

If previously covered with National Fire & Marine Insurance Company, please enter the policy number: \_\_\_\_\_

# National Fire & Marine Insurance Company

Omaha, Nebraska

## PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

For faster service, please enter your application online at [WWW.MEDPRO.COM](http://WWW.MEDPRO.COM)

### Application Instructions

- A. If additional space is needed, please complete Section X. Supplemental Information with a reference to the question.
- B. **Additional documentation may be requested by the company as necessary.** For example: A copy of your most recent professional liability policy, including all endorsements, Declarations Page, etc.
- C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

### I. General Information

A.   
Last Name

First Name (Full)

/  /   Male  Female  
Middle Name Suffix Date of Birth MM/DD/YYYY

-  -       
Social Security Number (Optional) National Provider Identifier Number

-  -   -  -   -  -   
Business Phone Business Fax Residence/Cell Phone

Email address:

B. If you have a web address, please provide the website address (URL): \_\_\_\_\_

#### C. Residence Address:

Number & Street Apartment #

City State Zip Code

County

#### D. Practice Locations: (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

Office  Hospital  Other If other please explain: \_\_\_\_\_  
% of practice

Practice/Hospital Name

Number & Street

Suite City State Zip Code

County Start Date: MM / YYYY

Office  Hospital  Other If other please explain: \_\_\_\_\_  
% of practice

Practice/Hospital Name

Number & Street

Suite City State Zip Code

County Start Date: MM / YYYY

**I. General Information (continued)**

3.  Office  Hospital  Other      If other please explain: \_\_\_\_\_  
% of practice \_\_\_\_\_  
Practice/Hospital Name \_\_\_\_\_  
Number & Street \_\_\_\_\_  
Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_  
County \_\_\_\_\_ Start Date: MM / YYYY

**E. Do you admit patients to any of the above hospital locations?**

Yes  No

If no, please explain your protocol to admit patients to a hospital if the circumstance would arise. \_\_\_\_\_

**F. Billing and Correspondence Address:**

Location # (from Question D above): \_\_\_\_\_  Residence  Other (Please enter below)  
Number & Street \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

**II. Educational Background**

**A. Medical School:**

Name of School \_\_\_\_\_ Degree \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Completed from: MM / YYYY To: MM / YYYY  
Country \_\_\_\_\_

**If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program?**  Yes  No

If no, please explain: \_\_\_\_\_

**B. Residency: List all Residency training programs.**

Please enter each specific specialty.

1. Name of Hospital/Facility/Program \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty Type \_\_\_\_\_  
Completed?  Yes  No  Still in training      From: MM / YYYY To: MM / YYYY

2. Name of Hospital/Facility/Program \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
Specialty Type \_\_\_\_\_  
Completed?  Yes  No  Still in training      From: MM / YYYY To: MM / YYYY



**III. Practice Information (continued)**

**Note:** All percentages requested below for specialties, procedures and surgical activities are of your total practice.

**\*\*Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.\*\***

**F. What is your present specialty?** \_\_\_\_\_

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**% of total practice**

**What is your sub-specialty?** \_\_\_\_\_

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**% of total practice**

**G. Are you permanently retired from the practice of clinical medicine?**  Yes  No

**H. American Board Certified?**  Yes  No \_\_\_\_\_  
Specialty Board

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Date most recently certified

\_\_\_\_\_ Specialty Board

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Date most recently certified

If not American Board Certified, are you board eligible?  Yes  No If yes, when do you plan on taking your boards?

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MM YYYY

If not American Board Certified, have you ever taken a specialty board examination and failed to pass?  Yes  No

If yes, how many times? 

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If yes, please explain: \_\_\_\_\_

**I. Indicate the estimated average weekly numbers, under each of the following categories, for which you require National Fire & Marine Insurance Company coverage.**

Hours per week 

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 Patients seen per week 

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 None

Unscheduled walk-in patients per week 

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 None

**J. Please check any of the following procedures you will perform:**

- Abdominoplasty - Tummy Tuck
- Abortions- Elective \_\_\_\_\_% of total practice
- Abortions- Therapeutic \_\_\_\_\_% of total practice
- Acupuncture - Therapeutic/Local Anesthetic
- Anesthesia General/Spinal/Caudal
- Angiography
- Angioplasty
- Arteriography
- Arthroscopy
- Assisting in major surgery - own patients only
- Assisting in major surgery - own & other than own patients
- Bariatric Surgery - Laparoscopic
- Bariatric Surgery - Non-Laparoscopic
- Biopsy - Endoscopic
- Blepharopigmentation - \_\_\_\_\_ % of total practice
- Blepharoplasty - Cosmetic \_\_\_\_\_ % of total practice
- Blepharoplasty - Reconstruction \_\_\_\_ % of total practice
- Botox \_\_\_\_\_ % of total practice
- Brachioplasty
- Breast Implants - Cosmetic \_\_\_\_\_ % of total practice
- Breast Implants - Reconstruction \_\_\_\_ % of total practice
- Breast Reduction - Cosmetic
- Bronchoscopy
- Bronco-esophagology
- Buttock Implants
- Calf Implants
- Cataract Surgery
- Catheterization - Left Heart
- Catheterization - Right Heart (other than CVP lines)/ Swan Ganz
- Cheek/Chin/Lip Implants
- Chelation Therapy
- Chemical Peels - Superficial / Medium
- Chemical Peels - Deep \_\_\_\_\_% of total practice
- Cleft Lip Surgery - Reconstructive
- Cleft Palate Surgery - Reconstructive
- Colonoscopy
- Cryosurgery (Cervical)
- Cryosurgery (non-external lesions)

- D & C
- Discectomy
  - Open
  - Other Than Open
- Electromagnetic Therapy
- Electroconvulsive/Shock Therapy
- Embolization
- ERCP
- Face Lifts
- Face Lifts Mini (done with laser)\_\_\_\_% of total practice
- Gastrointestinal Endoscopy
- Gynecology - Major Surgery
- Hair Transplants - Follicular Unit Transplantations
- Hair Transplants - Other
- HVLA on the cervical spine on patients younger than 18 years of age
- Intrathecal Pumps
- Kyphoplasty
- Laparoscopic Cholecystectomy
- Laparoscopy
- Laser Surgery
- Laser Therapy (Endoscopic)
- Laser Therapy (Non-Endoscopic)
- Lipoinjection \_\_\_\_\_% of total practice
- Liposuction
  - Other Than Tumescent Technique
  - Tumescent Technique Only\_\_\_\_% of total practice
- Lithotripsy
- Lymphangiography
- Mammograms
- Myelography
- Nerve Blocks
  - Facet
  - Lumbar Epidural Steroid
  - Myofascial
  - Occipital
  - Paraspinal/Paravertebral
  - Peripheral
  - Sciatic
  - Triggerpoint Injection
- Oxidation Therapy

- Pacemakers - Epicardial
- Pacemakers - Endocardial
- Pacemakers - Temporary
- Peritoneoscopy
- Phlebography
- Pneumoencephalography
- Polypectomy
- Prenatal /Gynecological Practice
  - Prenatal Practice - 1st & 2nd Trimester
  - Prenatal Practice - to term, no delivery
  - Prenatal Practice - to term, and delivery
  - Normal Deliveries - total per year \_\_\_\_
  - Cesarean Deliveries - total per year \_\_\_\_
- Prolotherapy
- Radial/Laser Keratotomy
- Radiation/X-Ray Therapy
- Rectal Ozone Therapy
- Rhinoplasty \_\_\_\_\_% of total practice
- Sigmoidoscopy - 60 cm or less
- Sigmoidoscopy - greater than 60 cm
- Silicone Injections\_\_\_\_ % of total practice
- Skin Flaps/Grafts
  - Cosmetic \_\_\_\_\_% of total practice
  - Reconstruction \_\_\_\_% of total practice
- Spinal Cord Stimulators
- Thigh Lift
- Tubal Ligations
- Upper GI Endoscopy
- Vasectomies - own patients
- Vasectomies - own & other than your own patients
- Weight Control Medication \_\_\_\_\_ % of total practice
- Other Medical Techniques

List Procedures (do not restate your specialty)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**III. Practice Information (continued)**

**K. Please indicate the percentage of your total practice performing the following surgical activities:**

<input type="text"/> <input type="text"/> <input type="text"/> % Cardiac	<input type="text"/> <input type="text"/> <input type="text"/> % Orthopedic (including back)	<input type="text"/> <input type="text"/> <input type="text"/> % Thoracic
<input type="text"/> <input type="text"/> <input type="text"/> % Gynecology	<input type="text"/> <input type="text"/> <input type="text"/> % Orthopedic (not including back)	<input type="text"/> <input type="text"/> <input type="text"/> % Traumatic
<input type="text"/> <input type="text"/> <input type="text"/> % Hand	<input type="text"/> <input type="text"/> <input type="text"/> % Otolaryngology	<input type="text"/> <input type="text"/> <input type="text"/> % Urology
<input type="text"/> <input type="text"/> <input type="text"/> % Neurosurgery	<input type="text"/> <input type="text"/> <input type="text"/> % Plastic (cosmetic enhancement only)	<input type="text"/> <input type="text"/> <input type="text"/> % Vascular
<input type="text"/> <input type="text"/> <input type="text"/> % Obstetrics	<input type="text"/> <input type="text"/> <input type="text"/> % Plastic (reconstruction only)	<input type="text"/> <input type="text"/> <input type="text"/> % Other (Describe) _____
<input type="text"/> <input type="text"/> <input type="text"/> % Ophthalmology		

**L. In the last 10 years,**

1. Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity?  Yes  No

If yes, list procedures/activities, reason for discontinuing, and date discontinued. Date:   /

MM / YYYY

2. Have you performed weight control surgery or prescribed weight control medication?  Yes  No

a. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?

<1%  1% - 10%  11%-50%  >50%  Never prescribed weight control medication

b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?

<1%  1% - 10%  11%-50%  >50%  Never performed weight control surgery

**M. Do you have ownership or financial interests in a weight control clinic?**  Yes  No

If yes, what is the name of the weight control clinic with which you are affiliated? \_\_\_\_\_

**N. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.)**  Yes  No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.)    hrs

2. On average how many of the above hours are you working in order to fulfill staff privilege requirements?    hrs

(If you have emergency room activities which are covered by another professional liability insurance policy, please complete Section IV, Question H.)

**O. Please use the space below for any comments you feel will help National Fire & Marine Insurance Company better understand any special circumstances concerning your practice.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IV. Additional Professional Information**

**Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the question.**

(For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)

**A. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates.**    hrs None

**B. Indicate the average hours per week devoted to treating non-federal prison inmates.**    hrs None

**C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes.**    % None

**D. Indicate the percentage of your practice devoted to working in a nursing home facility.**    % None

**E. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?**  Yes  No

If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

**F. Do you practice as a medical director?**  Yes  No

Type and name of facility: \_\_\_\_\_

If yes, what percentage of your practice is devoted to this activity?    %

Briefly describe your responsibilities: \_\_\_\_\_

**G. Do you devise or review plant/employer safety standards?**  Yes  No

What products are manufactured by the company? \_\_\_\_\_

Company Name: \_\_\_\_\_

Location: \_\_\_\_\_

**IV. Additional Professional Information (continued)**

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

If yes, are you a(n):  Employee  Independent Contractor  Resident/Fellow  Faculty

Practice Name: \_\_\_\_\_

Location: \_\_\_\_\_

Name of Insurer: \_\_\_\_\_

**I. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?**  Yes  No

If yes, please indicate the date(s) and explain: Date:  /  \_\_\_\_\_  
MM YYYY

**J. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy?**  Yes  No

If yes, please indicate the date(s) and explain: Date:  /  \_\_\_\_\_  
MM YYYY

**K. Have you ever been accused of sexual misconduct of any kind?**  Yes  No

If yes, please indicate the date(s) and explain: Date:  /  \_\_\_\_\_  
MM YYYY

**L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty?**  Yes  No  
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: \_\_\_\_\_

Date(s) of treatment(s): From:  /  To:  /   Currently in treatment  
MM YYYY MM YYYY

Name of treating physician(s): \_\_\_\_\_

Address(es): \_\_\_\_\_

**V. Loss Information (Important! Please fully complete.)**

Please complete the Loss Information Supplement for each written request, incident, claim or suit (A, B or C) below that has NOT been covered by a National Fire & Marine Insurance Company policy.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters 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. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?**

If yes, how many?  None

**B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to, the following:**

- ▶ Amputation
- ▶ Death
- ▶ Loss of major organ function
- ▶ Loss of vision
- ▶ Permanent neurological injury

If yes, how many?  None

**C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?**

If yes, how many?  None



**VII. Coverage Information**

**Notes:**

- 1. **Claims-Made coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**
- 2. **Requested limits and/or policy types may not be available in all states.**

**A. Coverage Desired:**

- Claims-Made coverage without Prior Acts coverage
- Claims-Made coverage with Prior Acts coverage
- Occurrence coverage
- Occurrence coverage with Prior Acts coverage

**B. Requested Coverage Period (12:01 am):**

Annual policy term will begin and end on the same month and day.

**From:** MM / DD / YYYY **To:** MM / DD / YYYY

**C. The retroactive date shown on your current Claims-Made policy is:**

(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.)

MM / DD / YYYY

**D. Desired Limits:**

Per Occurrence/Per Claim Filed \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Annual Aggregate \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**E. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.**

1. Current Insurer:

Occurrence  Claims-Made From: MM / DD / YYYY To: MM / DD / YYYY

2. Previous Insurer:

Occurrence  Claims-Made From: MM / DD / YYYY To: MM / DD / YYYY

3. Previous Insurer:

Occurrence  Claims-Made From: MM / DD / YYYY To: MM / DD / YYYY

**F. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your requested retroactive date.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**G. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:**

- An extended reporting endorsement (tail coverage) has been or will be purchased.
- An extended reporting endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying with National Fire & Marine Insurance Company, if offered, will not provide Prior Acts coverage.

\_\_\_\_\_

**Initial Here**

**VIII. Assignment of Right to Cancel Coverage**

**Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?**

Yes  No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to National Fire & Marine Insurance Company, 3024 Harney Street, Omaha, Nebraska 68131-3095.

\_\_\_\_\_

**Initial Here**

Name: \_\_\_\_\_  
 Street: \_\_\_\_\_ Suite: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.**





