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Individual Application for Physicians' and 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 a.m. on ______________________ (mo/day/yr)

Required Documents
In addition to this application, the following information is required:

1. **Loss runs, dated within 60 days of submission, covering the past ten years**
2. **Declarations page from current insurance carrier including retroactive date if claims-made coverage**
3. **Reporting endorsement from current insurance carrier if recently purchased**
4. **Corporate Healthcare Professional Liability Application if corporate coverage is desired**

NOTE: UMIA WILL NOT PROVIDE COVERAGE FOR ACTS PRIOR TO THE INCEPTION DATE OF THE POLICY UNLESS PRIOR ACTS COVERAGE IS APPROVED BY UMIA.

HAVE YOU PREVIOUSLY APPLIED FOR COVERAGE WITH UMIA? ☐ Yes ☐ No

I. NAME AND ADDRESS

Policy Number ______________________
(For UMIA use only)

First Name | Middle Name | Last Name | Title

Email Address

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
Number	Street	Suite	City	State	Zip	Phone

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

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

4. Mailing Address: ☐ HOME ☐ PRINCIPAL OFFICE ☐ PRINCIPAL HOSPITAL

Billing Address: ☐ HOME ☐ PRINCIPAL OFFICE ☐ PRINCIPAL HOSPITAL

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II. INSURANCE COVERAGES

1. PROFESSIONAL LIABILITY COVERAGE

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

☐ $1 Mil/$3 Mil ☐ $1.5 Mil/$4.5 Mil ☐ $2 Mil/$4 Mil

☐ $3 Mil/$5 Mil ☐ $4 Mil/$6 Mil ☐ $5 Mil/$7 Mil

2. BILLING MODE DESIRED

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

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.

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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 ECFMG #: ____________

c. INTERNSHIP:

____

Name of Hospital Address

From____________ to ____________

d. RESIDENCY:

____

Name of Hospital Address

From____________ to ____________ Completed ☐ Yes ☐ No

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e. ADDITIONAL MEDICAL TRAINING:

Type Location Date

Type Location Date

Type Location 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? ☐ Yes ☐ No
(i.e., reduced limits, assigned a deductible, restricted coverage, surcharged rates or non-renewed similar insurance?)

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".

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

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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

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 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

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.

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