ASPEN AMERICAN INSURANCE COMPANY


# PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE APPLICATION


655 Franklin Street, #1800 ▪ Tampa ▪ FL ▪ 33602 ▪ phyinfo@bbprograms.com ▪ www.phyinsurance.com

## GENERAL INFORMATION

1. Name (First, Middle Last): _____ ☐ M.D. ☐ D.O.
2. Date of Birth: _____ 3. Birthplace: _____
4. Mailing Address: _____
5. Office Telephone: _____
6. Office Fax: _____
7. Office Email: _____
8. Office Website: _____

## INSURANCE INFORMATION

9. Requested effective date: _____ 10. Requested Prior Acts Date: _____

11. a) If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier? ..... ☐ Yes ☐ No
    b) If **"NO",** please explain: _____

12. Requested limits of insurance:

    Per Claim: _____ Aggregate: _____

13. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage for? ..... ☐ Yes ☐ No
    If yes, please list name of employer and insurance company: _____

14. Have you ever practiced without insurance? ..... ☐ Yes ☐ No
    If **"Yes",** please explain: _____

15. Beginning with your most recent or current insurer, please list all professional liability insurers for the past 7 years.

| Name of Insurer | Coverage Type (Occurrence or Claims-made) | Limits of Liability | Policy Period |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |


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## EDUCATION AND TRAINING INFORMATION

16. Please list all Medical Schools attended:

| Medical School | City | State/Country | Graduation Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ..... ☐ Yes ☐ No ☐ N/A

17. Please provide details below for all internships/residencies undertaken:

| Location | Specialty | Mo./Yr. Completed |
|---|---|---|
| | | |
| | | |
| | | |

18. Indicate below any additional training (fellowships, etc.)

| Location | Specialty / Program | Mo./Yr. Completed |
|---|---|---|
| | | |
| | | |
| | | |

19. a) Do you hold board certification with ABMS, AOA or another board? ..... ☐ Yes ☐ No

b) If **"Yes",** please complete information below:

| Certifying Board | Date Certified |
|---|---|
| | |
| | |
| | |

c) Are you currently participating in a Maintenance of Certification Program? ..... ☐ Yes ☐ No

20. If you are **not** board certified, are you eligible? ..... ☐ Yes ☐ No ☐ N/A

## PRACTICE INFORMATION

21. Medical Specialty: _____ Subspecialty (if any): _____

22. Is your practice limited to your specialty and/or subspecialty? ..... ☐ Yes ☐ No

23. Has your practice specialty changed in the last 5 years? ..... ☐ Yes ☐ No
If **"Yes"**, please explain: _____


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24. Principal office address (if different than mailing address):

| | |
|---|---|
| Street: | Telephone: |
| City/State/Zip: | County: |

Other Current Practice Locations:

| |
|---|
| |
| |

Previous practice locations over the past 5 years:

| |
|---|
| |
| |
| |

25. Please list all states where you are licensed:

| State | License Number | Active/Inactive |
|---|---|---|
| | | |
| | | |

26. Please provide all hospitals and surgi-centers at which you have maintained privileges in the past five years and the status of those privileges:

| Name | City | State | Type of privileges | Status |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

27. Do you practice as a Hospitalist? ..... ☐ Yes ☐ No

28. a) Do you work in an emergency room? ..... ☐ Yes ☐ No
b) If **"Yes",** how many hours per week and for what institution? _____
c) Check any of the following certifications you hold: ☐ ACLS ☐ ATLS ☐ PALS

29. Do you provide medical services at any nursing home? ..... ☐ Yes ☐ No
If **"Yes",** please explain: _____

30. Do you have any Medical Director responsibilities?..... ☐ Yes ☐ No
If **"Yes",** please explain: _____

31. Are you a sports team physician for any professional or collegiate sports team? ..... ☐ Yes ☐ No


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32. In the last 5 years, have you practiced at a jail, prison, correctional facility, detention center or other similar facility? ..... ☐ Yes ☐ No

33. Who is responsible in your office for HIPAA compliance? _____

34. What protocols do you have in place to monitor and audit HIPAA compliance in your office? _____
_____

35. Do you employ or independently contract with any physicians or surgeons?* ..... ☐ Yes ☐ No
**If **"Yes",** please provide proof of insurance or submit a separate application for coverage.*

36. Average number of patients seen per week: _____

37. Are you currently working 20 hours or less per week? ..... ☐ Yes ☐ No
If **"Yes",** what date did you begin working these hours? _____

38. Does your practice offer concierge/retainer medicine or do you collect annual fees/retainers from patients? ..... ☐ Yes ☐ No

39. Do you maintain your patient records in an electronic medical record? ..... ☐ Yes ☐ No
If **"Yes",** who is your EMR provider? _____

40. Do you maintain a website or other social media presence? ..... ☐ Yes ☐ No
If **"Yes",** do you offer online consultations? ..... ☐ Yes ☐ No

## PROCEDURES

41. Please check all procedures which you will perform in the next 12 months or have performed in the past 5 years.

- ☐ Abortions – first trimester:
  - ☐ Hospital
  - ☐ Clinic
  - ☐ Office
- ☐ Abortions – after first trimester:
  - ☐ Hospital
  - ☐ Clinic
  - ☐ Office
- ☐ Acupuncture
- ☐ Adenoidectomies
- ☐ Addiction Medicine
  - ☐ Suboxone Therapy
- ☐ Anesthesia – obstetrical:
  - ☐ General
  - ☐ Spinal
  - ☐ Epidural
- ☐ Anesthesia – non-obstetrical:
  - ☐ General
  - ☐ Spinal
  - ☐ Epidural
  - ☐ Anesthesia (other) – Please describe:
    _____
- ☐ Angiographies
- ☐ Angioplasty
- ☐ Appendectomies

☐ Arteriographies
☐ Assisting in major surgery – own patients
☐ Bariatric Surgery
  ☐ Gastric Bands
  ☐ Bypass or Staples
  ☐ Gastric Sleeve
  ☐ Other: _____
☐ Botox and/or Dermal Fillers (elective cosmetic)
☐ Breast implants
☐ Breast reductions
☐ Catheterizations:
  ☐ Cardiac
  ☐ Arterial
  ☐ Other – Please describe: _____
  _____
☐ Chelation therapy
☐ Chemabrasion
☐ Chemical Peels
☐ Chemotherapy
☐ Colonoscopies
☐ Cosmetic implantation or injection of silicone or other materials. Please describe: _____
_____
☐ Cryosurgery – Please describe: _____
_____
☐ D & C's
☐ Deliveries:
  ☐ Vaginal
  ☐ Cesarean
  ☐ Vaginal after Cesarean
☐ Electromyography
☐ Endoscopy (other than proctoscopy or sigmoidoscopy): _____
☐ Eyeliner or Eyebrow pigmentation
☐ Fracture reductions – closed
☐ Fracture reductions – open
☐ Hair transplants, or other hair growing or replacement techniques
☐ Hemorrhoidectomies:
  ☐ Internal
  ☐ External
☐ Herniorrhaphies
☐ Laparoscopy:
  ☐ Diagnostic – Please describe: _____
  _____
  ☐ Surgical – Please describe: _____
  _____
☐ Laser Surgery – Please indicate type of surgery:
_____
☐ Laser refractive eye procedures:
# Patients Annually: _____
☐ Liposuction
☐ Lumbar punctures
☐ Manipulation therapy
☐ Needle aspirations
☐ Needle biopsies
☐ Neonatology
☐ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts. Please indicate type of surgery: _____
☐ Pacemaker insertion
☐ Pain management – Please indicate type:
_____
☐ Pre-natal care
☐ Radial keratotomies
☐ Radiation – diagnostic
☐ Radiation – therapeutic
☐ Sclerotherapy (choose one) ☐ <1mm ☐ >1mm
☐ Shock therapy
☐ Spinal Surgery
☐ Tattoo removal
☐ Thoracentesis
☐ Tonsillectomies
☐ Total joint replacements
☐ Tubal ligations
☐ Vasectomies
☐ Venography
☐ Any other procedure you reasonably believe will be of interest to a medical professional liability insurer: _____
☐ **I DO NONE OF THESE PROCEDURES**

## ALLIED HEALTHCARE PROVIDERS

42. Do you employ or independently contract with any of the following healthcare providers:

CRNAs ..... ☐ Yes ☐ No
Nurse Practitioners ..... ☐ Yes ☐ No
Physician Assistants ..... ☐ Yes ☐ No
Nurse Midwives ..... ☐ Yes ☐ No

If **"Yes",** please complete the following:

| Provider Type | # Employed or Contracted | Coverage Desired?* |
|---|---|---|
| CRNAs | | ☐ Yes ☐ No |
| Nurse Practitioners | | ☐ Yes ☐ No |
| Physician Assistants | | ☐ Yes ☐ No |
| Nurse Midwives | | ☐ Yes ☐ No |

*If no coverage is desired, please provide proof of insurance. If coverage is desired for any employed healthcare providers, please provide the following employee information:

| Name | Provider Type | Hire Date | Prior Acts Date | Limits of Liability |
|---|---|---|---|---|
| | | | | ☐ Shared ☐ Separate |
| | | | | ☐ Shared ☐ Separate |
| | | | | ☐ Shared ☐ Separate |
| | | | | ☐ Shared ☐ Separate |

## ORGANIZATION / ENTITY INFORMATION

44. Under which business structure do you practice? Check all that apply:

☐ **Employee**
Name of employer: _____

☐ **Independent Contractor**
Name of hiring party to contract: _____

☐ **Individual / Solo Practice**
Name of solo professional corporation*: _____
*Coverage is automatically provided on a shared limit basis.

☐ **Partnership / Shareholder in multi-physician owned corporation**
Do you desire coverage for your multi-physician owned legal entity? ..... ☐ Yes ☐ No

If **"Yes",** please complete the following:

| Corporation Name | List all owner physicians | Corporation Prior Acts Date | Limits of Liability |
|---|---|---|---|
| | 1) _____<br>2) _____<br>3) _____<br>4) _____ | | ☐ Shared<br>☐ Separate** |

**If **SEPARATE** limits of liability are desired for your multi-physician owned corporation, please indicate the limits of liability desired: _____

45. Do you have an ownership interest in any other legal entity or partnership other than those listed above or do you have any affiliation with any other healthcare related organization not previously disclosed on this application? ..... ☐ Yes ☐ No

If **"Yes",** please describe: _____

_____

## UNDERWRITING INFORMATION

*For questions 46 - 62, please explain any "Yes" responses on a separate sheet of paper.*

46. Has any professional society or association ever refused, suspended or revoked your membership? ..... ☐ Yes ☐ No

47. Has any state ever refused to issue you a license to practice medicine? ..... ☐ Yes ☐ No

48. Has any state ever restricted, suspended or revoked your license to practice medicine? ..... ☐ Yes ☐ No

49. Have you ever voluntarily surrendered a license to practice medicine? ..... ☐ Yes ☐ No

50. Has any state agency ever placed you on probation or restricted your practice? ..... ☐ Yes ☐ No

51. Have you ever been the subject of an investigation by any governmental agency? ..... ☐ Yes ☐ No

52. Have your hospital privileges ever been surrendered, restricted or revoked whether voluntarily or involuntarily? ..... ☐ Yes ☐ No

53. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? ..... ☐ Yes ☐ No

54. Are you now being, or have you ever been, treated for, or suffered from, alcoholism or other chemical dependency? ..... ☐ Yes ☐ No

*If **"Yes",** please provide details of rehabilitation program including dates of treatment.*

55. Have you ever incurred or become aware of any illness, or physical, emotional or mental health condition that impairs, or could impair, your ability to practice medicine? ..... ☐ Yes ☐ No

*If **"Yes",** please provide a physician's statement attesting to your fitness to practice.*

56. Have you ever had allegations of sexual misconduct made against you? ..... ☐ Yes ☐ No

57. Have you ever been convicted, had charges brought against you, or are you currently under investigation for a crime other than an a traffic offense? ..... ☐ Yes ☐ No

58. Have you ever been refused board certification? ..... ☐ Yes ☐ No

59. Have you ever had professional liability insurance declined, canceled or non-renewed? ..... ☐ Yes ☐ No

60. Do you use any non-FDA approved devices, drugs or procedures? ..... ☐ Yes ☐ No

61. Has any claim or suit for alleged malpractice ever been brought against you? ..... ☐ Yes ☐ No

If **"Yes":** Number of closed claims: _____ Number of open claims: _____

*Please complete a Claim Supplement for each open or closed claim in the last 10 years.*

62. Are you aware of any circumstances that could reasonably lead to a claim or suit, or have you received a request for medical records from a patient's legal representative? ..... ☐ Yes ☐ No

If **"Yes",** have these been reported to your current professional liability insurer? ..... ☐ Yes ☐ No

# FRAUD WARNINGS

**NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, FLORIDA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON**: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

**NOTICE TO COLORADO APPLICANTS:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** 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.

**NOTICE TO KANSAS APPLICANTS:** any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MAINE AND WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW MEXICO APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

**NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTICE TO VERMONT APPLICANTS:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

## APPLICANT'S REPRESENTATIONS AND AUTHORIZATIONS

I understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of the carrier intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned.

I understand that should an incident, injury, or death occur, subsequent to signing and dating this application, I will notify Aspen or their authorized broker, in writing, of such event.

The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I authorize the release of any underwriting and/or claim

information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents.

I authorize Aspen to release certificates of insurance and claim information to any third party payor, HMO, PPO, hospital or Managed Care Organization.

**Signature of Applicant** **Date**

**NOTICE TO MARYLAND APPLICANTS:** IN THE EVENT OF ANY MATERIAL CHANGE, THE INSURER HAS THE ABILITY TO CANCEL A BINDER OR POLICY, OR RECALCULATE THE PREMIUM FROM THE EFFECTIVE DATE OF THE POLICY, DURING THE FOURTY FIVE (45) DAY UNDERWRITING PERIOD, IN ACCORDANCE WITH MARYLAND INSURANCE ARTICLE §12-106.

# SUPPLEMENTAL CLAIM INFORMATION FORM

Please provide the information below for each additional claim or suit to report.

☐ If you do not have any claims/incidents open or paid, please check the box at the left and sign the bottom.

1. Physician's name (please print): _____
2. Patient's name: _____ Age: _____ Sex: _____
3. Date of first consultation: _____
4. Physical condition and diagnosis at the above date: _____

_____

_____

5. Nature of treatment given and dates of same: _____

_____

_____

6. Date of incident or occurrence from which claim resulted: _____
7. Date of claim: _____
8. Allegations made against you: _____

_____

_____

_____

9. Was this claim reported to your insurance carrier?..... ☐ Yes ☐ No
   If **"Yes",** list name of carrier and policy number: _____
10. Present status or disposition of claim including **amount of settlement or judgment**:

_____

_____

11. Subsequent condition or health of patient: _____

_____

12. Names of other doctors, and hospitals, if any, involved in the claim or suit:

_____

_____

_____

_____ _____

**Signature of Applicant** **Date**



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