

# INDIVIDUAL APPLICATION FOR PHYSICIANS' & SURGEONS' PROFESSIONAL LIABILITY INSURANCE

PLEASE TYPE OR PRINT RESPONSES AND ANSWER ALL QUESTIONS. COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETE.

I REQUEST MY INSURANCE COMMENCE NO EARLIER THAN 12:01 AM ON \_\_\_\_\_ (MO/DAY/YR)

NOTE: UMIA WILL NOT PROVIDE COVERAGE FOR ACTS PRIOR TO THE INCEPTION DATE OF THE POLICY UNLESS YOU COMPLETE THE ENCLOSED PRIOR ACTS APPLICATION AND COVERAGE IS APPROVED BY THE UNDERWRITING COMMITTEE.

HAVE YOU PREVIOUSLY APPLIED FOR COVERAGE WITH UMIA?  YES  NO

**I. NAME AND ADDRESS** **Policy Number** \_\_\_\_\_  
(For UMIA use only)

1. \_\_\_\_\_

First Name	Middle Name	Last Name	Title
Home Address			Home Telephone
Date of Birth	Place of Birth	Social Security No.	
Medical License No.	State	BNDD (DEA #)	Tax I.D. #

2. Please list all office locations for which you are requesting coverage. List principal location first.

Number	Street	Suite	City	State	Zip	Phone
Number	Street	Suite	City	State	Zip	Phone
Number	Street	Suite	City	State	Zip	Phone

3. Please list all hospital locations for which you are requesting coverage. List principal location first.

Name	Street	City	State	Zip	Phone
Name	Street	City	State	Zip	Phone
Name	Street	City	State	Zip	Phone

4. Mailing Address:  HOME  PRINCIPAL OFFICE  PRINCIPAL HOSPITAL

**II. INSURANCE COVERAGES**

**1. PROFESSIONAL LIABILITY COVERAGE**

Limits of Liability desired: (Limits indicated are Each Loss Limit and Aggregate Limit)

<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$500,000/\$1.5 Mil	<input type="checkbox"/> \$1 Mil/\$3 Mil	<input type="checkbox"/> \$2 Mil/\$4 Mil
<input type="checkbox"/> \$3 Mil/\$5 Mil	<input type="checkbox"/> \$4 Mil/\$6 Mil	<input type="checkbox"/> \$5 Mil/\$7 Mil	

**2. BILLING MODE DESIRED**

Annual  Semi-Annual  Quarterly  Monthly  
 (Only the monthly billing mode carries an interest charge)

**3. PROFESSIONAL PREMISES LIABILITY COVERAGE**--Office based physicians will be required to purchase Professional Premises Liability insurance. If purchased through UMIA, Limits of Liability are equal to the Professional Liability Limits selected up to \$1 million/\$3 million. In addition, property damage of \$50,000 each occurrence and premises medical payment of \$1,000 per person, \$25,000 each accident are included. UMIA does not underwrite coverage for office contents or personal property.

III. UNDERWRITING AND RATING INFORMATION

MEDICAL SPECIALTY \_\_\_\_\_ BOARD CERTIFIED  YES  NO
Date \_\_\_\_\_
SUBSPECIALTY \_\_\_\_\_ BOARD CERTIFIED  YES  NO
Date \_\_\_\_\_
NO SURGERY \_\_\_\_\_ MINOR SURGERY \_\_\_\_\_ MAJOR SURGERY \_\_\_\_\_

1. TYPE OF PRACTICE

Individual  Employee  Professional Corporation  HMO

Name and address of Corporation/HMO \_\_\_\_\_

Is corporation/clinic to be named as an Additional Named Insured?  YES  NO
(All members of the corporation must be insured with UMIA. Limits are shared.)

2. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME?  YES  NO

3. NUMBER OF HOURS PER WEEK INVOLVED IN DIRECT PATIENT CARE: \_\_\_\_\_
NUMBER OF HOURS PER WEEK INVOLVED IN RELATED ADMINISTRATIVE ACTIVITIES: \_\_\_\_\_
(Part time or limited exposure is restricted to non-surgical specialties.)

4. ANCILLARY PERSONNEL

I employ/supervise the following physician assistants or extenders:

a. \_\_\_\_\_
Name/Professional status
b. \_\_\_\_\_
Name/Professional status

I would like them named as an Additional Named Insured  YES  NO
Limits are shared. An application must be completed for any Additional Named Insured ancillary personnel. Please send a copy of any policy that provides coverage for ancillary personnel.

5. AS A PHYSICIAN, I PERFORM THE FOLLOWING PROCEDURES. PLEASE CHECK ALL THAT APPLY:

\_\_\_\_\_ Primary practice is office based.
\_\_\_\_\_ Primary practice is in an ambulatory care center.
\_\_\_\_\_ Primary practice is in a hospital emergency room.
\_\_\_\_\_ Major surgery--includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis; any other operation which because of the condition of the patient or the length of or circumstances of the operation presents a distinct hazard to life; assisting on other than your own patients and any procedure done under a general anesthetic.
\_\_\_\_\_ Major surgery of specialty.
\_\_\_\_\_ Major surgery on referred cases.
\_\_\_\_\_ Assist in major surgical procedures.
\_\_\_\_\_ Obstetrical procedures.
\_\_\_\_\_ Electro-shock therapy.
\_\_\_\_\_ Minor surgery. List Procedures: \_\_\_\_\_
\_\_\_\_\_ Cardiac catheterization.
\_\_\_\_\_ Plastic surgery-reconstructive \_\_\_\_\_ %
\_\_\_\_\_ Plastic surgery-cosmetic \_\_\_\_\_ %
\_\_\_\_\_ Percutaneous biopsy of diagnostic study of organs, tissue or structures.
\_\_\_\_\_ Surgical procedures in your office other than simple repair of lacerations or removal of warts or moles.
Please list: \_\_\_\_\_
\_\_\_\_\_ Therapeutic treatment with X-ray apparatus (other than Grenz Ray).
\_\_\_\_\_ Suction lipectomy.
\_\_\_\_\_ Angiography or arteriography.
\_\_\_\_\_ Myelography.
\_\_\_\_\_ Administer anesthesia.
\_\_\_\_\_ Tonsillectomies, adenoidectomies and simple hernias.
\_\_\_\_\_ Therapeutic D & C's.
\_\_\_\_\_ Orthopedic procedures. Please list if you are not an orthopedic surgeon (e.g., plating, pinning or "open" reduction of fractures): \_\_\_\_\_
\_\_\_\_\_ Endoscopic procedures. Please list: \_\_\_\_\_
\_\_\_\_\_ Other invasive procedures. Please list: \_\_\_\_\_
\_\_\_\_\_ OTHER \_\_\_\_\_

**6. EDUCATIONAL INFORMATION**

a. **MEDICAL SCHOOL:**  
 Name of School \_\_\_\_\_ Year Graduated \_\_\_\_\_

b. If you graduated from a foreign medical school, are you ECFMG certified?  YES  NO

c. **INTERNSHIP:**  
 Name of Hospital \_\_\_\_\_ Address \_\_\_\_\_  
 From \_\_\_\_\_ to \_\_\_\_\_

d. **RESIDENCY:**  
 Name of Hospital \_\_\_\_\_ Address \_\_\_\_\_  
 From \_\_\_\_\_ to \_\_\_\_\_ **Completed**  YES  NO

e. **ADDITIONAL MEDICAL TRAINING:**  
 Type \_\_\_\_\_ Date \_\_\_\_\_  
 Type \_\_\_\_\_ Date \_\_\_\_\_  
 Type \_\_\_\_\_ Date \_\_\_\_\_

f. Where have you practiced your profession since completion of your medical training?  
 City \_\_\_\_\_ State \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**7. Please answer the following questions. If any are answered "YES," attach complete details on a separate sheet.**

a. Are you a proprietor, superintendent, executive officer or administrative officer of any hospital, sanitarium, clinic with bed and board facilities, laboratory or business enterprise other than X-ray or pathological laboratory?  YES  NO

b. Have any of the following been investigated, denied, suspended, restricted in any way, or revoked?  
 1. State medical license  YES  NO  
 2. License to prescribe/dispense narcotics  YES  NO  
 3. Hospital privileges  YES  NO  
 4. Medical society membership  YES  NO

c. Have you ever:  
 1. Had any mental illness?  YES  NO  
 2. Had any chronic illness/physical defect?  YES  NO  
 3. Abused alcohol or drugs?  YES  NO  
 4. Been treated or had treatment recommended for abuse of alcohol/drugs?  YES  NO  
 5. Been convicted of any misdemeanor or felony other than minor traffic violation?  YES  NO

d. Are you in active military service?  YES  NO

e. Has any Professional Liability Insurer canceled, declined or modified coverage? (i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates or non-renewed similar insurance?)  YES  NO

f. Please indicate name and policy number of prior or current Professional Liability Insurer:

Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Policy Type:  Claims Made  Occurrence

**ENCLOSE A COPY OF YOUR CURRENT DECLARATION SHEET (FACE SHEET OF POLICY).**

1. Are you making application for Prior Acts coverage?  YES  NO  
 If "Yes," you will need to complete the enclosed "Prior Acts Coverage Application".

**NO COVERAGE FOR PRIOR ACTS WILL BE PROVIDED BY UMIA UNLESS APPROVED BY THE UNDERWRITING COMMITTEE. NO PRIOR ACTS COVERAGE IS AVAILABLE FOR MEDICINE PRACTICED OUTSIDE OF A STATE IN WHICH UMIA IS LICENSED TO WRITE BUSINESS.**

2. If Prior Acts coverage is NOT being requested, did you purchase the Reporting Form Endorsement "Tail" coverage from your current Professional Liability Insurer?  YES  NO

**8. CLAIM INFORMATION**

Please TYPE all claim information. Failure to provide complete information as requested will result in delays in processing your application for insurance. If an incident was reported by you but no claim was made or suit filed, it is not necessary to provide information. **ALL SUCH INFORMATION SUPPLIED WILL BE TREATED IN A CONFIDENTIAL MANNER.**

a. Have you been involved in a claim or suit in the past ten years?  YES  NO  
If "Yes," please provide a narrative description of the medical facts of each such claim or suit on a separate sheet. This narrative must include, but not be limited to, the following:

1. Age and sex of patient/claimant.
2. Date(s) and type(s) of treatment and/or surgery which led to the allegations against you.
3. Nature of allegations in claim or suit.
4. Specify whether a suit was ever filed.
5. Names of other doctors and hospital, if any, involved in claim or suit.
6. Disposition or current status of suit:

Open     Closed If closed, was payment made?  YES  NO

If payment was made from your policy, state amount: \$ \_\_\_\_\_

If additional defendant was involved, state amount: \$ \_\_\_\_\_

7. Name of Professional Liability Insurer defending you and policy number:

Name	Policy Number
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If suit occurred within the last five years, please document the above with complete copies of hospital and office records.

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT, AND I AUTHORIZE RELEASE AND EXCHANGE OF INFORMATION INVOLVING EITHER UNDERWRITING OR CLAIMS MATTERS BETWEEN ALL PRIOR PROFESSIONAL LIABILITY INSURERS AND THE UMIA. I FURTHER AUTHORIZE UMIA TO PROVIDE CERTIFICATES OF INSURANCE WHEN APPROPRIATE AND TO OBTAIN A COPY OF MY HOSPITAL PRIVILEGES IF NOT ENCLOSED, SECURE REPORTS DIRECT FROM HOSPITALS INVOLVING SITUATIONS WITH POTENTIAL LIABILITY, AND OBTAIN INFORMATION REGARDING DISCIPLINARY PROCEDURES BY HOSPITALS, COUNTY OR STATE MEDICAL ASSOCIATIONS OR SOCIETIES, SPECIALTY SOCIETIES AND LICENSING BOARDS.

Name/Signature	Date
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IN THE EVENT YOUR POLICY IS CANCELED, EITHER BY YOU OR UMIA, YOU WILL HAVE THE RIGHT TO PURCHASE THE EXTENDED REPORTING FORM ENDORSEMENT "TAIL" COVERAGE. THIS ENDORSEMENT EXTENDS THE PERIOD FOR REPORTING OF CLAIMS ARISING FROM MEDICAL INCIDENTS WHICH OCCUR SUBSEQUENT TO YOUR POLICY'S RETROACTIVE DATE, AND PRIOR TO ITS CANCELLATION DATE. YOU MUST EXERCISE THIS RIGHT WITHIN SIXTY DAYS FOLLOWING CANCELLATION, BY FULL PAYMENT OF THE PREMIUM.