following questions. Use the Remarks Section if needed.

Name of institution:

Location of institution:

Does the institution provide you with coverage for your supervision of residents? ☐ Yes ☐ No	What percentage of your weekly time is spent in the supervision of residents?

Do you have any medical director responsibilities? ☐ Yes ☐ No If yes, complete the following questions. Use the Remarks Section if needed.

Name of institution:

Location of institution:

Does the entity provide you with coverage for your administrative Responsibilities? ☐ Yes ☐ No	Does the entity provide you with coverage for your direct patient care? ☐ Yes ☐ No

(If no to either of the above, please provide proof of medical professional liability insurance for the entity.)

Ancillary Personnel

If you or your entity employs or contracts for the services of any health care personnel in the following categories indicated by *, a separate application form must be submitted for each.

Physician's Assistants*	Number Employed	Number Contracted	Insurer (if any)
Nurse Practitioners*	Number Employed	Number Contracted	Insurer (if any)
Certified Nurse Midwife*	Number Employed	Number Contracted	Insurer (if any)
Optometrists*	Number Employed	Number Contracted	Insurer (if any)
Certified Registered Nurse Anesthetists*	Number Employed	Number Contracted	Insurer (if any)

List other paramedical personnel, including nurses, technicians, technologists, physical therapists, etc.

Remarks Section

Remarks Section Continued

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information or material misrepresentation will cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application—in ink—and returned the original to the company with the required payment. (Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, inter-indemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

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

OHIO FRAUD WARNING: *ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AND APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.*

APPICANT'S SIGNATURE

I HEREBY DECLARE THE ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IF I DISCOVER THAT ANY OF SUCH INFORMATION IS NOT CORRECT OR COMPLETE, OR IF ANY OF THE ABOVE INFORMATION BECOMES INCORRECT OR INCOMPLETE BETWEEN THE DATE BELOW AND THE DATE PHYSICIANS PROFESSIONAL LIABILITY, PIC BINDS COVERAGE, I AGREE TO NOTIFY THE COMPANY AS PROMPTLY AS POSSIBLE.

Signature	Date

CLAIM INFORMATION FORM			
Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.			
Name of Patient:		Age (at time of Claim):	Gender:
Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon):			
Allegation:			
Date of Incident:	Report Date:	Location:	
Insurance Carrier :			
Other Defendants:			
Present Status: ☐ Open Claim ☐ Loss of $ ☐ Settlement ☐ Judgment ☐ Closed Claim / Date _____ ☐ Dismissed			
Condition and diagnosis at time of incident:			
Dates and description of professional services rendered:			
Condition of patient subsequent to professional services (and dates of follow-up visits) if known:			
I hereby declare the above information is complete and true to the best of my knowledge and belief.			
Signature		Date	