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)**

_____
_____
_____
_____
_____

16. Do you use x-ray equipment on your premises?_____

If yes, are your x-rays overread by a radiologist?_____

17. Do you perform any surgical procedures in your professional office or similar non-hospital facility?_____

If yes, list procedures_____

18. Percentage of Mental Health Work_____%

19. If you administer anesthetics, is there a pre-anesthesia examination and conference with the patient? ☐ Yes ☐ No

Do you use pulse oximetry and capnography with general anesthesia? ☐ Yes ☐ No

20. Do you participate in any activity (e.g. newspaper columns, broadcasts, etc.) whereby professional advice is offered to the public? ☐ Yes ☐ No

If yes, explain_____

21. In what states are you registered and licensed to practice?_____

Is your license limited? ☐ Yes ☐ No If yes, explain_____

22. a. Federal DEA No._____

b. Medical License No. for each state in which you are licensed._____

c. Are all the above licenses current? ☐ Yes ☐ No If No, which are not_____

23. List in chronological order all hospitals where you have applied, had privileges or have been denied privileges:

Hospital Name	Hospital Address	Start Date	End Date	% of Patients	Issue Certificate of Insurance?
					☐YES ☐NO
					☐YES ☐NO
					☐YES ☐NO
					☐YES ☐NO
					☐YES ☐NO
					☐YES ☐NO

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

If yes, explain_____

25. Are you credentialed at any hospital for any procedures which are not included in your primary medical specialty? ☐ Yes ☐ No

If yes, explain_____

26. If you have just completed your residency training or fellowship, name the institution where you trained, the director of your program and the telephone number of the department.

Institution_____ Program Director_____ Telephone_____

Institution_____ Program Director_____ Telephone_____

27. Are you a member of the staff, or do you practice in an ambulatory care center? ☐ Yes ☐ No

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

29. If your hospital does not employ full-time emergency physicians, do your staff privileges require you to take emergency call on a regular rotation? ☐ Yes ☐ No If yes, how many hours per month?_____

30. a. Do you work part-time outside of your regular practice ("moonlight") ? ☐ Yes ☐ No If yes, describe_____

_____

b. Is this activity insured by your employer? ☐ Yes ☐ No If yes, name of insurance company_____

31. a. Are you employed full-time by the Federal Government **or** are you under contract to any government entity? ☐ Yes ☐ No

If yes, explain_____

b. Do you work in either a federal or state prison? ☐ Yes ☐ No

If yes, describe your duties and hours worked_____

32. Are you currently in the Military Service? ☐ Yes ☐ No If yes, circle whether ☐ Active or ☐ Reserve

33. Are you a U.S. citizen? ☐ Yes ☐ No If no, indicate your status and date of entry into the USA_____

_____

34. 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

35. In what Medical Associations are you a member in good standing?_____

_____

Education and Training

36. Indicate your educational 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_____

_____

37. CME credits for the preceding year_____

38. a. Do you participate in, or are you a member of an HMO, PPO or similar healthcare system? ☐ Yes ☐ No

b. Is there a "hold harmless" clause in your contract requiring your professional liability insurance company to indemnify any hospital or institution? ☐ Yes ☐ No

c. Do you participate in peer review or similar activity with respect to above entities? ☐ Yes ☐ No

39. Please list your professional liability policies for the past five years

Company	Policy No.	Policy Limits	Deductible			Policy Period
_____	_____	_____	_____	Claims Made____	Occurrence____	_____
_____	_____	_____	_____	Claims Made____	Occurrence____	_____
_____	_____	_____	_____	Claims Made____	Occurrence____	_____

If at any time you were without insurance, please indicate on a separate sheet of paper.

40. Are you U.S. Board Certified? ☐ Yes ☐ No Specify_____

Organization extending certification_____

Are you Board Eligible? ☐ Yes ☐ No

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

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

Questions Below to be Completed by Physicians applying for individual policies

Business and Employee Information

42. List the number of any professional assistants you employ:

Number	Type of Employee	Number	Type of Employee	Number	Type of Employee
_____	Physicians	_____	Nurse Anesthetists	_____	Lab Technicians
_____	Nurse Practitioners	_____	Physician's Assistants	_____	Other
_____	Midwives	_____	X-Ray Technicians		

43. Are all assistants listed in question 42 licensed in accordance with applicable State and Federal regulations? ☐ Yes ☐ No
If no, explain_____

44. a. Do you supervise any individuals other than your own employees? ☐ Yes ☐ No
b. If yes, provide a detailed explanation of your responsibilities and your relationship to the entity which employs these individuals.
c. Also, indicate by profession the number of individuals supervised_____

45. I practice as a:
☐ Sole Practitioner (Unincorporated) ☐ Partner in a Group Practice
☐ Professional Association ☐ Professional Corporation
☐ Other_____

46. a. If you practice as an employee of an organization other than a hospital, list the names of all your partners or members of your professional association with whom you practice who are not insured by Coastal Insurance Company, Inc.
_____
_____
b. Give the formal corporate, association, partnership or business name_____
c. Attach a copy of your letterhead

47. Are you in the employ of an individual firm or corporation other than your own? ☐ Yes ☐ No
If yes, explain, giving details of your responsibilities_____

48. I practice medicine ☐ full time ☐ 20 hours per week or less

Coverage

49. a. If your prior coverage was "claims made" rather than "occurrence", please state your **retroactive date**_____
b. If requesting "prior acts" coverage, you will be asked to fill out a **"LIMITATIONS OF PRIOR ACTS COVERAGE ENDORSEMENT".**

50. a. Individual Professional Limit of Liability Requested.
☐ $1,000,000 each claim / $3,000,000 aggregate
b. Do you desire an excess (higher) limit of liability? ☐ Yes ☐ No If yes, check the amount to be added.
☐ $1 million ☐ $2 million ☐ $3 million ☐ $4million

51. a. Do you want a deductible to apply? ☐ Yes ☐ No If yes, check the deductible amount below. (Figure in parenthesis is the percentage discount to come off of the standard premium.)
☐ $5,000 (5.0%) ☐ $10,000 (8.0%) ☐ $25,000 (16.0%)-(letter of credit is required for $25,000 deductible.)
(Deductible applies only to indemnity; not to legal expenses)
b. Do you desire to purchase a separate policy for your Partnership, Association or Professional Corporation? ☐ Yes ☐ No
or do you desire to have shared limits at no extra cost? ☐ Yes ☐ No
c. I.R.S. Tax Identification Number (if entity coverage applies)_____

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)

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING:

1. Your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.

2. Up-to-date CV (curriculum vitae - also known as a resume).

3. Current *(i.e. obtained within 60 days of requested effective date)* Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years.

4. Letters or Evaluations from (3) professional references.

5. Copy of Medical License.

6. If you are an ER doctor please provide copies of your ACLS, PALS, ATLS certificates.

COASTAL INSURANCE COMPANY, INC.
SUPPLEMENTAL CLAIM INFORMATION

INSTRUCTIONS TO THE APPLICANT

A. This form should be completed by the applicant whose signature appears on the Coastal Insurance Company, Inc. 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 Individual(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 ☐ or 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: _____

_____

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.

13. If closed, what was the total loss paid including a deductible that may have applied? _____

14. If closed, was this amount paid subsequent to a: ☐ Court judgment or ☐ Out of court settlement

15. If pending (open), what is claimant's settlement demand? $ _____

16. If pending (open), what is defendant's settlement offer? $ _____

17. If pending (open), what is insurer's loss reserve? $ _____

18. If pending (open), what deductible (if any) applies? $ _____

19. If pending (open), is this claim in suit? ☐ Yes ☐ No $ _____

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

21. If pending (open), 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)

(X) _____
(Witness)

COASTAL INSURANCE COMPANY, INC.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, have provided Coastal Insurance Company, Inc. (Coastal) information in their insurance application in order for Coastal 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 Coastal with any information, whether written or otherwise, which may be material to evaluating my application for insurance with Coastal. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Coastal.

I consent for Coastal 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)

(X)_____
(Witness)

Submit via Email If Signed Electronically

Print