THE DOCTORS COMPANY

PROTECTING PHYSICIANS SINCE 1976

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

For Physicians and Surgeons

APPLICATION CHECKLIST

We have provided the following checklist to assist you in completing your application. Please verify all required information to assist us in processing your application promptly and efficiently. This application consists of A) an application for insurance, including a Remarks Section page and Claim Information form B) a Supplemental Procedures Questionnaire, C) a Proxy form, and D) a Subscriber Agreement and Power of Attorney.

☐ All questions should be answered. If you do not know the answer to a particular question, please note that in the Remarks Section on page 19.

☐ If you wish to explain any of your answers, please use the Remarks Section. If you need additional space, please attach a supplemental sheet to the application.

☐ Claims information should be provided for a 10-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current company loss runs.

☐ Be sure that all documents are signed and dated where indicated. Your initials or signature is required on pages 1, 4, 12, 17, 20, and 22.

☐ Please enclose a copy of the following:

a) Your letterhead and advertisements

b) The Declarations Page from your current policy, showing your existing policy number and policy period. (Please note: This document is not the same as your Certificate of Insurance.)

c) Curriculum vitae (CV) for each physician and ancillary

d) Loss runs from your current professional liability carrier

☐ Please indicate the date when you wish your insurance to be effective at number 7 on page 2.

If you need additional forms or have any questions about the application process, please call The Doctors Company Policyholder Services at (800) 421-2368, option 7.

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 or the use of your professional office premises, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the premium. No coverage exists until the premium is received and a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

ELIGIBILITY

1. Are any physicians or ancillary personnel employed that are not insured by The Doctors Company and are not listed on this application?
   ☐ Yes ☐ No

2. Are any physicians or ancillary personnel under contract for medical services at any long-term care facility or nursing home?
   ☐ Yes ☐ No

3. Does any physician or ancillary personnel contract to treat or review treatment at correctional facilities, prisons, or jails?
   ☐ Yes ☐ No
   If yes, please explain in the Remarks Section.

4. As of this date, is any applicant aware of any conduct, circumstances, or incidents that have occurred that could reasonably be expected to result in a claim, and that have not been reported to their present or prior insurer(s)?
   ☐ Yes ☐ No

INITIALS REQUIRED

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

Initials ______ Date ______

ENTITY COVERAGE

1. If entity coverage is required, enter zip code, retroactive date, and select type of limits. If a solo entity coverage is required, answer 'No Entity Coverage'.

   Zip Code ☐

   Retroactive Date ☐

   ☐ Shared Limits ☐ or Separate Limits (not available to single-physician practices)

2. Number of Locations
   Enter zip code for each location:

   Location 1 Zip Code ☐
   Location 2 Zip Code ☐
   Location 3 Zip Code ☐
   Location 4 Zip Code ☐
   Location 5 Zip Code ☐

BUSINESS DESCRIPTION

1. Is this an application to join a physician or group currently insured by The Doctors Company?

   ☐ Yes ☐ No
   If yes, enter policy number: ☐

2. Entity Name:

3. List partners' or members' names (Enter "none" if there are not any):

4. What is the practice structure and relationship, if any, with others in your practice?

   ☐ Partnership ☐ DBA or Fictitious Name
   ☐ Individual ☐ Solo Medical Corporation
   ☐ Other Medical Corporation

   Corporate I.D. number (if applicable): ☐

5. Desired liability limits for entity and all **ratable exposures** for this policy or group.

   ☐ $500,000 per claim/$1,500,000 annual aggregate
   ☐ $1,000,000 per claim/$3,000,000 annual aggregate
   ☐ $2,000,000 per claim/$5,000,000 annual aggregate
   ☐ Other (limits set by your state, etc., indicate amount): ☐

6. Are these limits higher than your current coverage?
   ☐ Yes ☐ No

7. What is your requested effective date (must be submitted to The Doctors Company at least 10 days prior to this date)?

8. What is your current policy expiration date? If this is your first policy, enter same as above.

PRACTITIONER LIST

1. Type:

Doctor

Prefix ☐ First Name ☐ Middle Name ☐ Last Name ☐ Suffix ☐

Professional Designation ☐ SSN ☐ Birth Date ☐

☐ Male ☐ Female

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier?

☐ Yes ☐ No

If no, do you wish to purchase retroactive coverage from The Doctors Company?

☐ Yes ☐ No

If yes, enter desired retroactive date: ☐

2. Employee Type:

☐ Doctor

☐ Ancillary–Own Limits

☐ Ancillary–Shared Limits

Prefix ☐ First Name ☐ Middle Name ☐ Last Name ☐ Suffix ☐

Professional Designation ☐ SSN ☐ Birth Date ☐

☐ Male ☐ Female Employment Date ☐

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier?

☐ Yes ☐ No

If no, do you wish to purchase retroactive coverage from The Doctors Company?

☐ Yes ☐ No

If yes, enter desired retroactive date: ☐

3. Employee Type:

☐ Doctor

☐ Ancillary–Own Limits

☐ Ancillary–Shared Limits

Prefix ☐ First Name ☐ Middle Name ☐ Last Name ☐ Suffix ☐

Professional Designation ☐ SSN ☐ Birth Date ☐

☐ Male ☐ Female Employment Date ☐

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier?

☐ Yes ☐ No

If no, do you wish to purchase retroactive coverage from The Doctors Company?

☐ Yes ☐ No

If yes, enter desired retroactive date: ☐

4. Employee Type:

☐ Doctor

☐ Ancillary–Own Limits

☐ Ancillary–Shared Limits

Prefix ☐ First Name ☐ Middle Name ☐ Last Name ☐ Suffix ☐

Professional Designation ☐ SSN ☐ Birth Date ☐

☐ Male ☐ Female Employment Date ☐

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier?

☐ Yes ☐ No

If no, do you wish to purchase retroactive coverage from The Doctors Company?

☐ Yes ☐ No

If yes, enter desired retroactive date: ☐

Retroactive coverage, which is also called tail or prior acts coverage, provides insurance for claims arising from incidents that took place while a previous claims-made policy (or policies) was in effect but were reported after the policy (or policies) has terminated. If your current policy is claims-made, you must either a) apply for a policy with a retroactive date back to the first day of your claims-made coverage, or b) purchase an extended reporting endorsement (tail coverage) from that insurance company.

Retroactive coverage does not cover claims that have already been filed against you or that were reported to your previous insurer(s) prior to the effective date of your policy with The Doctors Company. Any claims and all conduct, circumstances, or incidents that could reasonably be expected to result in a claim **must** be reported to your present insurance company prior to the requested effective date of this insurance. Your prior policy may require that such notification be made to the company in writing.

I have read and understand the above statement. I understand that if I do not purchase tail from my current insurance company or obtain prior acts coverage from The Doctors Company, I will be uninsured for any claim that arises from my acts prior to the effective date of coverage with The Doctors Company.

INITIALS REQUIRED

Initials ☐ Date ☐

PRACTICE LOCATION

List all current office or clinic practice locations in this section. Include all locations whether or not The Doctors Company insurance is desired at that location. If additional space is required to show more than two practice locations, please photocopy this section. **Do not include hospital privilege information within this section.**

A. Primary Practice Location

Location Name ☐ Street Address ☐ Bldg./Suite ☐

Zip Code ☐ City ☐ State ☐ County ☐

Telephone ☐ Fax ☐

Years at Location ☐

Primary Practice E-mail ☐

☐ May we use this e-mail address to send you The Doctors Company information?

Billing Address (if different than primary practice address):

Street Address ☐ Bldg./Suite ☐

Zip Code ☐ City ☐ State ☐

Please indicate all that apply for this location:

- ☐ Outpatient Office ☐ Abortion Clinic ☐ Commercial Laboratory ☐ Correctional Facility
- ☐ Emergency Center ☐ Nursing Home ☐ Surgery Center ☐ Urgent Care Center
- ☐ Hospital ☐ Other

If other, please describe:

This location is: ☐ Leased ☐ Owned ☐ Rented

Hours per week worked at this location: Percentage of Practice:

Is The Doctors Company insurance desired for this practice location: ☐ Yes ☐ No

If no, are you self-insured? ☐ Yes ☐ No

If not self-insured, please enter name of insurance carrier:

B. Other Practice Location

Location Name Street Address Bldg./Suite

Zip Code City State County

Telephone Fax

Years at Location

Please indicate all that apply for this location:

- ☐ Outpatient Office ☐ Abortion Clinic ☐ Commercial Laboratory ☐ Correctional Facility
- ☐ Emergency Center ☐ Nursing Home ☐ Surgery Center ☐ Urgent Care Center
- ☐ Hospital ☐ Other

If other, please describe:

This location is: ☐ Leased ☐ Owned ☐ Rented

Hours per week worked at this location: Percentage of Practice:

Is The Doctors Company insurance desired for this practice location: ☐ Yes ☐ No

If no, are you self-insured? ☐ Yes ☐ No

If not self-insured, please enter name of insurance carrier:

SPECIALTY

1. Primary Specialty

Name of Specialty: % of Practice:

Are you ABMS or AOA board certified? ☐ Yes ☐ No

If yes, date of certification:

Name of Board:

OR

- ☐ Not Board Certified
- ☐ Eligible for board certification, enter expiration date:
- ☐ Certification or board eligibility expired, please explain:

2. Secondary Specialty

Name of Specialty: % of Practice:

Are you ABMS or AOA board certified? ☐ Yes ☐ No

If yes, date of certification: ____

Name of Board: ____

OR

☐ Not Board Certified

☐ Eligible for board certification, enter expiration date: ____

☐ Certification or board eligibility expired, please explain: ____

MEDICAL PROCEDURES

Medical Procedures

☐ Abortions – 1st Trimester
☐ Abortions – Therapeutic
☐ Anesthesia – IV Analgesia (surgical)
☐ Anesthesia – Local
☐ Angiography
☐ Angioplasty
☐ Appendectomy
☐ Assisting in Surgery
☐ Autologous Fat Injection – Penis
☐ Bariatric Surgery
☐ Biopsy – Breast
☐ Biopsy – Cervical
☐ Biopsy – Heart
☐ Biopsy – Liver
☐ Biopsy – Other
☐ Blepharoplasty – Cosmetic
☐ Blepharoplasty – Functional
☐ Blocks – Spine*
☐ Blocks – Non-spine*
☐ Botox Injections – Cosmetic*
☐ Botox Injections – Other*
☐ Botox Injections – Pain Management*
☐ Breast Augmentation
☐ Cardiac Catheterization – Left Heart
☐ Cardiac Catheterization – Right Heart (Swan Ganz)
☐ Cataract Surgery
☐ Chalazion Excision from Eyelids
☐ Chelation Therapy
☐ Chemical Peel
☐ Circumcisions – Adult

Medical Procedures

☐ Circumcisions – Pediatric
☐ Corneal Transplant
☐ Cryosurgery
☐ Cryotherapy
☐ Dermabrasion
☐ Dilation and Currettage
☐ Endoscopy – Bronchoscopy
☐ Endoscopy – Colonoscopy
☐ Endoscopy – Esophagoscopy
☐ Endoscopy – Gastroscopy
☐ Endoscopy – Other
☐ Endoscopy – Pelvioscopy
☐ Endoscopy – Sigmoidoscopy (flexible to 65cm)
☐ Endoscopy – Sigmoidoscopy (flexible above 65cm)
☐ Endoscopy – Sigmoidoscopy (rigid)
☐ Enucleation
☐ Fracture Reduction – Closed – Simple
☐ Fracture Reduction – Closed – Other than Simple
☐ Fracture Reduction – Open
☐ Hair Transplant
☐ Hemorrhoidectomy – Ligation Only
☐ Hemorrhoidectomy – Other than Ligation
☐ Histories and Physicals
☐ Home Services
☐ Human Growth Hormone
☐ Hypnosis
☐ Hysterectomy – Abdominal
☐ In Vitro Fertilization (IVF)
☐ Independent Medical Evaluations
☐ Joint Injection (Intra-articular Block)

*__Please provide training and certificates of completion.__

- ☐ Laceration Repairs
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing – Face Only
- ☐ Laser Skin Resurfacing – Other
- ☐ Laser Surgery
- ☐ LASIK*
- ☐ Leeps/Leetz Procedure
- ☐ Lid Repair
- ☐ Lumpectomy – Superficial Skin Lesion
- ☐ Lumpectomy – Other
- ☐ Manipulation Under Anesthesia
- ☐ Myofascial Trigger Point Injections
- ☐ Nerve Root Injections
- ☐ Non-FDA Approved Experiments or Studies
- ☐ Obstetrical Deliveries – Birthing Center
- ☐ Obstetrical Deliveries – Home or Other
- ☐ Office Gynecology
- ☐ Pain Control/Management – Medication Only
- ☐ Pap Smears
- ☐ Pelvic Examination
- ☐ Photorefractive Keratotomy (PRK)
- ☐ Phototherapeutic Keratotomy (PTK)
- ☐ Physical Therapy
- ☐ Prenatal Exam – Diagnose Only (refer to others)
- ☐ Prenatal Exam – 1st Trimester
- ☐ Prenatal Exam – 2nd Trimester
- ☐ Prenatal Exam – 3rd Trimester
- ☐ Prolotherapy
- ☐ Radiation Therapy
- ☐ Rapid Detoxification
- ☐ Rhinoplasty – Cosmetic
- ☐ Rhinoplasty – Functional Only
- ☐ Sex Change Surgery
- ☐ Spinal Infusion Pump – Implants
- ☐ Spinal Surgery
- ☐ Suction Assisted Lipectomy (SAL) – Flanks/Buttocks/Abdomens/Thighs*
- ☐ Suction Assisted Lipectomy (SAL) – Full Body*
- ☐ Suction Assisted Lipectomy (SAL) – Limited to Head/Neck*
- ☐ Tendon Repair
- ☐ Therapeutic Radiology
- ☐ Tubal Ligation
- ☐ Ultrasound – For Obstetrics
- ☐ Ultrasound – Other
- ☐ Vasectomy
- ☐ Vein Stripping*
- ☐ Vertebroplasty
- ☐ Weight Control Treatment – Diet Only
- ☐ Weight Control Treatment – Drugs
- ☐ Wound Débridement

***Please provide training and certificates of completion.**

If you or your staff do not perform any of these procedures/services, or perform procedures/services other than those listed above, please list the types of procedures/services you provide in your practice. Include those procedures/services that you anticipate adding to your practice.

Have you been approved to perform all of the procedures that you indicated above by the credentials committee(s) of the hospital(s) in which you practice? ☐ Yes ☐ No

If no, please explain:

MEDICAL PROCEDURE FOLLOW-UP

Please answer the questions below that are pertinent to your practice. Write “NA” if a question is not applicable to your practice.

A. All Specialties

If you or any of your staff perform elective cosmetic procedures, please specify the procedure(s), and who is performing these procedures (include name, title, and proof of license if applicable):

B. Pain Management

1. Describe in detail the types of pain management procedure(s) practiced:

2. If spinal anesthesia is used, specify the types of procedures used:

3. If none of the following procedures are performed:

- Acupuncture – For Anesthesia
- Acupuncture – Other
- Anesthesia – Intravenous
- Anesthesia – IV Analgesia
- Anesthesia – Regional
- Anesthesia – Spinal
- Blocks – ALL
- Botox Injections – Cosmetic
- Botox Injections – Other
- Botox Injections – Pain Management
- Cervical Discogram
- Cryoanalgesia
- Dorsal Column Stimulator – Reprogram Only
- Epidural/Spinal Catheter Insertion
- Fluoroscopy
- Hypnosis
- Intradiscal Electrothermal Therapy

Please list the types of procedures/services you provide in your practice:

AFFILIATIONS

1. Is applicant entering practice for the first time since completing an internship, residency program, fellowship, or miltary service?

☐ Yes ☐ No

2. Please enter beginning date of applicant’s practice:

If anesthesiologist, complete question #3 and skip to question #8.

3. Indicate the number of billable hours per week:

4. Number of hours per week for office and clinical practice (direct patient care, consultation, administrative activities, etc.—only work to be covered by The Doctors Company): ______

5. Number of hours per week on call (only work to be covered by The Doctors Company): ______

6. Number of hours per week on hospital rounds (only work to be covered by The Doctors Company): ______

7. Number of hours per week for scheduled surgery (only work to be covered by The Doctors Company): ______

8. Estimate number of patients seen in clinical practice on an average weekly basis: ______

9. Enter number of ancillaries of each type below. If none, enter 0: ______

Type	No. Employed	No. Contracted	Insurance Company
PA:			
NP:			
CRNA:			
CNM:			
OPT:			
Other:			

If other, list other paramedical personnel, including nurses, technicians, technologists, physical therapists, etc.

10. Affiliations/Associations/Society Membership
Are you a member of any national, state, or county medical societies?

National Medical Society: ______

National Medical Specialty Society:

- ☐ American Society of Plastic Surgeons
- ☐ American Association of Neurological Surgeons
- ☐ American College of Physicians
- ☐ Otolaryngologists (AAO-HNS)

State Medical Society:

- ☐ Denver Medical Society
- ☐ Montana Medical Association
- ☐ Wyoming Medical Society Plan

County Medical Society: ______

PRIOR PRACTICE

☐ **I have had no prior practice.**

Please provide a 10-year history (if applicable).

A. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

B. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

C. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

D. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

E. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

F. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

G. Entity Name

Street Address Bldg./Suite

Zip Code City State

Start Date End Date

PRIOR INSURANCE

☐ **I have had no prior insurance.**

Please provide a 10-year history (if applicable). If additional space is required to show more than three insurance carriers, please photocopy this page.

Attach a copy of the Declarations Page from your most recent policy.

A. Current Carrier Name

Carrier Name ____ Date of Coverage ____ to ____

Policy Type: ☐ Claims Made ☐ Occurrence ☐ Claims Paid

Policy Limits:

Occurrence: ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐ Other ____

Aggregate: ☐ $1,500,000 ☐ $3,000,000 ☐ $5,000,000 ☐ $8,000,000 ☐ Other ____

Carrier considers claim to be: ☐ Formal Demand for Money ☐ Report of Medical Incident

Policy Name ____ Policy Number ____

What is your current premium? ____

Prior policy number with The Doctors Company (if applicable): ____

B. Prior Carrier Name

Carrier Name ____ Date of Coverage ____ to ____

Policy Type: ☐ Claims Made ☐ Occurrence ☐ Claims Paid

Policy Limits:

Occurrence: ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐ Other ____

Aggregate: ☐ $1,500,000 ☐ $3,000,000 ☐ $5,000,000 ☐ $8,000,000 ☐ Other ____

Carrier considers claim to be: ☐ Formal Demand for Money ☐ Report of Medical Incident

C. Prior Carrier Name

Carrier Name ____ Date of Coverage ____ to ____

Policy Type: ☐ Claims Made ☐ Occurrence ☐ Claims Paid

Policy Limits:

Occurrence: ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐ Other ____

Aggregate: ☐ $1,500,000 ☐ $3,000,000 ☐ $5,000,000 ☐ $8,000,000 ☐ Other ____

Carrier considers claim to be: ☐ Formal Demand for Money ☐ Report of Medical Incident

CLAIM INFORMATION FORM

☐ **I have not been involved in a malpractice claim, suit, or incident in the past 10 years.**

Please provide a 10-year history (if applicable).

Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

Patient First Name ______ Middle Name ______ Last Name ______

Age ______ ☐ Male ☐ Female

Relationship to Patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon, etc.) ______

Incident Location ______

Incident Date ______ Report Date ______ Close Date ______

Insurance Carrier ______

Claim Status ☐ Open ☐ Closed

Dispensation ☐ Dismissed ☐ Judgment ☐ Settlement

Paid Amount (Include Expenses) ______ Reserve Amount (Include Expenses) ______

Allegation:

Other Defendants:

Claimant Diagnosis:

Services Rendered:

Post Treatment Condition:

SIGNATURE REQUIRED

I hereby declare the above information is complete and true to the best of my knowledge and belief.

______ Date ______

INTERROGATORY

If you answer yes to any of the following questions, please accompany this application with full details including dates and copies of related documents.

1. Are you now being or have you ever been treated for alcoholism, narcotics addiction, or mental illness?

   ☐ Yes ☐ No

   If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.

2. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice medicine?

   ☐ Yes ☐ No

   If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.

3. Have you ever been investigated 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

   If yes, please provide copies of complaint and disposition documents.

4. Has any hospital ever restricted or revoked your privileges or invoked probation for any cause?

   ☐ Yes ☐ No

5. Have you ever been indicted for or convicted of a crime other than minor traffic violations?

   ☐ Yes ☐ No

6. Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)?

   ☐ Yes ☐ No

7. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible or surcharge assessed against you? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND.**

   ☐ Yes ☐ No

PRIOR EDUCATION

Enter the number of continuing medical education credit hours (past three years):

1. **Medical School**

Name of Institution:

City: State/Province: Country:

Start Date: Finished Date: Degree/Certificate:

Are you certified by the Educational Council for Foreign School Graduates?

☐ Yes ☐ No

2. **Internship**

Name of Institution:

City: State/Province: Country:

Start Date: Finished Date:

Type:

3. **Residency**

Specialty:

Name of Institution:

City: State/Province: Country:

Start Date: Finished Date:

Type:

Was residency completed?

☐ Yes ☐ No

4. **Residency**

Specialty:

Name of Institution:

City: State/Province: Country:

Start Date: Finished Date:

Type:

Was residency completed?

☐ Yes ☐ No

5. **Fellowship**

Name of Institution:

City: State/Province: Country:

Start Date: Finished Date:

Type:

6. Other Training

Name of Institution:

City: State/Province: Country:

Start Date: Finished Date: Degree/Certificate:

Type:

LICENSES

A. License Number:

License Status: ☐ Inactive ☐ Restricted ☐ Revoked/Suspended ☐ Active

License State:

If this license is or has been inactive, suspended, restricted, or revoked, please explain.

B. License Number:

License Status: ☐ Inactive ☐ Restricted ☐ Revoked/Suspended ☐ Active

License State:

If this license is or has been inactive, suspended, restricted, or revoked, please explain.

C. License Number:

License Status: ☐ Inactive ☐ Restricted ☐ Revoked/Suspended ☐ Active

License State:

If this license is or has been inactive, suspended, restricted, or revoked, please explain.

STAFF PRIVILEGES

☐ **This applicant has no staff privileges.**

List all facilities, including non-hospital facilities, where you have staff privileges. List principal location first.

A. Facility Name:

City: State:

Department: % of Practice:

Facility Type: ☐ Hospital ☐ Non-Hospital

B. Facility Name:

City: State:

Department: % of Practice:

Facility Type: ☐ Hospital ☐ Non-Hospital

C. Facility Name:

City: State:

Department: % of Practice:

Facility Type: ☐ Hospital ☐ Non-Hospital

ADDITIONAL UNDERWRITING

1a. Do you practice in any office surgical facility or surgery center?

☐ Yes ☐ No

If yes, list facilities:

1b. If yes, is the office certified by AAAASF, AAAHC, NCQA, JCAHO, or Medicare?

☐ Yes ☐ No

If yes, please submit a copy of current certification.

2. Do you have a Web site address?

☐ Yes ☐ No

If yes, specify name:

3. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunication, video, or information systems?

☐ Yes ☐ No

If yes, please describe:

4. Do you advertise your medical practice?

If yes, please provide samples:

☐ Yes ☐ No

PERSONAL INFORMATION

Home Address:

Street Apt.

Zip Code City State

Telephone

E-mail Address

PRACTICE INFORMATION

1. Do you employ any physicians besides yourself in your practice?

☐ Yes ☐ No

If yes, please provide list and details:

2. Do you independently contract with any entities or physicians?

☐ Yes ☐ No

If yes, please provide list and details:

If you are an independent contractor, please complete the following statement:

My association with ____________ is that of an independent contractor,

Group/Physician Name

and the relationship conforms to the guidelines of the Internal Revenue Service.

SIGNATURE REQUIRED

I hereby declare the above information is complete and true to the best of my knowledge and belief.

Date

Group/Physician Name

Carrier

A current Declarations Page or Certificate of Insurance for the group or physician above must be attached.

3. Are you employed by any physicians or entities?

☐ Yes ☐ No

If yes, please provide list and details:

4. Please list any personal entities, corporations, or DBAs under which you practice or bill:

5a. Do you peform medical legal evaluations?

☐ Yes ☐ No

If yes, with whom?

5b. What percentage of your practice does this entail?

6a. Do you have any teaching responsibilities?

☐ Yes ☐ No

If yes, complete the following questions:

6b. Name and location of institution?

6c. Does the institution provide you with coverage for your supervision of residents?

☐ Yes ☐ No

6d. What percentage of your weekly time is spent supervising residents?

7a. Do you have any medical director responsibilities?

☐ Yes ☐ No

If yes, complete the following questions:

7b. Name and location of entity?

7c. Does the entity provide you with coverage for your administrative responsibilities?

☐ Yes ☐ No

7d. Does the entity provide you with coverage for your direct patient care?

☐ Yes ☐ No

Please provide proof of medical professional liability insurance for the entity.

8. Will you be performing activities which will be covered by another professional liability policy?

☐ Yes ☐ No

If yes, please provide proof of coverage, including name and address of entity.

9. Have your practice specialties/procedures, etc., changed in the past five years?

☐ Yes ☐ No

If yes, please explain how the specialties/procedures, etc., have changed and give the dates of changes:

REMARKS SECTION

If additional space is needed, please photocopy this page. For question number, please indicate question number and letter (if applicable)—5 and 7d for example.

Page Number	Question Number	Remarks

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information or material misrepresentation will cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application—in ink—and returned the original to the company with the required payment.

(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: I understand that in connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

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 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 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 York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and shall also be subject to a civil penalty not to exceed $5,000 (five thousand dollars) and the stated value of the claim for each such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he or she 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 Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

Notice to Tennessee 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 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, denial of insurance benefits, and civil damages.

SIGNATURE REQUIRED

Applicant Signature ______________________ Date __________

PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them, my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company, an Interinsurance Exchange.

This proxy is solicited on behalf of the management of the Exchange and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.

You may revoke this proxy by giving the Exchange written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

SIGNATURE OPTIONAL

Signature

Type or Print Name

Street

City State Zip Code

Date

(If undated, the date of receipt will be inserted by The Doctors Company. Address any question you may have to the Secretary of the Exchange.)

SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors Company, an Interinsurance Exchange ("the Exchange"), and agrees with the Exchange and with other Subscribers, through their Attorney-in-Fact, The Doctors Management Company ("the Attorney") to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by the Exchange's Board of Governors.

2. Subscriber designates and appoints the Attorney to be its true and lawful agent and Attorney-in-Fact to act in its name, place, and stead and in the name of the Exchange, to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of the Exchange and the business of interinsurance. Subscriber adopts and approves the Management Agreement between the Exchange and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.

3. Subscriber delegates to the Board of Governors of the Exchange authority to negotiate all the terms and conditions of the Management Agreement between the Exchange and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or Exchange.

4. Subscriber further delegates to the Board of Governors of the Exchange all necessary and proper powers to conduct, manage, and control the affairs and business of the Exchange, subject to those retained by law or through the Rules and Regulations of the Exchange, or as they may be further amended at the Annual Meeting of Subscribers.

5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.

6. Subscribership begins with the commencement of the policy period of a claims-made insurance policy issued by the Exchange and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of the Exchange.

7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to "Attorney" shall then be deemed to include such successor Attorney-in-Fact.

8. The principal offices of the Exchange and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.

9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word "Subscriber" is used, it refers to all members of the Exchange, including the Subscriber who has signed this document.

SIGNATURE REQUIRED

Executed this ____________ day of ____________ 20____

Signature ______________________________

Print or Type Name ______________________________

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