



NORTHWEST PHYSICIANS

THE DOCTORS COMPANY

2965 Ryan Drive SE : PO Box 13400 : Salem, OR 97309-1400
(503) 371-8228 : (800) 243-3503 : Fax (503) 371-0087: www.npictdc.com

APPLICATION **PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE** **CLAIMS MADE POLICY**

IMPORTANT - You are applying for Claims Made Coverage.
For your own protection, report to your CURRENT insurer BEFORE THE CURRENT POLICY EXPIRES ANY:

- ✓ Incident that might lead to a claim;
- ✓ Unfavorable result in treatment;
- ✓ Request for medical records;
- ✓ Knowledge of a patient or family who might consider bringing a claim against you.

THIS APPLICATION WILL BE ATTACHED TO AND FORM A PART OF YOUR POLICY

If space is insufficient for a complete reply, please attach a separate sheet.

I. GENERAL INFORMATION

AGENT _____ Your Title: _____ Desired effective date _____/_____/_____

Your full name: _____ Your birth date: _____/_____/_____

Principal office address: _____ Telephone # _____

City: _____ State _____ Zip _____ County _____

Other office address: _____ Telephone # _____

Other office address: _____ Telephone # _____

Home address: _____ Telephone # _____

City: _____ State _____ Zip _____

E-mail Address (Optional): _____ Social Sec. # _____

II. LIMITS OF COVERAGE REQUESTED

All limits may not be available in all states.

PROFESSIONAL LIABILITY:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 100,000/300,000 | <input type="checkbox"/> 1,000,000/3,000,000 | <input type="checkbox"/> 2,000,000/4,000,000 | <input type="checkbox"/> 3,000,000/3,000,000 |
| <input type="checkbox"/> 250,000/500,000 | <input type="checkbox"/> 1,000,000/5,000,000 | <input type="checkbox"/> 2,000,000/5,000,000 | <input type="checkbox"/> 4,000,000/4,000,000 |
| <input type="checkbox"/> 500,000/1,000,000 | <input type="checkbox"/> 2,000,000/2,000,000 | <input type="checkbox"/> 2,000,000/6,000,000 | <input type="checkbox"/> 5,000,000/5,000,000 |
| <input type="checkbox"/> 1,000,000/1,000,000 | | | |

APPROVED DECLINED DATE ____/____/____ Rate Spec _____

III. EDUCATIONAL and PRACTICE BACKGROUND

Please complete this page in detail or provide a current curriculum vitae (CV) as an attachment to this application.

If you are in training, in your first two years of practice, or began practice in this State within the last two years, you must provide two letters of recommendation.

Medical School: _____ from ____/____/____ to ____/____/____
 Internship: _____ from ____/____/____ to ____/____/____
 Residency/training: _____ from ____/____/____ to ____/____/____
 Other training (fellowships, military service, etc):
 _____ from ____/____/____ to ____/____/____
 _____ from ____/____/____ to ____/____/____

Please provide practice information for entire practice history, or attach CV showing practice history in detail:

Present practice location at _____ from ____/____/____ to ____/____/____
 Prior practice location at _____ from ____/____/____ to ____/____/____
 Prior practice location at _____ from ____/____/____ to ____/____/____
 Prior practice location at _____ from ____/____/____ to ____/____/____

Please explain any breaks of more than 3 months in your training or practice or attach CV:

Have you attended any loss prevention workshop or classes within the last 3 years for which you are applying for a premium credit? Yes No
 If YES, name of course or workshop _____ Date Taken ____/____/____

NOTE: Premium credit will be allowed for approved NPIC and TFME programs, and credit may be considered for other programs, based on program content. Please attach copy of the certificate of attendance. Also attach a description of the program, if other than an NPIC program.

How many hours of continuing professional education do you attend annually? _____

Foreign medical school graduates:
 Are you certified by the Education Commission for Foreign Med School Graduates? _____ Yes No
 Do you hold the foreign equivalent of board certification _____ Yes No
 If YES, please explain _____

License number (List all states where you have ever been licensed):

State _____ # _____	License Status: <input type="checkbox"/> Current <input type="checkbox"/> Other (explain): _____
State _____ # _____	License Status: <input type="checkbox"/> Current <input type="checkbox"/> Other (explain): _____
State _____ # _____	License Status: <input type="checkbox"/> Current <input type="checkbox"/> Other (explain): _____
State _____ # _____	License Status: <input type="checkbox"/> Current <input type="checkbox"/> Other (explain): _____

BOARD CERTIFICATION (Must be recognized by the American Board of Medical Specialists or the American Osteopathic Association)

Expiration Date, if any: ↓

Specialty: _____ % of current practice Currently Board certified? Yes No _____
 Subspecialty: _____ % of current practice Currently Board certified? Yes No _____

If not currently board certified, are you eligible for Board certification? _____ Yes No

If YES, expected date you plan to become Board certified ____/____/____

If NO, please explain _____

IV. INFORMATION ABOUT YOUR PRACTICE

Please attach a copy of your letterhead

Primary Practice Name: _____ Taxpayer ID No.: _____

Do you wish coverage for this entity, if eligible, as: Additional Insured: no separate limit, no additional premium; or Named Insured: Separate limit of coverage, additional premium required

Type of Practice (check all that apply): Solo Limited Liability Company (LLC) Limited Liability Partnership (LLP) General Partnership Professional Association Professional Corporation (PC) Owner/Member Employee Independent Contractor 'DBA' only Other, explain: _____

If you wish NPIC to contact someone other than you with questions regarding your policy or billing, please provide:

Name: _____ Title: _____ Telephone #: _____
Address (if different from your Principle Office Address shown on page 1): _____
E-mail address: _____

Physicians who are part of this practice:	Relationship (owner, employee, contractor, etc.):	Present Insurer:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check all that apply: Share Office Space Only Share employees Common billings Share profits Share calls Other, explain: _____

List any additional practice address(es) for physicians in your group, if any, that are not already shown on page 1, or attach a copy of letterhead showing all practice addresses for your group. Attach separate sheet, if necessary:

Address: _____ Telephone # _____
City: _____ State _____ Zip _____ County _____
Other office address: _____ Telephone # _____

Do you advertise in the newspaper, magazines, telephone directory (other than basic listing of address and phone number), on the Internet, or have an Internet website for your practice? If so, please attach a copy of advertising materials and list website address(es) :

Please indicate your average number of hours per week:
Office Practice: _____ hours Hospital Practice: _____ hours Emergency Room: _____ hours
On-Call: _____ hours Other: _____ hours (Explain): _____

If you work part-time, is your office staffed to provide medical services during hours that you are not present? If so, please explain:

How many of the following non-physician employees (full-time equivalents) are employed by you or your practice at your office site? (See following page for independent contractors, volunteers, or others who work in your practice, but are not employees.)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Chiropractors | <input type="checkbox"/> Nurse Midwives | <input type="checkbox"/> Physician Assistants | <input type="checkbox"/> Surgeon Assistants |
| <input type="checkbox"/> Inhalation Therapists | <input type="checkbox"/> Nurse or Clinical Perfusionists | <input type="checkbox"/> Podiatrists | <input type="checkbox"/> Technicians – Lab/x-ray/other |
| <input type="checkbox"/> Naturopaths | <input type="checkbox"/> Nurse Practitioners | <input type="checkbox"/> Psychologists | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nurse Anesthetists | <input type="checkbox"/> Pharmacists | <input type="checkbox"/> Psychotherapists | <input type="checkbox"/> Other _____ |

Are all employees subject to license regulations currently licensed?..... Yes No

If NO, explain: _____

MOST EMPLOYEES are covered automatically under your policy. Exceptions include medical doctors, dentists, nurse anesthetists, nurse midwives, naturopaths, chiropractors, podiatrists and psychologists. A separate application must be completed and approved, and a premium paid if you wish coverage for these employees. You may request separate limits for other employees, if desired. List the name and specialty of each employee for whom you wish to apply for separate limits:

Do you supervise any non-physician providers who are not employees?..... Yes No

If YES, explain: _____

Individuals who work in your office, but are not employees, are NOT automatically covered under your policy. If you supervise non-physician providers who are not employees, do you require they provide you with a Certificate of Insurance at least annually?..... Yes No

If NO, explain: _____

Do you supervise or otherwise practice (except call share) with physicians, dentists, podiatrists, chiropractors, psychologists, naturopaths, nurse midwives, or nurse anesthetists who are not insured with NPIC?..... Yes No

If YES, explain: _____

List physicians outside your group with whom you share call: _____

Have your practice characteristics changed within the last five (5) years (such as added/discontinued procedures or surgeries, changed number of hours per week you practice, type or status of ancillary care providers, practiced under another practice name, etc.)?..... Yes No

If YES, explain, including names and titles of employees, practice name and relationship, procedures / surgeries added or discontinued, etc.:

NOTE: Former employees, procedures and practice names are not automatically covered under the policy. NPIC will consider adding coverage as an Additional Insured sharing your limit of coverage, or by rating your policy to include coverage for discontinued procedures.

HOSPITAL AFFILIATIONS

Hospitals granting you privileges	Nature of privileges (name restrictions, if any)	% work in each	How many years?
(1) _____	_____	_____	_____ years
(2) _____	_____	_____	_____ years
(3) _____	_____	_____	_____ years

Check all of the following that apply:

Practice is office based; no surgery other than simple repair of lacerations or simple removal of warts or moles

Provide Emergency Care for my own patients, or as required for Hospital privileges only

Provide Emergency Care, other than above. Please explain: _____

Provide care in an Urgent Care or walk-in care facility

Surgical procedures in office, other than simple repair of lacerations or removal of warts or moles. Please List:

Check all of the following that apply (continued):

____ Surgical procedures in ambulatory surgery centers or other non-hospital facilities. Please list names of facilities and procedures:

____ Practice outside the State, such as conduct IME's, consult, provide telemedicine, see patients, or other practice. If so, please explain: _____

PROCEDURES

Please indicate your best estimate of the NUMBER of each procedure you or your staff performed in the last 12 months, or anticipate you or your staff will perform in the next 12 months. NOTE: Procedures marked by an ** will not be covered by the policy. Certain other procedures are excluded unless added by an endorsement to the policy.

____ Abortions: ____ Elective ____ Therapeutic Maximum gestation age: _____

____ Acupuncture Therapy

____ Aesthetic procedures:

____ autologous fat lip or facial augmentation ____ Botox, collagen, silicon or other injectable fillers, or similar substances

____ chemabrasion (superficial chemical peels) ____ CO2 laser procedures

____ dermabrasion ____ deep (dermal) peels ____ deep (dermal) dermabrasion

____ laser hair removal ____ laser spider vein treatment

____ other laser treatment (Describe): _____

____ sclerotherapy (Describe): _____

____ skin rejuvenation such as ECHO 2 Plus, Skin Enhancing / Rejuvenating Facials, Cellulite Reduction, or similar procedures

____ spider vein treatment ____ other aesthetic procedures (Describe): _____

____ Aesthetic procedures performed in boutiques, salons, or any location other than your medical office**

____ Addiction Medicine: ____ outpatient only ____ hospitalized patients

____ Amniocentesis

____ Anesthesia: ____ spinal ____ caudal ____ epidural ____ general ____ acupuncture anesthesia

____ Autologous fat injections into breasts or penises**

____ Balloon Angioplasty: ____ coronary ____ peripheral

____ Biopsy:

____ breast, cyst aspiration ____ vaginal ____ other (List): _____

____ breast, excisional ____ endometrial

____ breast, incisional ____ lymph node

____ breast, needle ____ skin

____ cervical ____ subcutaneous

____ Blepharoplasty ____ % cosmetic

____ Bone marrow aspiration

____ Cardiac catheterization

____ Cardiac – Swan-Ganz

____ Cardiac pacemaker implant ____ permanent ____ temporary

____ Chelation therapy for treatment of heavy metal poisoning only

____ Chelation therapy (other than for the treatment of heavy metal poisoning)**

____ Chemotherapy

____ Chymopapain disc injection**

____ Chorionic gonadotrophin in the treatment of obesity**

____ Cryosurgery, benign or pre-malignant dermatological lesions

____ Cryosurgery, other: (List): _____

____ Dermatological Radiation Therapy

____ Discogram

Electro shock therapy
 Endoscopy (Examples: bronchoscopy, carpal tunnel, sigmoidoscopy, colonoscopy, cystoscopy, ERCP, etc.) (List): _____

 Experimental equipment or procedures, clinical trials, drug studies, or experiments NOT FDA approved (Describe): _____

FDA Approved Experiments, clinical trials, or drug studies (Describe): _____

Fracture reduction: Closed – no joint involved Closed – joint involved Open

Hair Transplants
 Homeopathic medicine (Describe): _____
 Hyperbaric Chamber treatments
 Hypnosis

Injection treatment of varicose veins
 Issue prescriptions based on an Internet or telephonic consultation without a valid patient-practitioner relationship**
 Intravascular absolute alcohol embolization, other than for renal pathology**

Laetril (Amygdalin or Vitamin B17)**
 Laser procedures not listed elsewhere (Describe): _____
 Laser therapy (Describe): _____

Myelography

Obstetrics pregnancy care to 12 weeks only pregnancy beyond 12 weeks, but no deliveries
 vaginal delivery C-section VBAC (vaginal birth after C-section)
 elective home delivery** waterbirth (water-assisted labor or delivery)**

Pain Management (invasive procedures for management of chronic pain) (Describe): _____

Penile implants or augmentation

Radiology: Diagnostic, including radiopaque studies Interventional Therapeutic
 Angiography, lymph Angiography, other (List): _____

Rapid opiate detoxification**
 Renal dialysis

Sclerotherapy or prolotherapy injections into the spine or joints**
 Sperm bank for other than interim storage for the insemination of your own patients**

Weight control - non-surgical only
 dispense weight control drugs gastric balloon prescribe weight control drugs
 other (Describe): _____

Procedures not normally a part of your medical specialty, or experimental procedures (Describe): _____

SURGERY:

Surgery – Assist only
 Bariatric / weight control Surgery (Describe): _____

- Cardiac surgery
- Colon & rectal surgery
- Dermatological surgery not listed elsewhere (Examples: acne surgery, MOHS)
- Gynecologic Surgery (Examples: hysterectomy, tubal ligation – post partum, tubal ligation – other, LEEP)
- Hand surgery
- Head and/or neck surgery only _____% of total practice
(Examples: rhinoplasty, submucous nasal resection, myringotomy, otoplasty, maxillofacial surgery)
- Laparoscopy (Examples: cholecystectomy, herniorrhaphy, Nissen fundoplication, etc.)
(List): _____
- Liposuction (Describe): _____
- Neurological surgery, including cranial surgery
- Neurological surgery, not including cranial surgery
- Orthopedic Surgery, including spine surgery
- Orthopedic Surgery, not including spine surgery
- Ophthalmic Surgery, other than ophthalmic plastic surgery (Examples: cataract surgery, corneal transplant, KME (epikeratophakia), keratomileusis, laser – limited to anterior of eye, laser – other, lens implant – no cataract surgery, pars plana vitrectomy, vision correction surgery such as radial keratotomy, refractive keratoplasty, retinal detachment surgery, retrobulbar mass)
(List): _____
- Ophthalmic plastic surgery; _____% reconstructive _____% cosmetic (Describe): _____
- Ophthalmic surgery at location(s) other than local hospitals or ambulatory surgery centers, or your office
(List locations and procedures): _____
- Pediatric Surgery
- Plastic surgery, not listed elsewhere
 - _____% cosmetic _____% reconstructive
 - Silicone implant _____% reconstructive _____% cosmetic (If discontinued, date of last implant _____)
 - Breast reduction or augmentation (other than silicone implants)
- Spine Surgery
- Trauma Surgery
- Thoracic (non-cardiac)
- Transsexual (sex change) Surgery**
- Vascular Surgery
- Surgery – Minor Surgery not listed elsewhere (Examples: acne surgery, circumcision)
(List procedures): _____
- Surgery – Intermediate Surgery not listed elsewhere (Examples: dilation & curettage, external or internal hemorrhoidectomy, tonsillectomy /adenoidectomy, vasectomy)
(List procedures): _____
- Surgery – Major Surgery not listed elsewhere (Examples: amputation (major), appendectomy, biliary surgery, herniorrhaphy, intestinal resection, laminectomy, cholecystectomy, lipectomy, liposuction, mastectomy, organ transplant, prostatectomy, thyroidectomy, urological)
(List procedures): _____

In the course of surgery described above, is general anesthesia administered: by you by others no general anesthesia
 Do you personally provide pre-operative examination and post-operative care for all surgical patients?..... Yes No
 If NO, please explain: _____

V. OTHER AFFILIATIONS

Do you work outside your primary practice?..... Yes No
If YES, list in space below:

Do you have any medical related duties for which you do not desire coverage by NPIC?..... Yes No
If YES, please list organization, responsibilities and name of insurance company providing coverage:

Are you associated in a capacity involving the practice of medicine with any organization other than listed above?..... Yes No
If YES, list name of organization(s) and capacity below:

Is insurance coverage provided by that organization?..... Yes No

ANESTHESIOLOGISTS (Also complete Supplemental Application Form D – Anesthesiologists)

Do you comply with the monitoring standards established by the American Society of Anesthesiologists?..... Yes No

Do you practice medicine other than anesthesia?..... Yes No

If YES, describe: _____

Do you administer anesthesia in a non-hospital setting?..... Yes No

If YES, describe: _____

Do you employ or supervise any nurse anesthetists not listed elsewhere?..... Yes No

Do you employ or supervise any inhalation therapists not listed elsewhere?..... Yes No

If YES, please explain, including the supervisory relationship and the number of full-time equivalent nurse anesthetists and/or

Inhalation therapists: _____

FAMILY PRACTITIONERS/GENERAL PRACTITIONERS

Is your practice limited to general office, which may include simple procedures such as repair of lacerations, removal of moles and warts and superficial biopsies?..... Yes No

Do you perform biopsy procedures of lesions on the skin, and of the mucous membranes of the mouth, nose, throat, vagina, uterine cervix and rectum, or needle aspiration, incisional or excisional breast biopsies, that are not listed elsewhere on the application?..... Yes No

If YES, please list: _____

Does your practice include obstetrics?..... Yes No

If YES, complete Supplemental Application Form B - Obstetrics

GENERAL, THORACIC and CARDIAC SURGEONS

Do you perform organ transplants?..... Yes No

If YES, what type: _____

OBSTETRICIANS AND GYNECOLOGISTS

Do you limit your practice to Gynecology only?..... Yes No

Do you employ or supervise any nurse midwives not listed elsewhere?..... Yes No

If YES, please explain, including the supervisory relationship and the number of full-time equivalent nurse midwives:

OPHTHALMOLOGISTS

Do you limit your practice to eye refractions and surgical assist?..... Yes No

VI. CLAIM, INCIDENT and INSURANCE HISTORY

List professional liability insurers for the past 5 years:

Company	Policy Number	Limits	From	To	Type of coverage form?	
					Occurrence	Claim Made
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

If current policy is Claims Made, are you applying for retroactive (nose) coverage with Northwest Physicians Insurance Co.? Yes No
 If YES, attach a copy of the prior carrier's declarations page and fill in the retroactive date here. ____/____/____
 If NO, attach a copy of your prior carrier's extended reporting endorsement (tail).

Have you EVER had a claim (demand for money or services) or a suit for alleged malpractice? Yes No
IF YES, COMPLETE 'FORM A – CLAIM/INCIDENT REPORT' FOR EACH CLAIM AND ATTACH IT TO THIS APPLICATION.

Have there been any incidents in the last 5 years:

- that involve your misdiagnosis that resulted in injury or might result in a claim? Yes No
- that involve brain damage, quadriplegia, paraplegia, loss of major function? Yes No
- with injury that could involve lifelong care or fatal prognosis? Yes No
- with an unfavorable or adverse result which might result in a claim? Yes No
- in which a patient or his/her family was upset and/or threatened legal action? Yes No
- where you feel a patient may file a claim or bring suit for procedure or treatment rendered? Yes No

IF YES TO ANY OF THE ABOVE, COMPLETE 'FORM A – CLAIM/INCIDENT REPORT' FOR EACH INCIDENT AND ATTACH IT TO THIS APPLICATION.

- If YES to any of the above, was each incident reported to your professional liability insurance carrier? Yes No
- I have listed all claims known to me, or of which I should reasonably be aware, on Form A Yes No
- I have listed all incidents known to me, or of which I should reasonably be aware, that have occurred within the last five (5) years on Form A Yes No

COVERAGE WILL NOT BE PROVIDED BY NORTHWEST PHYSICIANS INSURANCE COMPANY FOR KNOWN INCIDENTS OR CLAIMS DESCRIBED ON 'FORM A – CLAIM/INCIDENT REPORT' OR ANY ATTACHMENTS, OR OTHERWISE EXCLUDED BY THE POLICY.

Please attach a separate sheet with full explanation of any YES answers below. Questions refer to both voluntary and involuntary changes in licensing, DEA Certification, and other practice limitations:

- Has any state license to practice medicine ever been denied, limited, restricted, suspended, revoked, subject to probationary conditions or non-renewed, other than your voluntary non-renewal due solely to no longer practicing in that state? Yes No
- Has your Drug Enforcement Agency Certification ever been denied, revoked, suspended, reduced or not renewed? Yes No
- Are you now on probationary status with any licensing board? Yes No
- Are any investigations in progress or pending, or have there ever been any disciplinary actions or suspensions not listed elsewhere, by any licensing board, hospital, medical staff, medical peer review organization, government agency, or similar organizations regarding you, your staff or your practice? Yes No
- Has your membership in any professional society or association ever been suspended or revoked? Yes No
- Have you ever been diagnosed with, treated for, or been recommended to be treated for alcoholism, drug addiction, substance abuse, or mental illness other than minor situational depression? Yes No
- Do you have any personal health problems that might affect your practice of medicine? Yes No
- Have you ever been convicted of, pled no contest, or pled guilty to a crime other than traffic offenses? Yes No
- Has your Board certification ever been refused, revoked, relinquished, suspended or reduced? Yes No
- Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge, issued on any special terms or had renewal refused? Yes No
- Has anyone ever filed a complaint of any kind against you with your medical society or any medical licensing board? Yes No
- Have your hospital privileges ever been denied, restricted, suspended, revoked or not renewed? Yes No
- Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital or other health care facility? Yes No

CERTIFICATE OF INSURANCE: I authorize you to issue Certificates of Insurance to:

- All hospitals and entities that request
- Those I specifically authorize here or in the future _____

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF YOUR POLICY.

I hereby represent the truth of my statements and reasons mentioned in this application and any attachments, and that I have not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. I agree to notify Northwest Physicians Insurance Company of any change in the information contained in this application. I further agree to be bound by the underwriting guidelines of Northwest Physicians Insurance Company.

Acceptance of advance payment does not bind the Company to provide insurance.

I acknowledge that I am responsible for payment of all unpaid premiums, regardless of whether anyone has agreed to pay premiums on my behalf.

I authorize release and exchange of information involving past and future underwriting and claims matters, including, but not limited to, investigations for material information on my reputation and fitness to practice medicine.

Signature _____ Date _____

An underwriter may contact you for further information or clarification.