



RENEWAL APPLICATION

FOR PHYSICIANS
AND SURGEONS

PENNSYLVANIA PHYSICIANS' RECIPROCAL INSURERS
RADNOR, PENNSYLVANIA

**APPLICATION FOR PHYSICIANS AND SURGEONS
PROFESSIONAL LIABILITY INSURANCE**

Insurance Coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the Named Insured.

Help us expedite the processing of your application:

- Please print your responses in ink or type.
- Answer every question or mark it “not applicable” (N/A).
- Use the “Remarks” section to amplify your answers where requested.
- Incomplete answers and/or missing attachments **will** delay our processing of the application.

Please fully complete this application and return it to your broker or to us at:

**Pennsylvania Physicians’ Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11576**

For assistance please call our office at (888) 771-4762 or (516) 869-1200

NOTICE

This information pertains to policies written on a claims-made basis

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

A claims-made policy covers claims actually made against the insured and incidents reported while the policy remains in effect. All coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases extended reporting period coverage.

The rates for extended reporting period coverage will be determined in accordance with the rates in effect at the beginning of the current policy period.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims made or incidents reported after such period of sixty (60) days. The extended reporting coverage provides coverage for claims which are reported during the policy period and which are reported for an unlimited time period after the termination of the policy.

During the first few years of coverage under a claims-made policy, the annual rate is comparatively lower than occurrence rates. However, such annual rate increases significantly, independent of overall rate level increases, until the claims-made rate reaches maturity.

**RENEWAL
APPLICATION FOR PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

Please answer every question or mark it "not applicable" (N/A). Incomplete answers and/or missing attachments **will** delay our processing of your renewal policy.

Producer: _____

A. GENERAL INFORMATION (Please type or print clearly in ink)

1. Name: _____ () MD DO (Check One)
 First Middle Last Maiden
2. Date of Birth: _____ 3. Male Female
4. Social Security Number: _____ 5. License Number: _____
6. Home Address: _____ () _____
 Number Street Telephone
 City County State Zip Fax
7. Policy Number: _____

B. PRACTICE INFORMATION

Please include any out of state locations.

1. List all locations, other than hospitals and surgicenters, at which you currently render professional services. Include all office locations, nursing homes, urgent care clinics and other non-hospital locations. Attach additional pages if needed. **FAILURE TO LIST A LOCATION MAY RESULT IN IT BEING EXCLUDED FROM COVERAGE UNDER THIS POLICY.**

a. Location #1 - Primary Address for which coverage is desired:

_____ () _____
 Number Street Telephone
_____ () _____
City County State Zip Fax

Number of hours per week you are at this location: _____
Is this location a: Private Office Nursing Home Clinic Other (describe)

b. Location # 2 - Additional Address:

_____ () _____
 Number Street Telephone
_____ () _____
City County State Zip Fax

Number of hours per week you are at this location: _____ Coverage desired? Yes No
Is this location a: Private Office Nursing Home Clinic Other (describe)

2. Privileges – List all hospitals and surgicenters at which you currently have privileges or to which you are applying for privileges. Attach additional pages if needed. **FAILURE TO LIST A LOCATION MAY RESULT IN IT BEING EXCLUDED FROM COVERAGE UNDER THIS POLICY.**

a. Facility No. 1:

_____ () _____
 Number Street Telephone
_____ () _____
City County State Zip Fax

Number of hours per week you are at this location: _____ Coverage desired? Yes No
Is this location a: Surgicenter Hospital Other (describe)
Privileges: Active Type and Extent _____
 Pending Restrictions _____

b. Facility No. 2:

_____		() _____
Number	Street	Telephone
_____		() _____
City	County	State
_____		Zip
Number of hours per week you are at this location: _____		Coverage desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is this location a: <input type="checkbox"/> Surgicenter <input type="checkbox"/> Hospital <input type="checkbox"/> Other (describe) _____		
Privileges: <input type="checkbox"/> Active Type and Extent _____		
<input type="checkbox"/> Pending Restrictions _____		

c. Facility No. 3:

_____		() _____
Number	Street	Telephone
_____		() _____
City	County	State
_____		Zip
Number of hours per week you are at this location: _____		Coverage desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is this location a: <input type="checkbox"/> Surgicenter <input type="checkbox"/> Hospital <input type="checkbox"/> Other (describe) _____		
Privileges: <input type="checkbox"/> Active Type and Extent _____		
<input type="checkbox"/> Pending Restrictions _____		

Do you want Certificates of Insurance provided to these locations? Yes No

All Locations/Facilities listed, or Location 1 Location 2 Facility #1 Facility #2 Facility #3

3. If you do not have admitting privileges, please describe in detail your mechanism for handling your patients who may require immediate in-patient care.

4. Mailing Address: Home Primary Office Other (list below):

C. SPECIALTY INFORMATION

- 1. Specialty:**
 - a. Medical Specialty Currently Practiced: _____ Board Certified? Yes No
Sub-Specialty: _____ Board Certified? Yes No
 - b. Name(s) of any professional medical association(s) to which you belong: _____
- 2. Do you serve as a medical director or department head of a hospital, nursing home, hospice or other institution?** Yes No
If yes, please list location and position held: _____
Coverage desired under this policy? Yes No
- 3. Do you teach, supervise or proctor medical students, residents or fellows?** Yes No
If yes, please list location and position held: _____

D. PRIOR COVERAGE INFORMATION

1. Have you ever had professional liability insurance refused, declined, cancelled or accepted on special terms? (If yes, explain in Remarks, see page 5). Yes No

2. 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. PRACTICE INFORMATION

REMINDER: Answers to the questions in this section should reflect your **current** practice as of the date you are completing the application.

1. Practice Situation

a. Indicate all practice situations that apply to you:

- "Solo" Physician
- "Solo" Medical Corporation
- Medical Corporation with more than one shareholder
- Medical Partnership
- Independent Contractor/Contractee
- Use of Assumed name (DBA)
- Employed by another physician
- Employ another physician
- Other: _____

If you check any boxes above other than "Solo" Physician or "Solo" Medical Corporation, list below the name of the applicable entity (ies) and/or any physician(s).

Name of Entity	Name of Physician Employer or Shareholders	Professional Liability Insurance Carrier
_____	_____	_____
_____	_____	_____
_____	_____	_____

- b. Do you wish coverage for any of the above entities?** Yes No
 If yes, please complete a Professional Corporation/Partnership Application
- c. Do you advertise in/on magazines, journals, radio, television, etc?** Yes No
 If yes, please supply a copy of advertisement.
- d. Do you advertise on the internet?** Yes No
 If yes, please list all website addresses _____
- e. Do you treat prison inmates?** Yes No
- f. 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

2. Have there been any of the following changes in your practice since your last application with this company? (If yes, explain in Remarks, see page 7).

	Yes	No
a) Medical specialty or subspecialty	<input type="checkbox"/>	<input type="checkbox"/>
b) Board certification status	<input type="checkbox"/>	<input type="checkbox"/>
c) Weekly patient load	<input type="checkbox"/>	<input type="checkbox"/>
d) Number of hours worked per week	<input type="checkbox"/>	<input type="checkbox"/>
e) Surgical or non-surgical procedures	<input type="checkbox"/>	<input type="checkbox"/>
f) Surgery being performed in your office or other non-hospital location	<input type="checkbox"/>	<input type="checkbox"/>
g) Provision of professional services under any corporate or fictitious name	<input type="checkbox"/>	<input type="checkbox"/>
h) License Status	<input type="checkbox"/>	<input type="checkbox"/>

F. MEDICAL CONDUCT INFORMATION

1. Governmental Action

- a. Since your last application, 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. Since your last application, have you been convicted of a crime? (If YES, explain in Remarks) Yes No

2. Hospital Privileges

Has your privileges at any hospital or other institution been reduced, revoked, restricted, or suspended since your last application with this company? (If Yes, explain in Remarks) Yes No

3. Health

Have you had any health problems, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty since your last application with this company? (If Yes, explain in Remarks) Yes No

4. Claims or Suits

Have you been named as a defendant in a malpractice claim or suit since your last application with this company? (If YES, submit a separate form for each case, see page 7) 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 automatically renewed Loss Free Discount will be removed and you will be invoiced the additional premium.**

G. PRACTICE AND PROCEDURES: GENERAL QUESTIONS

1. Please check the category that most closely describes your current practice.

- Major Surgery:** Performing any operative procedure done under general, spinal or caudal anesthesia or assisting in “Major Surgery” on other than your own patients.
- Minor Surgery*:** Performing any operative procedure other than as included in “Major Surgery” or assisting in “Major Surgery” on your own patients
- No Surgery*:** NOT performing any operative procedure including “Major Surgery” or “Minor Surgery”.
 *Note: Incising of boils and superficial fascia, suturing of minor lacerations and removal of superficial skin lesions are not considered operative procedures for the purpose of this application.

2. Indicate percentage of time devoted to the following activities commonly associated with the following surgical specialties:

Percentage	Specialty	Percentage	Specialty	Percentage	Specialty
_____ %	Abdominal	_____ %	Gynecology	_____ %	Otorhinolaryngology
_____ %	Bariatric	_____ %	Hand	_____ %	Plastic
_____ %	Cardiac	_____ %	Head & Neck	_____ %	Thoracic
_____ %	Cardiovascular	_____ %	Laryngology	_____ %	Traumatic
_____ %	Colon&Rectal	_____ %	Neoplastic	_____ %	Urological
_____ %	Gastroenterology	_____ %	Otology	_____ %	Vascular
				_____ %	Other _____

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 judgement 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 11576**

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.

SIGNATURE: _____

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 (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
- 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 (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
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- 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: _____