INSPIRIEN INSURANCE COMPANY
P.O. Box 211359
Montgomery, AL 36121-1359

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS (CLAIMS MADE)

PLEASE TYPE OR PRINT LEGIBLY

Personal Information

Proposed Coverage Effective Date:_____ **Requested Retro Date:**_____

1. Full Name of Applicant (include Professional Degree)_____
2. Applicant's Date and Place of Birth_____
3. Home Address (Street, City, State and Zip Code)_____
4. Principle Business Address (Street, City, State and Zip Code)_____
5. County_____ 6. E-mail_____
7. Principle Correspondence Address_____
8. Social Security No._____ 9. Business Phone_____ 10. Home Phone_____
11. a. Cell Phone_____ b. Fax_____ c. Web Address_____
12. Your specialty or type of practice for which you are applying for coverage_____
13. Have you ever: **(explain any yes answers on a separate sheet of paper)**

		YES	NO
a.	Been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	☐	☐
b.	Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses?	☐	☐
c.	Had any state professional license or license to prescribe or dispense narcotic refused, suspended, revoked, renewal refused, restricted or accepted only on special terms?	☐	☐
d.	Had any insurance company or Lloyd's cancel, notify you of intent to cancel, decline, deny, surcharge, refuse to renew, accept on special term or accept professional liability insurance on a consent-to-rate basis?	☐	☐
e.	Failed any medical licensing or specialty organization examination or not eligible for Boards?	☐	☐
f.	Been named in a claim or suit for professional malpractice of the type that would be addressed by this policy? If Yes, please complete a **Supplemental Claim Information Form** (attached hereto) for each claim.	☐	☐
g.	Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including, but not limited to depression and/or chronic fatigue?	☐	☐
h.	Had or do you presently have any chronic or life-threatening physical illness or defects?	☐	☐
i.	Had any judgment made against you or any out-of-court settlements made on your behalf?	☐	☐

14.

a.	Are you aware of any acts, errors, omissions, or circumstances which may result in a malpractice claim or suit being brought against you, your partners, or members of your P.A. or P.C.?	☐	☐

PRACTICES AND PROCEDURES

15. Check the procedures performed by you:

- ☐ Abortion, elective
- ☐ Acupuncture
- ☐ Amniocentesis
- ☐ Anesthesia
  - ☐ Caudal
  - ☐ Consious sedation
  - ☐ General
  - ☐ Local
  - ☐ Regional nerve block
  - ☐ Spinal
  - ☐ Other _____
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On own patients
  - ☐ On patients of others
- ☐ Bariatric Surgical procedures
  - ☐ Gastric banding
  - ☐ Gastric bubble
  - ☐ Gastric bypass
  - ☐ Gastric stapling
- ☐ Blepharoplasty
  - ☐ Cosmetic
  - ☐ Reconstructive
- ☐ Breast Biopsy
- ☐ Breast Implants
- ☐ Breast Reduction
- ☐ Cardiac surgery
- ☐ Cataract surgery
- ☐ Caesarean sections
- ☐ Chelation therapy
- ☐ Chemonucleolysis
- ☐ Chemotherapy
- ☐ Cholecystectomy
- ☐ Circumcision
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Cryosurgery, other than external lesions
- ☐ Catheterizations
  - ☐ Arterial
  - ☐ Cardiac
  - ☐ Swan-Ganz
  - ☐ Ureteral
  - ☐ Umbilical
- ☐ Dermatological or Aesthetic Procedures _____%
  - ☐ Botox injection
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen injection/Derma fillers
  - ☐ Dermabrasion
  - ☐ Fat transfer
  - ☐ Hair transplant
  - ☐ Laser hair removal
  - ☐ Laser skin resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone injection
  - ☐ Spa
  - ☐ Other _____
- ☐ D & C
- ☐ Dermatopathology
- ☐ Dialysis procedures
- ☐ Discography
- ☐ Echocardiography
- ☐ Endoscopic laser therapy
- ☐ Endoscopy
  - ☐ Cystoscopy
  - ☐ Bronchoscopy
  - ☐ EGD
  - ☐ Gastroscopy
  - ☐ Hysteroscopy
  - ☐ Proctoscopy
  - ☐ Sigmoidoscopy
  - ☐ Other _____
- ☐ Experimental procedures or research or drug testing. (Including a copy or form used to obtain informed consent) Are procedures FDA approved?_____
- ☐ ERCP/ERC
- ☐ Exchange transfusion
- ☐ Facial plastic surgery
  - ☐ Elective cosmetic
  - ☐ Reconstructive
- ☐ Fluoroscopy
- ☐ Fracture Reduction
  - ☐ Closed
  - ☐ Open
- ☐ Hand surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailing
- ☐ Hyperbaric medicine
- ☐ Hysterectomy
- ☐ Injection of radioisotopes
- ☐ Intensive care for newborns
- ☐ Intensive care medicine for adults
- ☐ Infertility treatment
  - ☐ Medical
  - ☐ In vitro fertilization
  - ☐ Other surgical
- ☐ Laminectomy
- ☐ Laparoscopy: Certified? _____
- ☐ Laser surgery: Type_____
- ☐ LASIK
- ☐ Left heart catheterization
- ☐ Liposuction
  - ☐ Tumescent
  - ☐ Other
- ☐ Lithotripsy
- ☐ Mammography
- ☐ Medical Weight Loss Management _____%
- ☐ Mesotherapy
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Normal deliveries
- ☐ Organ transplantation
- ☐ Orthopedic surgery
  - ☐ Including spinal surgery
  - ☐ Without spinal surgery
- ☐ Osteopathic manipulative medicine
- ☐ Pain management
  - ☐ Cordotomy
  - ☐ Dorsal root gangliotomy
  - ☐ Facet blocks
  - ☐ Medication only
  - ☐ Nerve root blocks
  - ☐ Pump implantation and removal
  - ☐ Rhizotomy
  - ☐ Sphenopalatine lesioning
  - ☐ Spinal injections
  - ☐ Thoracic sympathectomy
  - ☐ Trigeminal lesioning
  - ☐ Other _____
- ☐ Paracentesis
- ☐ Percutaneous vertebroplasty
- ☐ Peripheral nerve surgery
- ☐ Pacemaker placement
- ☐ Polypectomy
- ☐ Prenatal care – 1st Trimester
- ☐ Prenatal care – 2nd Trimester
- ☐ Prenatal care – 3rd Trimester
- ☐ Prolotherapy
- ☐ Provertin retinal therapy
- ☐ Radiation therapy
- ☐ Radiopaque dye injection
- ☐ Roux-en-Y
- ☐ Sclerotherapy
- ☐ Shock herapy
- ☐ Spinal fusion
- ☐ Spinal surgery, other
- ☐ Thoracic surgery _____%
- ☐ Thorancentesis
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery/hormonal gender conversion
- ☐ Tubal ligation
- ☐ Vascular surgery _____%
- ☐ Vasectomy
- ☐ X-Ray Procedures
  - ☐ Noninvasive
  - ☐ Invasive
- ☐ **None of the above apply to my practice (Initial)**_____
- ☐ **Other procedures not listed above (Please list)**

_____
_____
_____
_____
_____

52. a. Do you desire coverage for professional premises liability? ☐ Yes ☐ No

b. If yes, list the square footage of your office referenced in question #4 _____

c. If yes, what limit of liability do you request?

☐ $300,000 Bodily Injury / $50,000 Property Damage ☐ $500,000 Bodily Injury / $50,000 Property Damage

53. a. Do you wish to have your professional employees endorsed on this policy? ☐ Yes ☐ No

b. If yes, complete the following:

Name	Professional Classification	Date of Employment

54. What is the name and version of your EHR (Electronic Healthcare Records) software? _____

(Please provide a current copy of your EHR contract. You may mark out the cost.)

APPLICATION MUST BE SIGNED AND DATED ON PAGES 6, 7, AND 8 AT TIME FIRST COMPLETED AND SENT BACK TO US.

Signing this application does not bind Coastal Insurance, Inc. to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information, or attempt to defraud or attempt to defraud or lie to Coastal Insurance Company, Inc. about any matter contained in this application, then coverage provided by virtue of this application is void. **Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.**

Date: _____ (X) _____

(Applicant)

(X) _____

(Witness)