Physician supplemental
Application form

Please complete one application for each physician that requires coverage for direct patient care.

Applicant information

1. Physician name (you):

2. Address of location where services will be provided:

   (attach separate sheet if more than one location)

3. Medical or surgical specialty:

   Sub-specialty:

4. Are you currently licensed to practice medicine in the state listed above? Yes ☐ No ☐

5. Are you American Board certified? Yes ☐ No ☐

Operations and activities

6. Do you want to be covered for professional services performed on behalf of an entity? Yes ☐ No ☐

   If Yes, please list the entity(ies).

7. Do you have any ownership interest in the entity(ies) referenced above? Yes ☐ No ☐

8. Do you currently practice outside of the entity(ies) listed above in question 6? Yes ☐ No ☐

   If Yes, please provide details:

9. Please describe the services you are performing on behalf of the entity(ies) listed above in question 6:

10. Do you perform administrative duties as a medical director for the entity(ies) listed above in question 6? Yes ☐ No ☐

11. Do you perform any of the following activities as **part of your services performed for the entity(ies) listed above in question 6?**:

    a. surgery, other than the incision of boils, superficial abscesses or suturing skin and superficial fascia Yes ☐ No ☐

    b. any invasive procedures (not including injections) Yes ☐ No ☐

    c. prescribe any medication Yes ☐ No ☐

    d. prescribe medication for weight reduction of patients Yes ☐ No ☐

    e. administer any anesthesia (other than topical) Yes ☐ No ☐

    f. participate in any clinical trials Yes ☐ No ☐

    g. chart sign-off for any nurse practitioner or physician assistant Yes ☐ No ☐

    h. obstetrics or pre-natal care Yes ☐ No ☐

    If Yes to any of the above, please provide detail in the additional comments section.

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Coverage and claims history

12. Are you currently covered for professional services performed on behalf of the entity(ies) listed above in question 6? Yes ☐ No ☐ n/a ☐

If claims made coverage, what is your retroactive date? / /

(note that we will require proof of current coverage in order to match prior acts coverage)

13. If Yes to any of the below, please provide detail in the additional comments section.

a. Has any insurer ever declined, cancelled or non-renewed your professional liability or medical malpractice coverage? Yes ☐ No ☐

b. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or voluntarily surrendered in any state? Yes ☐ No ☐

c. Have you ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

d. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

e. Have you ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

f. Has (have) any malpractice judgment(s), settlement(s), payment(s), claim(s), suit(s) or demand(s) ever been made against you? Yes ☐ No ☐

g. Are you aware of any facts, circumstances or situations which might afford grounds for a malpractice claim for any medical services performed by you (not limited to services performed for the entity listed in question 6)? Yes ☐ No ☐

Additional comments

It is understood and agreed that with respect to question 13, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the underwriters.

Declaration

Name of physician

Signature

Date

A copy of this proposal should be retained for your records.