INSPIRIEN

P.O. Box 211359
Montgomery, AL 36121-1359
Return to: notifications@inspirien.net

Application For Professional Liability Insurance for Physicians and Dentists

Proposed Coverage Effective Date _____

Section 1: General Information

1. Full Name of Applicant _____ ☐MD ☐DO ☐DDS ☐DDM ☐Other _____
2. Date of Birth _____
3. Home Address _____
   City _____ State _____ Zip _____
   Home Phone _____ Cell Phone _____
4. Organization Name _____ Tax ID # _____
5. Type of Practice ☐Solo Unincorporated Provider ☐Individual(solo) ☐Corporation ☐Partnership ☐Member of Multi-person Corporation
   Employee of _____ Independent Contractor of _____ Other
6. Principle Business Address _____
   City _____ State _____ Zip _____
   County _____ Email Address _____ Web Address _____
7. Is billing address different from principal business address? If yes, please list.

   _____
8. Administrator Contact at Business Name _____
   Phone _____ Email _____

Section 2: Provider Information

Answer each question. For all YES answers, please explain in space provided or by attachment.

9. Describe the professional activities for which you are requesting coverage

   Specialty Sub-specialty

Have you ever:	Yes	No
a. Been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative or licensing 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?	☐	☐

		Yes	No
d.	Has any insurance company canceled, declined, denied or refused to renew or placed conditions or restrictions on your professional liability insurance?		
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, or have any judgements been made against you or any out-of-court settlements made on your behalf? *If yes, please complete a Supplemental Claims Information Form at the end of the application.*		
g.	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?		
h.	Had or do you presently have any chronic or life-threatening physical illness or defect which affects your ability to practice medicine?		
i.	Had your privileges denied, suspended, revoked, or monitored at any hospital, health program or medical facility?		
j.	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 you organization?		

Please explain any YES answers from above questions in space provided below or by attachment.

10. Check the procedures preformed by you.

- ☐ Abortion, elective
- ☐ Acupuncture
- ☐ Amniocentesis
- ☐ Anesthesia
  - ☐ Caudal
  - ☐ Conscious 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 Ganglionectomy
  - ☐ 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 Therapy
- ☐ Spinal Fusion
- ☐ Spinal Surgery, other
- ☐ Thoracic Surgery _____%
- ☐ Thoracentesis
- ☐ 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)

Section 3: Practices and Procedures

11. In what States are you requesting Inspirien to provide you coverage?

State _____ License # _____ % of Practice _____

State _____ License # _____ % of Practice _____

12. National Provider Identifier No. _____

13. Federal DEA License No. _____

Has your DEA license ever been restricted or revoked? ☐ Yes ☐ No

If YES, explain:

14. Has there been any changes in your practice or specialty in the past 5 years? ☐ Yes ☐ No

If YES, explain:

15. Do you perform procedures which are not included in your primary medical specialty? ☐ Yes ☐ No

If YES, explain:

16. Do you normally staff an emergency department? ☐ Yes ☐ No How many hours per month?

a. Is this required for staff privileges at the hospital? _____

17. Do you work part-time outside of your regular full-time practice for which you are applying by this application ("moonlight")?

☐ Yes ☐ No If YES, describe

b. Is this activity insured by your part-time ("moonlighting") employer? ☐ Yes ☐ No

c. If YES, name of insurance company _____

d. If NO, how many hours do you work per month? ☐ Yes ☐ No

Do you desire this policy to extend to cover this work? ☐ Yes ☐ No

18. I practice medicine ☐ Full Time ☐ Part Time (20 Hours per week or less)

19. Are you in the employment of an individual firm or corporation other than the organization you listed in 4? ☐ Yes ☐ No

If YES, explain, giving details of your responsibilities:

20. Do you provide professional health care services to correctional institution inmates (i.e. federal or state prisons, county jails, or youth detention centers? ☐ Yes ☐ No If YES, please describe your duties and hours worked?

21. Do you provide health care services to nursing homes, assisted living, or other convalescent home? ☐ Yes ☐ No

If YES, please list name of facility _____

Do you have professional liability coverage for this exposure? ☐ Yes ☐ No With whom? _____

22. Do you or will you render medical professional services via telecommunications technology that involve patients who reside outside your primary state of practice that you are requesting Inspirien to provide you coverage? ☐ Yes ☐ No

If YES, explain and list all states and type of professional services rendered.

23. Do you supervise any individuals other than your own employees? ☐Yes ☐No

If YES, provide a detailed explanation of your responsibilities and your relationship to the entity which employs these individuals.

Section 4: Education and Training

24. Indicate your education background (or attach a copy of your Curriculum Vitae if such information is included)

a. Undergraduate School _____ Year Completed _____

b. Graduate School _____ Year Completed _____

c. Medical School _____ Location _____ Year Completed _____

d. Internship at _____ Location _____ Year Completed _____

e. Residency at _____ Location _____ Year Completed _____

Location _____ Year Completed _____

f. Fellowship or Advanced Training _____ Year Completed _____

g. Please explain any gaps in above chronological sequence

25. Are you a U.S. Citizen? ☐Yes ☐No If NO, indicate your status and date of entry into the USA

26. Are you a foreign medical school graduate? ☐Yes ☐No

If YES, are you certified by the Educational Council for Foreign Medical School Graduates? ☐Yes ☐No

27. Are you U.S. Board Certified? ☐Yes ☐No Specify

Organization Extending Certification _____

Are you Board Eligible? ☐Yes ☐No

28. Are you in your first year of practice? ☐Yes ☐No

Section 5: Organization and Employee Information
(Only needs to be completed once for entire group practice)

29. Legal Name of Your Organization _____

30. Date Organization was formed? _____

31. Do you desire to purchase a separate limit for your organization listed in #29? ☐Yes ☐No

If YES, Retroactive Date of Organization _____

* must attach declarations page from current policy to evidence retroactive date

Do you desire to have shared limits at no extra cost? ☐Yes ☐No

If YES to separate limits, please list all physicians or dentist who are working for your organization, but are not applying for coverage with Inspirien Insurance Company.

Employee Information

Certain mid-levels presents additional exposure to the practice and are not automatically covered by the policy. The types of mid-levels requiring a charge are Nurse Practitioners, Physicians Assistants, Midwives, Nurse Anesthetists, Chiropractors, Psychologists, Podiatrists. There are two ways to cover them:

1. They can share in the physician's limit or
2. You can name them on your policy and provide separate limits to each of them.

Allied Provider Name	License Type (PA/NP, CRNA)	Hire Date	Shared or Separate Limits	Avg Hours Worked/Week	Retroactive Date*

Please attach separate roster in excel if additional space is needed for listing of names

* Note: When separate limits are requested proof of the current retroactive date from your declaration page and a reporting endorsements (tail) will need to be purchased when they depart your employment.

Section 6: Coverage

Limits Available : 1 Million/ 3 Million If you desire higher limits, we can provide an excess limits quote.

Please indicate excess limit desired ☐ 1 Million ☐ 2 Million ☐ 3 Million

32. Do you want a deductible to apply? ☐ Yes ☐ No If YES, check the deductible amount below

☐ $5,000 per claim ☐ $10,000 per claim ☐ Other

Current/Prior Coverage Information

Company	Policy No.	Policy Limits	Deductible	Policy Type				Policy Period
				Claims Made		Occurrence		
				Claims Made		Occurrence		
				Claims Made		Occurrence		
				Claims Made		Occurrence		

33. Were you at any time without insurance? ☐ Yes ☐ No

If YES, please indicate on a separate sheet of paper when and the reason.

34. Are you requesting prior acts coverage? ☐ Yes ☐ No If NO, skip the section 34a.

Retroactive date requested (this date should match the retroactive date on your current professional liability policy)

Prior acts coverage is not automatic and is subject to underwriting approval. Because you are requesting coverage on a claims-made basis you will either need to purchase a reporting endorsement from your prior claims-made insurance carrier or request we provide you with prior acts with the same retroactive date that is on your expiring policy. If you do not purchase a reporting endorsement or request prior acts coverage, professional healthcare incidents that occurred prior to the date you are applying to this coverage will no longer be covered. The ability to purchase a reporting endorsement is time sensitive and typically needs to be done within 30 days of your policy cancellation date.

a. If you are applying for prior acts answer the following questions regarding adverse patient outcomes which may have occurred in your practice in the last two years which you have not already reported to your current professional liability insurance company. Any YES answer must be reported to your current insurance carrier prior to your coverage being offered.

1. Since the retroactive date listed above has your practice or coverage changed? (Different limits, different states, Different procedures) ☐Yes ☐No
2. Fetal distress during labor and delivery, newborn Apgar score less than six at either one or five minutes, or evidence of neurological or physical compromise of an infant? ☐Yes ☐No
3. Any UNEXPECTED death (including stillbirths), organ failure (heart, liver, lung, kidney), or any significant neurological or functional deficit, or intractable pain, following surgery which were not present upon admission, which are not explained by the medical condition and/or general health of the patient? ☐Yes ☐No
4. Any alleged failure or delay to diagnose a condition resulting in death or serious permanent disability, or any delayed communications of positive diagnostic imaging or pathology reports? ☐Yes ☐No
5. Contact by an attorney either requesting records of a patient or notifying you that a malpractice action is being investigated or contemplated ☐Yes ☐No
6. Any acute myocardial infarction, arrest, embolism, aneurysm, or cerebral vascular accident during or within 48 hours of surgery or 72 hours of an office visit? ☐Yes ☐No
7. Any admission or return to the ER/OPD within 5 days of treatment due to complications from surgery resulting in serious temporary or permanent injury or death? ☐Yes ☐No

APPLICATION MUST BE SIGNED AND DATED BY THE PROVIDER REQUESTING COVERAGE.

Signing this application does not bind Inspirien Insurance Company 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 Inspirien Insurance Company 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 Signature)

_____

(Printed Name)

THE FOLLOWING IS REQUIRED WITH THE APPLICATION

a. Your expiring insurance policy Declarations Page showing Retroactive Date

b. Current CV (curriculum vitae – also known as a resume)

c. Current dated Loss Run report from all Prior Insurance Companies over the last 5 years or length of practice if less than 5 years.

Inspirien Insurance Company

Authorization for Release of Information

I, the undersigned, have provided Inspirien Insurance Company (Inspirien) information in their insurance application in order for Inspirien to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including, but not limited to, prior liability carriers, hospitals and their officers, directors, medical staff, and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide Inspirien with any information, whether written or otherwise, which may be material to evaluating my application for insurance with Inspirien. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Inspirien.

I consent for Inspirien to use photocopies of this "Authorization for Release of Information" to present to those persons or entities supplying information as provided herein. Each photocopy is to be considered an original copy.

Date _____ (x) _____

(Applicant Signature)

_____

(Printed Name)

Supplemental Claim Information

Instructions to the Applicant

a. This form should be completed by the applicant whose signature appears on the Inspirien Insurance Company Professional Liability Insurance Application.

b. One of these forms should be completed for each claim or incident in which the applicant has been involved. If additional forms are needed, applicant may photocopy this form for use in reporting other claims.

c. If space is insufficient to fully provide answers to the questions below, use reverse of this form or separate sheet.

d. Answer all questions completely. Complete information is necessary for the equitable and careful evaluation of your application.

1. Full Name of the Applicant _____

2. Full Name of the Individuals(s) of your firm involved in this claim

3. Full Name of the Claimant _____

4. Age _____ 5. Sex _____

6. Indicate whether this was a ☐ Claim ☐ Incident ☐ Suit

7. Date of Alleged Error _____ 8. Date of Claim _____

9. Additional Defendants

10. What is the name of the insurer involved in this claim? _____

11. What is the insurer's claim number assigned to this claim (if known)? _____

12. Description of the claim (please provide enough information to allow for evaluation and use the reverse side of this sheet if necessary)

Alleged act, error, or omission upon which the claimant bases claim

Description of the type and extent of injury or damage allegedly sustained

If claim is closed, answer questions 13 and 14. If claim is pending (open), answer questions 15 through 21.

If closed:

13. What was the total loss paid including a deductible that may have applied?

14. Was this amount paid subsequent to a ☐ Court Judgement or ☐ Out of Court Settlement

If pending (open):

15. What is claimant's settlement demand? $ _____

16. What is defendant's settlement offer? $ _____

17. What is insurer's loss reserve? $ _____

18. What deductible (if any) applies? $ _____

19. Is this claim in suit? ☐ Yes ☐ No $ _____

20. If claim is in suit, what amount (if any) was asker for in summons? $ _____

21. Who is defense counsel (please include address and phone number if known or available)? _____

I hereby understand that information submitted herein becomes a part of and is incorporated with my Professional Liability Application and is subject to the same conditions.

Date _____ (x) _____

(Applicant Signature)

_____

(Printed Name)