PHYSICIANS PREFERRED
The Physician-Owned Insurance Company

USA InsuranceNet
Your Full Service Agency
Appointed Agent

Physicians and Surgeons Professional Liability Application

IMPORTANT: Please attach the following documents with the submission of your application to ensure a timely application and underwriting process:

- Copy of Florida medical license
- Copy of current Curriculum Vitae
- Copy of Certificate of Insurance/Declarations Page if currently carrying insurance

I – General Information

Name: _____ □ MD □ DO Social Security Number: ___-___-_____
First Middle Last

Date of Birth: ___/___/_____ Florida medical license #: _____ Status of license: _____

FL practice start date: ___/___/_____ How did you hear about Physicians Preferred? _____

Home Address:

_____
Number & Street City State Zip Home Phone# Cell/Alternate Phone#

Primary practice location for which coverage is desired:

_____
Number & Street City State Zip County % of Practice time at this location

_____
Telephone# Fax# E-Mail Address Website Name of Primary Contact in your office

Desired mailing address: □ Home □ Primary practice location □ Other (specify "Other" address in Remarks section)

II – Coverage/Practice Information

Please complete the following specifics for the insurance coverage you are requesting:

Effective date: ___/___/____ Medical Specialty: _____ Sub-Specialty:_____

Requested Limits of Liability: □ $100,000 per incident / $300,000 annual aggregate
□ $250,000 per incident / $750,000 annual aggregate

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier? □Yes □No
If no, Do you wish to purchase prior acts coverage from PPIR? □Yes □No
What is your requested retroactive date? ___/___/____

Insurance history for previous 10 years – please include loss report(s) from prior carrier / National Practitioner Data Bank report:

Coverage Period Mo./Yr. to Mo./Yr.	Insurance Carrier	Policy #	Type of Policy Claims-Made/Occurrence	Retroactive Date (if claims made policy)	Policy Limits

Indicate reason for changing insurance carrier: _____

Indicate practice situation(s) that apply to you: □ Solo Physician □ Employed Physician □ Shareholder/Partner

Indicate Corporation, Partnership or Employer Name: _____

Do you employ any of the following healthcare professionals listed below? □Yes □No
If Yes, please include number of each below.

Nurse Anesthetist, PAAA _____ Certified Nurse Midwife _____ Psychologist _____
Physician/Surgeon Assistant _____ Certified Nurse Practitioner _____

(In order for vicarious/defense coverage to be provided to you, these individuals must provide proof of individual coverage with this application or apply to PPIR for coverage.)

What is your average weekly patient load? _____ What is total weekly hours of practice time? _____

Please indicate what level of surgery you perform or intend to perform. □ No Surgery □ Minor Surgery □ Major Surgery

Please indicate which of the following procedures, techniques or practices you perform or intend to perform.

□ Assisting in Major Surgery
□ Baker's Chemical Peels
□ Blepharoplasty
□ Cardiac Catheterization (left Heart) # done annually _____
□ C-Sections (# done annually _____)
□ Chelation therapy (other than for the treatment of heavy metal poisoning)
□ D & C (diagnostic only)
□ Deliveries (# done annually _____)
□ Experimental Surgery
□ Hair Transplants
□ Hydrogen Peroxide Therapy
□ Pain Management (if yes, please explain)
□ Prenatal Care
□ Radiation Oncology
□ Scalp Reductions
□ Sclerotherapy (deep vein)
□ Shock Therapy
□ Spine Surgery
□ Polymethylmethacrylate injections (bone cement)
□ Suction Lipectomy – type and areas of use (submit proof of training if outside of residency)
□ Telemedicine(if yes, please explain)
□ Ultraviolet Light Therapy (other than UVB or PUVA)
□ Vasectomies
□ None of these apply

Additional Practice Locations not identified in Section I – General Information including all offices, nursing homes, urgent care clinics and other non-hospital locations:

Number & Street	City	State	County	% of Practice

Hospital practice locations:

Hospital	City	State	County	Privilege Type	% of Practice

In order to give you the most favorable consideration, please list any special groups, society affiliations, provider organizations or other group programs with which you are affiliated and/or participate (discounts may be available):

_____ _____
_____ _____
_____ _____

III – Underwriting Questionnaire

Please answer all of the following questions. If the answer is "Yes" to any of the questions below, please explain and provide details in the Remarks.

Has your license to practice medicine or your permit to dispense or prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way been limited, or is it currently under investigation? □Yes □No

Have you ever been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, non-renew or revoke your privileges? □Yes □No

Have you ever been notified to respond to, appear before or be investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct? □Yes □No

Have you ever had Medicare/Medicaid fraud charges filed against you? □Yes □No

Have you ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations? □Yes □No

Have you ever been evaluated, treated or hospitalized for alcoholism, drug addiction, or any mental or emotional disorders? □Yes □No

Have you ever had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? □Yes □No

Have you ever had professional liability application or insurance declined, non-renewed or cancelled? □Yes □No

Have you ever practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage? □Yes □No

Have you ever been involved in a malpractice claim or suit, including any expression of intent (i.e. medical records requests, incident reports and/or Notices of Intent) even if suit was never filed? □Yes □No

Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit? (such as a request for records from a patient and/or attorney related to an adverse outcome, a letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient, or intra-operative complications or other complications resulting in death, paralysis or other significant disabilities) □Yes □No

Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits (even if you believe the claim or suit would be without merit) that have not been reported to your current or previous professional liability carrier? □Yes □No

Are you currently treating or do you intend to treat any patient by mean of an experimental, Investigative or unconventional drug or therapy? □Yes □No

Do you treat professional athletes? □Yes □No

Do you provide direct patient treatment (not limited to obstetrical care) during delivery (including immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital? □Yes □No

Do you perform procedures in a non-hospital setting where other than local anesthesia is administered by anyone other than an anesthesiologist? □Yes □No

Does your practice involve weight reduction or control, other than prescribing exercise? □Yes □No

Are there any unusual procedures that you perform within or outside of your specialty? □Yes □No

Do you have a plan in place for protection of your assets? □Yes □No

Would you like a referral for a review of your asset protection plan? □Yes □No

IV – Additional Underwriting Information

Please answer the following questions as it relates to your practice.

Obstetrics / Gynecology:

a. Do you limit your practice to gynecology only? □Yes □No
If Yes, is your practice strictly office based? □Yes □No
b. Do you render prenatal care exclusive of delivery? □Yes □No
c. How many deliveries do you perform annually? _____

Ophthalmology Surgery:

a. How many major surgical procedures (excluding Laser Refractive Surgical procedures) have you performed in the last 12 months? _____
b. How many Laser Refractive surgical procedures have you performed in the last 12 months as primary surgeon? _____

Radiology:

I practice as a:
□ Diagnostic Radiologist
□ Invasive Radiologist
□ Neuroradiologist

Surgery:

a. List the number of major surgical procedures performed in the last 12 months
1) as primary surgeon _____
2) as assisting surgeon _____
b. Indicate the percentage of surgical time devoted to the following surgical activities:

_____ % Bariatrics	_____ % Obstetrics (inc. C-sections)	_____ % Plastic (cosmetic)
_____ % Cardiovascular	_____ % Organ Transplants	_____ % Plastic (reconstructive)
_____ % Colon and Rectal	_____ % Orthopaedic	_____ % Spine
_____ % General	_____ % Otorhinolaryngology	_____ % Thoracic
_____ % Gynecology	_____ % Pediatric	_____ % Urological
_____ % Hand	_____ % Pediatric-Neurosurgery	_____ % Vascular
_____ % Other		

Orthopaedic Surgery:

a. Do you currently perform spinal surgery? □Yes □No
If No, have you ever performed spinal surgery? □Yes □No
b. When did you discontinue the performance of spinal surgery? _____

V – Remarks Section

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information and applicable attachments constitutes my application for professional liability insurance with Physicians Preferred Insurance Reciprocal (PPIR). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences, or circumstances related to each particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of PPIR in considering this application. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by PPIR and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by PPIR. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Recovery Network, individuals and PPIR. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by PPIR, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with PPIR, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of PPIR that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to PPIR.

Signature of Applicant _____ Date _____

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or PPIR to complete the insurance.

(A Photostat copy of this authorization shall be considered as effective and as valid as the original.)

Fraud Statement
Section 817.234(1)(b), Florida Statutes

The statute requires the statement to contain in substance the following language:

“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.”

USA InsuranceNet
Your Full Service Agency

PO BOX 770158 MIAMI, FL. 33177
Phone: 786-293-3637
Fax: 786-293-3669
Service@usainsurancenet.com

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The Physician-Owned Insurance Company

Smarter Strategy.
Safer Practice.

INCIDENT/CLAIM INFORMATION

(YOU MUST COMPLETE THIS FORM, IF NO CLAIMS, WRITE NO CLAIMS, SIGN, WRITE NAME, AND DATE)

(Use separate page for each claim / incident and please include loss report(s) from prior carrier of National Practitioner Data Bank report for each Incident/Claim)

Name of patient: _____ Age of Patient:_____

Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____

Date of Incident: _____ Date reported to insurance carrier: _____ Insurance carrier: _____

Name of your defense attorney: _____ Other defendants: _____

Present status of claim: _____ If Open - Reserve: $_____ If Closed - amount paid: $_____

Location of incident:_____ _____

Condition and diagnosis at time of incident:_____

Description of treatment rendered: _____

_____

Allegations of negligence directed against you: _____ ____

_____

_____

Condition of patient subsequent to treatment: _____

_____

_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed: _____ Date Signed: _____

Print Name _____

Note: If the claim was reported to the National Practitioner Data Bank, you may obtain this Report by self query at the following web address: http://www.npdb-hipdb/iqrs.