Medical Professional Liability Insurance
Physician Renewal Application

Ob-Gyn Risk Alliance
Underwritten by ProAssurance

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

Date: _____ Policy #: _____ Expiration Date: _____

Important: Please review, complete, and return this renewal application with a copy of your updated curriculum vitae and a copy of your current business letterhead. Make any necessary changes to the pre-filled information below. Your prompt, accurate reply assists your policy's renewal. Thank you.

1. Personal Information

Name: _____ Degree: _____
FIRST MIDDLE LAST

Email Address: _____

Home Address: _____

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

Practice Specialty _____

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

List all current state medical association memberships: _____

2. Education, Training, and Certification

A. Are you board certified? Yes ☐ No ☐

i. If yes, please indicate which board and specialty/subspecialty:
American Board of _____

ii. If not board certified, 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)

3. Practice Location

Practice Office Street Address: _____

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

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Billing Address: _____

Contact Name: _____ Title: _____

Contact Email Address: _____

4. Practice Information

A. 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.

B. Please provide the name of any newly formed or dissolved solo or professional group practice entity (e.g., P.A., P.C., L.L.C., L.L.P., Inc., etc.) or DBAs related to your practice:
_____

C. Do you desire coverage for this new entity: Yes ☐ No ☐

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 this 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 this 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; procedures are not grouped by rating classification.

- ☐ Provide total number of 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	☐ Mammography
☐ Blepharoplasty	☐ Laser Hair Removal
☐ Botox Injections	☐ Laser Skin Resurfacing
☐ Chemical Peels	☐ Laser Vein
☐ Chemabrasion	☐ Lipodissolve/Mesotherapy
☐ Collagen Injections	☐ Liposuction
☐ Cryosurgery (superficial only)	☐ Microdermabrasion
☐ Dermabrasion	☐ Sclerotherapy
☐ Silicone Injections	
☐ Fat Transfer	☐ Other: _____
☐ Hair Transplants	

☐ Moderate (Conscious) Sedation ☐ Hospital ☐ Surgical Suite ☐ Office
☐ General Sedation ☐ 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 list the procedures in the space provided at the end of this application.

5. 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: _____/_____ (MONTH/YEAR) End Date: _____/_____ (MONTH/YEAR)

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

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

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

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

6. 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.**

7. Professional Insurance and Claims History

I have noted below and agree to notify the Company going forward of any of the following events within thirty (30) days of its occurrence: (Please note any circumstances below under Additional Comments.)

A. A change in my specialty or medical procedures performed;

B. A change in my practice location, my provision of services to out-of-state patients, or telemedicine services;

C. Complaint, grievance, investigation restriction, suspension, or surrender of any state medical license, DEA license, or hospital privileges;

D. Investigation of my Medicare/Medicaid billing procedures;

E. Any physical or mental condition or illness, including treatment for alcohol or substance abuse or any accusation of sexual misconduct or inappropriate contact not previously disclosed to the Company in writing;

F. Conviction, plea, or agreement related to any charges or a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses;

G. A claim or suit for alleged malpractice has been made against me and reported to **another insurance carrier or hospital self-insured trust,** or if any claim or suit resulted in payment by me or on my behalf, since I became an insured of a ProAssurance company.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

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 includes cooperating with ProAssurance and its employees and independent contractors in all risk management assessments 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.