

C. TRAINING INFORMATION

1. **Nursing Training Program:**
Name _____ Location _____ From/To _____ Completed Y/N _____ Degree _____
Program Attended: _____
2. **Nurse- Midwifery Training Program:**
Name _____ Location _____ From/To _____ Completed Y/N _____ Degree _____
Program Attended: _____
3. Are you certified in Pennsylvania to practice nurse-midwifery? Yes No
4. Are you certified by the American College of Nurse-Midwives?
(If No, please explain in Remarks on page) Yes No
5. Do you perform ANY cosmetic procedures including, but not limited to, laser treatments, injections, weight loss/fat reduction treatments, etc.? (if yes, explain in remarks) Yes No

D. COVERAGE INFORMATION

1. Requested Effective Date: _____
2. Requested Policy Limits: \$500,000/1,500,000
3. Do you want a Claims-Made policy, or an Occurrence policy?
4. **Prior Acts**
a. Is this to replace an existing Claims-made policy? Yes No
b. Do you wish prior acts coverage (nose) beginning on the initial issue date of your Claims-Made Policy? Yes No
- Retroactive Date: _____
Prior Acts coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase Tail coverage from your present carrier. Please complete the attached Prior Acts warranty statement.
- c. If you are not requesting Prior Acts coverage, did you secure Tail coverage from your current carrier? Yes No
5. **Current or immediate past carrier:** _____ **Policy expiration date:** _____
(Please attach a copy of your most recent declarations page.)
7. **Have you ever had professional liability insurance refused, declined, cancelled or accepted on special terms?**
(If yes, explain in Remarks). Yes No
6. **List all previous insurance carriers for the past ten (10) years:**
- A. Insurance Carrier _____ Policy # _____ Medical Specialty _____
Type (CM/OCC) _____ From _____ To _____
- B. Insurance Carrier _____ Policy # _____ Medical Specialty _____
Type (CM/OCC) _____ From _____ To _____
- C. Insurance Carrier _____ Policy # _____ Medical Specialty _____
Type (CM/OCC) _____ From _____ To _____
- D. Insurance Carrier _____ Policy # _____ Medical Specialty _____
Type (CM/OCC) _____ From _____ To _____

E. MEDICAL CONDUCT INFORMATION

1. Governmental Action

- a. Has any governmental agency ever investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice? (If YES, explain in Remarks) Yes No
- b. Have you ever been convicted of a crime? (If YES, explain in Remarks) Yes No

2. Have you been involved in, or are you presently involved in a diversion or rehabilitation program?

(If YES, explain in Remarks) Yes No

3. Health

Do you have any health problems, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? (If Yes, explain in Remarks) Yes No

4. Claims or Suits

Have you ever been named as a defendant in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten (10) years, or are you presently involved in malpractice litigation? (If YES, submit a separate form for each case in the last ten (10) years, see page) Yes No

5. Loss Free Discount

You may qualify for an optional Loss Free Discount if you represent and warrant to Pennsylvania PRI that no professional liability claims/ incidents have had a **payment** to a claimant made by you or on your behalf within five (5) years prior to your policy's anticipated effective date by signing below. This discount depends on the date of payment and not the date of the claim/incident, or the date the incident/claim was reported.

Representation of No Paid Losses: By signing in the space below, I represent and warrant that, after conducting a good faith investigation into the facts attested to herein, no medical professional liability claims/incidents stemming from my medical practice have been paid by me or on my behalf to a claimant in the last:

- (___) 5-9 years
- (___) 10+ years
- (___) I do not qualify for the Loss Free Discount

I understand the above information is material to Pennsylvania PRI's decision to provide me with a Loss Free Discount, and that a misrepresentation by me constitutes a criminal fraudulent insurance act that may subject me to criminal and civil penalties.

Full Name: _____

Signature: _____

Date: _____

Pennsylvania PRI may also, in its sole discretion and at its cost, require you to provide a "Response to Self-Query" from the National Practitioner Data Bank (NPDB) dated within the past six (6) months to qualify for the optional Loss Free Discount. You can access this information via their website at <http://www.npdb-hipdb.com/>. If you currently have a Loss Free Discount it will be renewed automatically. **The NPDB "Response to Self-Query" must be received by Pennsylvania PRI within 30 days of the date requested or the Loss Free Discount will be removed and you will be invoiced the additional premium.**

F. PRACTICE AND PROCEDURES: GENERAL QUESTIONS

- 1. a) What is your patient load per week? _____
- b) How many hours per week are you on call? _____

- 2. a) Is your practice OB/GYN GYN only
- b) Describe your practice: _____
- c) Does your employment/practice require that you ever be in an operating room? Yes No
- If Yes, do you: Observe Assist Second Assist Other
- If Other, please describe: _____

- 3. a) Are you associated with a: Hospital Birthing Center Other
- If Other, please explain: _____
- b) Name and address: _____
- c) Birthing Center license number: _____
- d) Are you an employee? Yes No
- If No, please explain the nature of your privileges: _____

- 4. a) If your practice is OB/GYN, how many deliveries do you perform per year?

- b) What percentage of your deliveries are routinely done in each of the following locations? (Must total 100%)
___% Hospital ___% Birthing Center ___% Home ___% Other
- If Other, please describe: _____
- c) Which method of natural childbirth do you practice? _____
- d) Do you participate in the performance of Cesarean sections as part of your practice?
 Yes No
- If Yes, specify in what capacity: _____

- 5. Of your total practice, what percentage of time is spent for the following: (Must total 100%.)
___% Antepartum Care ___% Well Women Gynecology ___% Administrative
___% Intrapartum Care ___% Postpartum Care ___% Family Planning
___% Other, specify: _____

I do hereby represent that any statements and answers mentioned herein are true, and that I have not misrepresented or withheld any information, which is calculated to influence the judgment of the Company in considering this application for professional liability insurance.

The application duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature form does not bind the applicant or the Company to issue coverage.

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 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.

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

Since I understand that 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 agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

SIGNATURE: _____

Date: _____

Pennsylvania Physicians' Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11567

Producer Affirmation: by my signature, I hereby represent that the applicant has granted me full authority to complete and/or submit this application on their behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that the applicant understands and agrees that such representation is binding upon him or her, even though I am completing and/or submitting the application on their behalf. I further acknowledge that any material misrepresentation or omission made on this application may result in the termination of my broker agreement.

PRODUCER SIGNATURE: _____

Date: _____

CONSENT OPTION

The Company will provide a **5% premium reduction** for policyholders who opt to forego the customary consent to settle any claim. Please indicate by checking the appropriate box below, the option that you wish.

"NO CONSENT" OPTION

I hereby authorize the Company to act on my behalf to settle any claims reported without first obtaining my written consent.

"CONSENT" OPTION

I wish to maintain the terms of the policy, which, under Part 4, currently requires the Company to obtain my written consent prior to settling any claim on my behalf.

Signed: _____ Date _____

Please make additional copies of this page as necessary. If you have had claims or suits filed against you, please complete this form for each claim or suit in the past ten (10) years. Provide information on all claims that have also been resolved (closed, tried or settled) within the past ten (10) years. Also include all "incidents".

CLAIM INFORMATION

- 1. Name of Patient _____ 2. Age _____ 3. Sex _____
- 4. Your relationship to patient: _____
- 5. Allegation _____
- 6. Date of incident _____ 7. Report date _____
- 8. Insurance carrier _____
- 9. Other defendants _____
- 10. Present Status: Open claim Closed claim Date closed _____ Settlement or Judgment Amount _____
- 11. Location of incident _____
- 12. Condition and diagnosis at time of incident _____

- 13. Dates and description of treatment rendered _____

- 14. Condition of patient subsequent to treatment and dates of follow-up treatment _____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: _____ Date Signed: _____

CLAIM INFORMATION

- 1. Name of Patient _____ 2. Age _____ 3. Sex _____
- 4. Your relationship to patient: _____
- 5. Allegation _____
- 6. Date of incident _____ 7. Report date _____
- 8. Insurance carrier _____
- 9. Other defendants _____
- 10. Present Status: Open Claim Closed Claim Date closed _____ Settlement or Judgment Amount _____
- 11. Location of incident _____
- 12. Condition and diagnosis at time of incident _____

- 13. Dates and description of treatment rendered _____

- 14. Condition of patient subsequent to treatment and dates of follow-up treatment _____

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: _____ Date Signed: _____

**Pennsylvania Physicians' Reciprocal Insurers
Radnor, Pennsylvania**

COSMETIC PROCEDURE QUESTIONNAIRE

(Addendum to Application for Physicians)

Pursuant to recent advances in Medicine, please complete this form in its entirety and return to our office. Please check off the appropriate statement and follow the instructions. You must select one of the two statements below.

- I perform **NO** cosmetic procedures (including but not limited to lasers, injections, fillers, microderm abrasions and/or any elective cosmetic surgery). If you checked this statement, please skip questions #1-5 below, then sign and date.
- I have been or anticipate performing cosmetic procedures since/on _____.
If you checked this statement, complete questions #1-5 below, then sign and date. **It is required that you submit a copy of your Curriculum Vitae & patient consent form along with this questionnaire.**

1. What cosmetic procedures will you be performing? (please list all that apply, including but not limited to lasers, injections, fillers, micro dermabrasions and/or any other elective cosmetic surgery)

2. What training have you completed to justify performing these procedures? (please list all residencies and/or fellowships applicable & dates of completion)

3. What type of medical equipment will be utilized during these procedures? (list all that apply)

4. Approximately how many patients do you see throughout your weekly **regular** patient load?

5. Approximately how many patients per week do you see for **cosmetic** procedures?

I understand that completing/completion of this questionnaire does not guarantee this request will be granted, as an underwriting decision must be made.

Physician Signature

Date

In the event that an Insured chooses to purchase Prior Acts Coverage then the following warranty statement must be completed, dated and signed by the Insured before any such Prior Acts Coverage can become effective. The signing of this statement alone does not guarantee that Pennsylvania Physicians' Reciprocal Insurers will be bound to offer the Prior Acts Coverage to the Insured.

Prior Acts Coverage - Warranty Statement

In consideration of the premiums charged under the above policy, the undersigned warrants that as of *(effective date)* _____ all known claims or suits or medical incidents which occurred during the retroactive period *(retro date)* _____ to *(effective date)* _____ have been reported to our previous insurance carrier, *(insurance carrier)* _____.

It is also warranted that any and all acts, medical incidents and/or circumstances, of which any director, shareholder, officer, or employee of *(insured name)* _____ is aware, and which might reasonably be expected to result in a claim under the proposed coverage afforded by this policy, were disclosed to *(broker)* _____ prior to binding of such coverage *(effective date)* _____ are listed below:

These warranties are material to the acceptance of coverage by the Insurer, and the warranties are made a part of the insurance policy. This policy would not be offered or placed in the absence of such warranties.

Further, *(insured name)* _____ acknowledges and agrees that any claims resulting from medical incidents committed prior to the binding of coverage, and of which *(insured name)* _____ is aware, are specifically excluded from coverage under this policy. *(Insured name)* _____ acknowledges and agrees that such excluded claims would not have coverage under the policy of any other carrier, unless properly reported to such insurance carrier under the terms and conditions of such policy.

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 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.

ACKNOWLEDGED AND AGREED:

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

APPENDIX A

SUBSCRIBERS AGREEMENT

The undersigned subscriber to Pennsylvania Physicians' Reciprocal Insurers (the "Exchange"), a Pennsylvania reciprocal insurance exchange, agrees together with all other subscribers to the Exchange, and with Physicians Reciprocal Managers, Inc. (the "Company"), a Pennsylvania corporation, as the Attorney-in-Fact for the Exchange, as follows:

1. The undersigned agrees to pay its policy premiums and to exchange with the other subscribers to the Exchange policies providing insurance for any insured loss as stated in those insurance policies at the offices of the Company in Harrisburg, Pennsylvania.

2. The undersigned appoints the Company as Attorney-in-Fact with the power to (a) exchange insurance policies with other subscribers to the Exchange, (b) take any action necessary for the exchange of such insurance policies, (c) issue, change, non-renew or cancel insurance policies, (d) obtain reinsurance, (e) collect premiums, (f) invest and reinvest funds, (g) receive notices and proofs of loss, (h) appear for, compromise, prosecute, defend, adjust and settle losses and claims under the insurance policies of subscriber, (i) accept service of process on behalf of the Exchange as insurer and (j) conduct the business and affairs of the Exchange as set forth herein, in the Declaration of Organization and the Attorney-in-Fact Agreement between the Exchange and the Company. This power of attorney is limited to the purposes described in this Subscribers Agreement.

3. The undersigned agrees that the compensation to the Company for the Company (a) becoming and serving as Attorney-in-Fact for the subscribers to the Exchange, (b) managing the business and affairs of the Exchange as provided herein and (c) paying the general administrative expenses of serving as Attorney-in-Fact for the Exchange, including sales commissions, salaries and employee benefits, taxes other than premium taxes, rent, depreciation, supplies, and data processing, shall not exceed 21% of all premiums written or assumed by the Exchange. The remainder of all premiums written or assumed by the Exchange shall be used for losses, loss adjustment expenses, investment expense, damages, legal expenses, court costs, premiums taxes, assessments, licenses, fees, any other governmental fees and charges, establishment of reserves and surplus and reinsurance, and may be used for dividends and other purposes the Company decides are to the advantage of the subscribers to the Exchange.

4. The undersigned agrees that this Subscribers Agreement, including the power of attorney set forth herein, shall apply to all insurance policies for which the undersigned applies at the Exchange, including changes in any of the undersigned's coverages.

5. The undersigned agrees to sign and deliver to the Company all papers required to carry out this subscribers agreement.

6. This Subscribers Agreement, including the power of attorney set forth herein, shall not be affected by your subsequent disability or incapacity.

7. The subscribers Agreement and the Declaration of Organization of the Exchange are and shall be binding upon the Company and the undersigned and all of their respective executors, administrators, personal representatives, successors, and assigns.

IN WITNESS WHEREOF, the undersigned subscriber hereto sets his hand and seal.

Signature of Subscriber

Date

Name of the Subscriber (please print)