Medical Professional Liability Insurance
Physician Application

Ob-Gyn Risk Alliance
Underwritten by ProAssurance
Treated Fairly

ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

With your fully completed, signed and dated application, please submit the following information:

1. Current coverage verification (i.e., declaration page, certificate of insurance).
2. Written verification of the purchase of an extended reporting endorsement (tail) from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Current loss runs from prior insurance companies or explanation as to why they are not available.
5. Copy of curriculum vitae (CV).
6. Copy of Continuing Medical Education (CME) Programs completed in the past three years.

Note: Submission of a complete application confers no obligation upon the Company to bind coverage.

1. Personal Information

Name: _____ Degree: _____
FIRST MIDDLE LAST

Social Security Number: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Email Address: _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Medical License Number(s):	State	License Number	Expiration Date	% of Practice

List all State Medical Associations you currently belong to: _____

Please provide additional license information in the space provided at the end of the application.

2. Education, Training, and Certification

A. Please list the name and location of all medical schools attended:

Institution and Location	Dates Attended	Degree Obtained

B. If degree was granted from a foreign medical school, are you ECFMG certified? Yes ☐ No ☐

i. Have you ever failed the ECFMG examination? Yes ☐ No ☐

If yes, please explain in the space provided at the end of the application.

C. Please list all internships, residencies, or fellowships.

Internship

Institution Name: _____

Institution Location: _____

☐ Rotating ☐ Transitional ☐ Straight (Specialty: _____)

Dates Attended: From _____ To _____
MM/DD/YY MM/DD/YY

Did you successfully complete this program? Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

Residency

Institution Name: _____

Institution Location: _____

Specialty/Department: _____ Dates Attended: From _____ (MM/DD/YY) To _____ (MM/DD/YY)

Did you successfully complete this program? Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

Fellowship

Institution Name: _____

Institution Location: _____

Type of Fellowship: _____ Dates Attended: From _____ (MM/DD/YY) To _____ (MM/DD/YY)

Did you successfully complete this program? Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

☐ Please indicate here if you attended more than one medical/professional school or participated in additional programs to those listed above and include information in the space provided at the end of the application.

D. Are you board certified? Yes ☐ No ☐

i. If yes, please indicate which board and specialty/subspecialty:

☐ American Board of _____

☐ American Osteopathic Board of _____

ii. If not boarded, when do you plan to take your boards? _____

iii. Are you required to recertify? Yes ☐ No ☐

If yes, please provide date of recertification: _____

iv. Have you ever failed a board certification or recertification examination? Yes ☐ No ☐

If yes, how many times? _____ (Oral) _____ (Written)

E. Please indicate your current life support certification information:

☐ ACLS Certified ☐ BCLS Certified ☐ ATLS Certified ☐ PALS Certified

3. Personal History

If you answer yes to any of the following questions, provide complete details in the section at the end of the application or on a separate sheet.

A. Has your license to practice medicine or your permit to prescribe drugs *ever* been denied, revoked, suspended, voluntarily suspended, or otherwise investigated or limited in any way? Yes ☐ No ☐

B. Have you *ever* appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes ☐ No ☐

C. Have you *ever* had a patient, patient's family member, or patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes ☐ No ☐

D. Have you *ever* been convicted of, pled guilty to, or pled no contest to, or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? Yes ☐ No ☐

E. Have you *ever* been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any mental illness, including but not limited to depression and/or chronic fatigue? Yes ☐ No ☐

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

G. Do you have any physical handicap or chronic illness? Yes ☐ No ☐

H. Has membership in any professional association or society *ever* been revoked or refused? Yes ☐ No ☐

4. Practice Location

Practice Name: _____ Employment Date: _____/_____/_____ (MONTH / DAY / YEAR)

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Billing Address: _____

Contact Name: _____ Title: _____

Contact Email Address: _____

Please list other practice locations:

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ % of Practice: _____

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ % of Practice: _____

Please list additional practice locations in the space provided at the end of the application.

5. Practice Information

A. What is your present specialty? _____ % of Practice: _____

B. What is your present sub-specialty? _____ % of Practice: _____

C. Have there been any changes in your specialty, procedures, or practice activity within the past five years? Yes ☐ No ☐
If yes, please describe in the space provided at the end of the application.

D. How many patients do you see on average per week? _____

E. How many hours do you practice on average per week? _____
(Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision, and on-call hours involving patient contact, whether direct or by telephone.)

F. Do you practice any of the following?
- ☐ Ayurvedic Medicine
- ☐ Chinese Medicine (including Acupuncture)
- ☐ Holistic Medicine
- ☐ Homeopathic Medicine
- ☐ Naturopathic Medicine

G. Do you perform medical or surgical procedures in an office-based surgical suite? Yes ☐ No ☐

H. Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine program? Yes ☐ No ☐
If yes, what percentage of your practice does this constitute? _____%

i. Do you provide these services to patients in states outside your primary practice location? Yes ☐ No ☐
If yes, please provide a list of states: _____

I. Do you have an agreement/contract to provide care at:
- ☐ Nursing Home
- ☐ Correctional Facility
- ☐ Emergency Department
- ☐ Mobile Health Services
- ☐ Home Health

J. Do you serve as a Medical Director for any off-site delivery programs? Yes ☐ No ☐

If yes, please list the name of the facility(ies): _____

i. Is professional liability insurance provided by the facility for your duties as Medical Director? Yes ☐ No ☐

If yes, please provide proof of coverage.

K. Have you participated in a clinical trial within the last ten years? Yes ☐ No ☐

If yes, please provide details in the space provided at the end of the application.

L. Are you employed full-time or part-time by the Federal, State, or Local Government? Yes ☐ No ☐

If yes, please provide the nature of such employment in the space provided at the end of the application.

M. Are you on active duty in the U.S. Military Service? Yes ☐ No ☐

N. Have you completed a fetal monitoring course or update within the previous 24 months? Yes ☐ No ☐

O. **Procedures**

i. This information is used for rating purposes; the procedures are not grouped by rating classification.

☐ Provide total number of annual deliveries performed in the past year: _____
☐ SpontaneousVaginal Deliveries; Number Per Year: _____
☐ Assisted Vaginal Deliveries; Number Per Year: _____
☐ C-Sections; Number Per Year: _____
☐ VBAC; Number Per Year: _____
☐ Unattended Deliveries; Number Per Year: _____
☐ Unattached Deliveries; Number Per Year: _____
☐ Prenatal Care
☐ Fertility Treatment
☐ Labor epidurals
☐ Hysterectomy
☐ Assist in surgery
  ☐ On Own Patients
  ☐ On Patients of Others
☐ Circumcision (infants only)
☐ Colposcopy
☐ Cryosurgery (other than external lesions)
☐ D&C
☐ Robotic Surgery
  ☐ Tubal Ligation
☐ Transgender Surgery
☐ Abortions; Number Per Year: _____
☐ Breast Biopsy
☐ Weight Control: _____% of Practice
Medications Prescribed (please list): _____

☐ Hysteroscopy
☐ Blepharoplasty
☐ Botox Injections
☐ Chemical Peels
☐ Chemabrasion
☐ Collagen Injections
☐ Cryosurgery (superficial only)
☐ Dermabrasion
☐ Silicone Injections
☐ Fat Transfer
☐ Hair Transplants

☐ Mammography
☐ Laser Hair Removal
☐ Laser Skin Resurfacing
☐ Laser Vein
☐ Lipodissolve/Mesotherapy
☐ Liposuction
☐ Microdermabrasion
☐ Sclerotherapy

☐ Other: _____

☐ Moderate (Conscious) Sedation ☐ Hospital ☐ Surgical Suite ☐ Office
☐ General ☐ Hospital ☐ Surgical Suite ☐ Office

If none of the above procedures apply to your practice, please initial here: _____

ii. Do you perform procedures that are outside the customary scope of practice within your specialty? Yes ☐ No ☐

If yes, please list procedures: _____

_____

iii. Do you perform any diagnostic or therapeutic procedures which have been introduced to the medical profession within the past two (2) years? Yes ☐ No ☐

If yes, please provide the name of the procedures in the space provided at the end of the application.

6. Hospital Affiliations and Privileges of the Group

A. Please list all hospitals where you have active privileges or a pending application.

1. Hospital Name: _____ Percentage of your patients admitted into this facility: _____%
   Location: _____ Privileges: Active ☐ Pending ☐
   Department: _____ Start Date: _____/_____ End Date: _____/_____
   MONTH YEAR MONTH YEAR

2. Hospital Name: _____ Percentage of your patients admitted into this facility: _____%
   Location: _____ Privileges: Active ☐ Pending ☐
   Department: _____ Start Date: _____/_____ End Date: _____/_____
   MONTH YEAR MONTH YEAR

3. Hospital Name: _____ Percentage of your patients admitted into this facility: _____%
   Location: _____ Privileges: Active ☐ Pending ☐
   Department: _____ Start Date: _____/_____ End Date: _____/_____
   MONTH YEAR MONTH YEAR

4. Hospital Name: _____ Percentage of your patients admitted into this facility: _____%
   Location: _____ Privileges: Active ☐ Pending ☐
   Department: _____ Start Date: _____/_____ End Date: _____/_____
   MONTH YEAR MONTH YEAR

B. Has any group or hospital suspended, restricted or refused your staff privileges, or have you ever voluntarily surrendered or limited your privileges? Yes ☐ No ☐
   If yes, please describe in the space provided at the end of the application.

C. Do you provide laborist services to any one of these hospitals? Yes ☐ No ☐
   If yes, what hospital(s)? 1 2 3 4

7. Information on Paramedical Employees

Any person licensed, certified, or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician is considered a Paramedical, including the following:*

- Certified Nurse Anesthetist (CRNA)
- Certified Nurse Practitioner (CNP)
- Physician Assistant (PA)
- Surgical Assistant (SA)
- Nurse Midwife

A. Do you supervise paramedical employees as defined above who are under your employ? Yes ☐ No ☐

B. Do you or any member of your group currently supervise paramedical employees as defined above who are not in your employ? Yes ☐ No ☐

***Any paramedical desiring coverage must submit a paramedical application. A separate charge may apply. Coverage may not be available in all states.**

8. Coverage Requested

A. Requested effective date: _____ / _____ / _____
   MONTH DAY YEAR

B. Please indicate your desired level of coverage.
   Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
   Excess Coverage Limits (where available): _____

C. Deductible amount (where available): $_____
   ☐ Indemnity Only ☐ Indemnity & Expense ☐ None

D. Do you desire coverage for a practice entity? Yes ☐ No ☐
   If yes, we require a corporate application to be completed.

E. Will you be carrying additional professional liability insurance with another company? Yes ☐ No ☐

9. Prior Acts Coverage

(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

A. Are you requesting Prior Acts Coverage? If no, please skip to Section 10. Yes ☐ No ☐

Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes ☐ No ☐

If yes, please describe the changes in your practice, including all applicable dates in the space provided at the end of the application.

10. Professional Insurance and Claims History

A. List current and former professional liability information. (Please provide a minimum ten year history.)

Name of Insurance Company (current): _____

Practice/Employer: _____ Location: _____

Policy Type: Claims-Made ☐ Occurrence ☐ Policy Limits: _____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____
MONTH DAY YEAR

Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

Name of Insurance Company: _____

Practice/Employer: _____ Location: _____

Policy Type: Claims-Made ☐ Occurrence ☐ Policy Limits: _____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____
MONTH DAY YEAR

Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

Name of Insurance Company: _____

Practice/Employer: _____ Location: _____

Policy Type: Claims-Made ☐ Occurrence ☐ Policy Limits: _____

Dates Covered: From: _____ To: _____ If Claims-Made, Retro Date: _____/_____/_____
MONTH DAY YEAR

Did you purchase/receive a reporting endorsement (tail coverage)? Yes ☐ No ☐

B. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? *(This question is not applicable in Missouri.)* Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

C. Have you *ever* been involved in a medical professional liability claim or suit? The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes ☐ No ☐

D. Other than the situations indicated in 10.C. above, are you aware of any of the following circumstances:

i. A request for records from a patient, family member, attorney, or patient representative related to an adverse outcome or treatment of a patient? Yes ☐ No ☐

ii. A letter from an attorney regarding your treatment of a patient? Yes ☐ No ☐

iii. A patient, family member, or patient representative's dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes ☐ No ☐

iv. Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? Yes ☐ No ☐

E. Have all circumstances in question 10.D. above been reported to your current or prior professional liability carrier? Yes ☐ No ☐ N/A* ☐

If yes, how many? _____ Please attach documentation of all such reports.

If no, please explain in space provided at the end of the application.

*For purposes of this question, N/A means that you answered "No" to each subpart of question 10.D.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Texas and Virginia Purchasing Group Intent to Join

The undersigned insured hereby consents to join the Ob-Gyn Risk Alliance Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

Risk Management Agreement Language

I agree that my office staff and I will comply with all Ob-Gyn Risk Alliance risk management programs administered by ProAssurance companies. Our compliance includescooperating with ProAssurance and its employees and independent contractors in all risk managementassessments and recommendations, participating in educational programming, and committing to work with the OB-Gyn Risk Alliance to improve patient care and thus reduce losses.

I agree to ensure that my staff will work to further such risk management collaboration and comply with all education and risk management improvement recommendations.

I understand that compliance with this statement is necessary for membership in the Ob-Gyn Risk Alliance Purchasing Group, and failure to comply may jeopardize further participation in the program.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Additional Comments

Please attach additional sheets as necessary.

Physicians's Supplementary Claims Information Sheet

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Name and Address of the Attorney Assigned to Your Case: _____
5. Date of Incident and Your Treatment: _____
6. Allegations: _____

   _____

   _____
7. What is the present condition of the patient? _____

   _____

   _____
8. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes ☐ No ☐
9. Status of claim (check applicable answer):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed, but dropped by claimant	☐ Jury verdict	☐ Awaiting court action
☐ Summary Judgment in your favor	☐ Directed verdict	Reserve Amount: _____
☐ Suit settled Out-of-Court	☐ Court outcome in favor of plaintiff	
Date claim paid: _____	☐ Jury verdict	
Amount paid: _____	☐ Directed verdict	
	Amount of Loss: _____	

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
    If yes, amount was: $_____

Name (Printed): _____

Signature: _____ Date: _____