



Professional Liability Insurance Application

Application Check List

Call 800.634.9513 for application assistance.

- Complete Application
- Completed claim form for every previous medical malpractice claim
- Curriculum Vitae
- Declaration sheet from your current carrier
- Copy of your license

Mail application and requested documents to:

Gallagher Healthcare
12621 Featherwood, Dr., Ste. 300
Houston, TX 77034

Preparers Signature x _____ Date _____



APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

Claims made Professional Liability Insurance for

Physicians & Surgeons

General Information Application





APPLICATION COMPONENTS

- ◆ General Information Application (completed by physician)
- ◆ Supplemental Application-Specialty Specific (completed by physician)

Items to be completed and submitted with Supplemental Application:

1. General Risk Questionnaire (completed by physician)
2. Self Assessment Questionnaire (completed by physician)
3. Staff Questionnaire (completed by physician staff member)
4. Copy of Medical and DEA Licenses
5. Copy of Curriculum Vitae
6. Copy of Current Declarations for Professional Liability Insurance
7. Copy of any Purchased Extended Reporting Endorsements
8. Copies of one or more of the following as specified in the Supplemental Application:
 - ◆ Patient consultations, patient history & physical, progress notes, evaluations and/or pre-operative notes.

◆ **Additional Information**

Please see the Supplemental Application section for further documentation requirements specific to your specialty.





INSURANCE NOTICE

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the named insured.

This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services, and B) are first made against you and are reported to the company while the policy is in force.

A M S R R G	<p>This application is part of a new process established by the AMS RRG to help assess each applicant more thoroughly. This data will also be used to help physicians develop procedures that will reduce medico-legal risk. Help us expedite the processing of your application:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Please print your responses in ink or type. <input type="checkbox"/> Answer every question or mark it not applicable (N/A) <input type="checkbox"/> Please ensure that all of the supplemental information is forwarded to us expeditiously. <input type="checkbox"/> Use the Remarks section for all additional information <input type="checkbox"/> Please make sure you have provided the appropriate detail on all <u>claims, incidents or suits filed against you</u> for the last 15 years. Complete a separate Claims Information form for each event. <input type="checkbox"/> There are several components to this application. <input type="checkbox"/> Please make sure that all the requested information is provided. <input type="checkbox"/> Please make sure that you have completed all of the required signatures.
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Broker Information: Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____



APPLIED MEDICO-LEGAL SOLUTIONS

RISK RETENTION GROUP, INC.

GENERAL INFORMATION:

1) First Name Middle Name Last Name Suffix Title
Jr./Sr./III MD/DO

2) Social Security Number - - 3) Male Female

3) Please indicate your Primary Specialty of Practice _____

4) Requested Effective / / Current Policy Expires / /

5) Requested Retroactive Date / /

6) Formal Name of Partnership, Corporation or Employer Corporate ID#

ADDRESSES:

7) Please list all office locations where you currently practice. List your primary practice office first. Use the Remarks Section to list additional locations at which you render professional services.

A. Street Bldg. /Suite
 City State Zip Code
 County Number of years at location % of practice

B. Street Bldg. /Suite
 City State Zip Code
 County Number of years at location % of practice

C. Street Bldg. /Suite
 City State Zip Code
 County Number of years at location % of practice



8) Please list the following information regarding your home address.

Street Apt
 City State Zip Code

9) Telephone/E-Mail Address

Primary Practice Office:

Phone Number Fax Home Phone

E-Mail Address

Web Site Address

10) Billing Address if other than Primary Practice address.

Street/P.O. Box Bldg/Suite
 City State Zip Code

11) 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

Explain any additional years spent in any training programs:

Explain any gaps in time from the date of medical school graduation to completion of your training.

PRACTICE INFORMATION:

12) Are you entering practice for the first time since completing an internship, residency or fellowship program?

Yes No

13) Are you entering practice for the first time since completing military service?

Yes No

14) Indicate your number of practice hours per week:

(Include office hours, administrative activities for your practice as well as any hospitals, procedures, direct patient care, consultations etc.)

15) Please indicate the practice hours to be insured by AMS-RRG:



16) Changes in practice

a. Have you practiced continuously for the past ten (10) years? Yes No

If No, please explain in the Supplemental Information Worksheet

b. Have your practice procedures, specialty, location(s), etc., changed in the past ten (10) years Yes No

If Yes, please explain noting dates of changes

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c. Are you a military physician? Yes No

If Yes, is/was your military obligation in remuneration for medical school tuition? Yes No

17) Estimate the number of patients you see on an average day of clinical practice.

18) If semi-retired or practice part-time, indicate approx. monthly practice time.

19) When did you begin practicing on a part time basis? / /
MM/DD/YY

20) Do you expect to continue the reduced practice for at least the next year? Yes No

21) Do you practice less than 26 weeks per year? Yes No

22) If less than 26 weeks per year, are the weeks all consecutive? Yes No

23) Please list the maximum consecutive weeks out of practice.

LICENSES, AFFILIATIONS:

24) Licenses – Please specify states where you are or have been licensed.

State	Year	License #	Permanent	Temporary	Status*
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

State	Year	License #	Permanent	Temporary	Status*
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

State	Year	License #	Permanent	Temporary	Status*
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

State	Year	License #	Permanent	Temporary	Status*
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>

*If any of your licenses are or have been inactive, suspended, restricted or revoked, please explain on the Supplemental Information Worksheet.



25) Affiliations/Associations/Society Membership:

Please list all medical societies you are a member of including national medical and specialty societies as well as state and county medical societies.

Name:	Name:

PRIOR PRACTICE EXPERIENCE:

25) Please list all of your practice locations for the past ten (10) years **other than your current practice locations**. Please explain any gaps in your practice of medicine on the Supplemental Information Worksheet.

Practice Name	Address		
City	State	From	To

Practice Name	Address		
City	State	From	To

Practice Name	Address		
City	State	From	To

Practice Name	Address		
City	State	From	To

Practice Name	Address		
City	State	From	To



TEACHING/MEDICAL DIRECTORSHIPS:

26) a) Do you have any teaching, medical director responsibilities for any insurance or health care related organization. Yes No

b) Do you hold any positions outside of your principal medical or surgical practice (e.g., moonlighting in an E.R. or serving part-time at a clinic or nursing home)? Yes No

If **Yes**, to either a or b above, please complete the following information using the Supplemental Information Worksheet as necessary.

Name of Facility and Address: _____

Title: _____

Responsibilities: _____

27) Do you receive medical malpractice coverage from the entity for:

Administrative activities Yes No
 Direct patient care Yes No

28) If you are involved in teaching activities, what percentage of your time is devoted to teaching?

STAFF PRIVILEGES:

29) List all facilities, including non-hospital facilities, where you have staff privileges, listing the principal location first. Please use the Supplemental Information Worksheet if necessary.

Facility	City	State	Department	% of Practice



INSURANCE HISTORY:

30) Please detail your insurance carriers for the previous fifteen years. Please explain any gaps in your coverage on the Supplemental Information Worksheet.

Coverage Period		Insurance Carrier	Policy #	Type of Policy (Claims Made/Occurrence)	Retroactive Date
From	To				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- 31) Have you ever practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage? Yes No
- 32) Have you ever had professional liability insurance refused, declined, non-renewed, cancelled, or accepted on special terms? Yes No
- 33) Have you ever been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge? Yes No

If you answered **Yes** to any of the above three questions, please provide a detailed explanation on the Supplemental Information Worksheet.

34) Limits of Liability

A. Limits of Liability you are requesting (Please check one)

- \$200,000 per claim / \$600,000 aggregate per single policy year
- \$250,000 per claim / \$750,000 aggregate per single policy year
- \$500,000 per claim / \$1,500,000 aggregate per single policy year
- \$1,000,000 per claim / \$3,000,000 aggregate per single policy year

B. Indicate the Limits of Liability you are currently carrying. (If you are requesting different limits of liability than what you are currently carrying, please provide explanation on the Supplemental Information Worksheet).



RETROACTIVE COVERAGE:

If your current policy or any previous policies are claims-made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage) from that carrier, there will be **NO COVERAGE** for any claim from any act or omission that took place during that period of claims-made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims-made policy. Retroactive coverage insures that for claims made against you for incidents that took place while your previous claims-made insurance was in effect, but that were not brought to your attention until after the effective date of the AMS RRG policy.

Retroactive coverage does **NOT** cover claims that have been filed against you and/or reported to the previous insurers prior to the effective date of the policy with AMS RRG. Any claims and all conduct, circumstances, or incidents that could reasonable be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

I have read and understand the above statement.

SIGNATURE

/ /

DATE (MM/DD/YY)

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

36) If **NO**, do your wish to purchase retroactive coverage from the AMS RRG? Yes No

Desired retroactive date:

/ /

MM/DD/YY

37) Please indicate the reason for termination of your latest policy.

Please note that Retroactive coverage is not granted automatically. It is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.



PRACTICE SITUATION:

38) Indicate all practice situations that apply to you

- | | |
|---|--|
| <input type="checkbox"/> “Solo” Physician (unincorporated) | <input type="checkbox"/> Locum Tenens |
| <input type="checkbox"/> “Solo” Professional Corporation | <input type="checkbox"/> Independent Contractor |
| <input type="checkbox"/> Stockholder of a Professional Corporation with more than one physician shareholder | <input type="checkbox"/> Use of assumed name (DBA) |
| <input type="checkbox"/> Medical Partnership | <input type="checkbox"/> I employ another physician (If this is not insured by AMS, please submit current proof of coverage) |
| <input type="checkbox"/> Employed by another physician/Corporation or Association. | <input type="checkbox"/> Professional Corporation or Association |

39) Please list below the name of all Applicable entity(ies) and/or physicians (s) referenced above.

Name(s) of Entity(ies)	Name(s) of Physician Employer or employee	Professional Liability Insurance Carrier	Employ/Contract Date
			/ / to / /
			/ / to / /
			/ / to / /
			/ / to / /

Please list any further information necessary to complete this section on the Supplemental Information Worksheet.

40) Do you wish corporation coverage for any of the above listed entities? Yes No
 If “Yes”, please list which one(s)

--

Check One: ___ Solo Professional Corporation ___ Medical Partnership
 ___ Professional Corporation/Association ___ Other (provide description)

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Check One: ___ Solo Professional Corporation ___ Medical Partnership
 ___ Professional Corporation/Association ___ Other (provide description)

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Check One: ___ Solo Professional Corporation ___ Medical Partnership
 ___ Professional Corporation/Association ___ Other (provide description)



PRACTICE SITUATION (continued):

List all physicians practicing in the Professional Entities noted on page 8:

Physician's Name (Shareholder or Employee)	Currently insured thru AMS or applying with AMS	If not w/AMS, attach copy of proof of coverage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please included the total number of physicians listed here and all others in the Supplemental Information Worksheet: _____

Limits of Liability requested for the Professional Entity (Please note that you may add your Solo Corporation to your individual policy, sharing in the limits of liability, at no additional charge):

- ___ \$200k/\$600k
- ___ \$250k/\$750k
- ___ \$500k/\$1.5m
- ___ \$1m/\$3m
- ___ Shared limits of liability – Solo Corporation added to individual policy

41) Do you require vicarious liability coverage under this corporate policy for former employees? Yes No

If **Yes**, please indicate the physician's name, employment start date and termination date:

Physician Name	Employment Start Date	Employment Termination Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

42) Do you practice with other physicians that are not listed above? This includes physicians that either cover your practice or those whose practices you cover. Yes No

If **Yes**, please provide the following information:

Physician Name	Phone Number	Association	Hrs of coverage/Wk
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



MISCELLANEOUS:

43) Have you **EVER**:

- a. Had or become aware of any chronic illness or physical defect that impairs or could possibly impair your ability to practice any aspect of medicine? Yes No
- b. 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 clinical privileges. Yes No
- c. Been treated evaluated or hospitalized for any of the following disorders? Yes No
(Please check all that apply.)
 - Alcohol
 - Narcotics
 - Central nervous systems stimulants or depressants
 - Mental or emotional disorders
- d. Been indicted and/or convicted of a crime other than minor traffic violations? Yes No
- e. Been under investigation 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
- f. Had Medicare/Medicaid fraud charges filed against you? Yes No
- g. Been suspended, restricted, or put on probation by any governmental health program (e.g. Medicare or Medicaid)? Yes No

If you answered yes to any of the above questions, please provide full details on the Supplemental Information Worksheet. In addition, if you answered any question related to your personal health with a yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

44) Have you **EVER** been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last fifteen (15) years, or are you presently involved in malpractice litigation?

Yes No

If you answered YES, please submit a separate incident/claim information worksheet for each event in the last fifteen (15) years.



MISCELLANEOUS (continued):

45) Are you aware of any of the following circumstances that might reasonable lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?

a. A request for records from a patient and/or attorney related to an adverse outcome?
Yes No

b. A letter from a patient and/or attorney regarding your medical treatment of a patient?
Yes No

c. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities?
Yes No

d. Has your hospital filed any governmental reports regarding a complication related to your treatment of a patient?
Yes No

46) Are you aware of a patient dissatisfaction with the outcome of a procedure, treatment or diagnosis?

Yes No

47) Have all circumstances that might reasonably lead to an incident, claim or suit (**EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT**) been reported to your current or prior professional liability carrier? If no, please explain (i.e. none to report).

Yes No _____

If you answered yes to any of the above questions please provide all of the specifics for each case on a separate incident/claims information worksheet.

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

SIGNATURE

/ /

DATE (MM/DD/YY)



PRIOR CLAIMS INFORMATION WORKSHEET

Please copy this page as necessary to summarize all medical malpractice claims that you have experienced in the last 15 years. This includes all patients requesting payment to avoid a lawsuit, all notices of intent to sue that did not lead to a lawsuit and information on all lawsuits filed whether or not a payment was made.

Name of Patient: _____

Name of Insurance Carrier: _____

Date of Medical Incident: _____ Date of claim reported to your insurer: _____

Has a suit been filed? **YES** or **NO**

Current status: Open, Closed (If closed, indicate date closed) **Open** **Closed** **Date closed** _____

Amount paid on your behalf: _____ Amount paid on behalf of all defendants: _____

Amount of reserve for open claim (if known): _____

Is this an incident that you reported to your insurer even though a claim has not yet been made? **Yes** **No**

Are these circumstances that you think may result in a claim but have not been previously reported to your insurer? **Yes** **No**

Please provide a detailed account of the events surrounding this claim. This will help us better understand the nature of the claim. In addition, this information will be used to help our physicians reduce their risk of future claims. Please use the supplemental page as necessary. Again, Please be detailed in your description.

Note: You may be requested to provide additional information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.



Assignment of Right to Cancel Coverage

I assign to my employer, _____, both the right to cancel my policy and the return of any unearned premium due to policy changes (e.g. termination of coverage, limit decrease, etc.) for which my employer has paid the premium. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

Initial Here []

Authorization to Release Shares of Stock

I hereby authorize the release of all shares of stock to my employer, _____, for which my employer has paid the capital contribution.

Initial Here []

Physician Certification

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts. I agree to immediately notify the company in writing if there is any future material change in any answer to this application, including without limitation, any change in my professional status, specialty, affiliation, or working arrangement with any other physician, firm, or professional association, and I understand and agree that such changes are material to the risks covered by the policy of insurance I am applying for.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) offered me a premium quote, and (3) received, as a precondition to coverage, the total premium due or, if the company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.



Physician Certification (continued)

I also understand that the company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the company any information regarding me, which the company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

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 in the third degree.

By your signature, you indicate to all the rules and regulations set by Applied Medico-Legal Solutions Risk Retention Group

Print Applicant Name

Date

Applicant Signature

