Application for Professional Liability Insurance (Connecticut)

This is an application for insurance and is not a binder. No coverage exists until authorized in writing by the Company.

1. Personal and Demographic Information

Name:		**Requested effective date**:
Office Address:		Office Phone: ( )
		Office Fax: ( )
		Email:
City/State/Zip Code:	**County**:	Web Site:

Residence Address:	**Billing Address (Complete if different from Office Address):**	Last four digits of Social Security #:
		Date of Birth:
		Female ☐ Male ☐

Preferred Mailing Address: **Please check one**

Office	Residence	Other
☐	☐	☐

If not chosen, default is office address.

If "other," state here:

2. Professional Education

Please indicate the name of the medical or dental school and/or hospital and the city and state where located.	**Degree and/or Specialty**	**Completed?** Yes	No	**Date Completed** (or expected)
Medical or Dental School:				
Internship:				
Residency:				
Residency:				
Fellowship:				

3. Certification/Specialty

	Yes	No		Yes	No
Are you Board Certified (By a member-board of the American Board of Medical Specialties or Osteopathic Specialties)?			**Are you Board Eligible** (and currently in the exam process)?		
In what specialties are you Board Certified?			**Have you ever failed a specialty or sub-specialty exam? Number**:		

General and/or Subspecialty Certificate (or other training, e.g., laser or laparoscopic procedures) in:

Describe the specialty you will be practicing while insured by MDAdvantage:

List the primary focus of your practice:

4. Licensure

Please indicate in which states you are presently licensed to practice and indicate what percentage of your total practice is spent in each. For surgeons or obstetricians, base your percentages on surgeries or deliveries.

State	License Number	Date of License	% of Total Practice

D.E.A. Registration Number:

If you answer "Yes" to any of the first three questions, please attach a complete explanation.	**Yes**	**No**
1. Has your medical or dental license in any state ever been suspended, revoked or limited?		
2. Are you currently under investigation by any state or federal licensing board or agency?		
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited?		
4. In the past two years, have you been diagnosed or treated for any substance abuse?		
5. In the past two years, have you been diagnosed or treated for disability, mental illness, serious physical injury, or illness that has or might affect your ability to practice medicine or surgery?		
6. If you answered yes to either question 4 and/or 5 above, then are you being monitored by a Professional Assistance Program approved by the State Board of Medical Examiners?		

5. Practice Locations

Please state the name and location(s) including street address, city, and state where you work/practice. Describe if your duties differ from your practice specialty: Attach additional sheets if needed.

1.

2.

3.

4.

5.

6.

If you are approved for coverage, do you want MDAdvantage to send you a Certificate of Insurance for each hospital listed above?	**Yes**	**No**
Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges or your application or reapplication for medical staff privileges? If yes, attach complete explanation.		
Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? If yes, attach complete explanation.		

Name of Practice Manager:	**Practice Manager's Email Address**:

6. Other Exposures

Do you wholly or partially own or directly or indirectly operate, or serve as an executive or administrative officer, medical director or department head for any hospital, nursing home, non-hospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization? If "**yes**," indicate its name and describe your relationship(s) below.	**Yes**	**No**

7. Type of Coverage

Policy Selection (Indicate Policy Type)			**Limits of Insurance**
Please indicate your choice of policy type:			**Limits of Insurance** Please check the limits of insurance desired: (each medical incident/aggregate) ☐ $500K/$1.5M ☐ $750K/$2.5M ☐ $1M/$4M ☐ $2M/$5M ☐ $3M/$6M ☐ $5M/$8M
Claims-made		Extended Reporting Period ("Tail") coverage is optional.	
Occurrence		Extended Reporting Period (Tail) is not applicable with this coverage.	
Permanent Protection **(Modified Claims-Made)**		Extended Reporting Period (Tail) coverage is provided without additional charge	

Optional Policy Provision – Waiver of Right to Consent to Settle	**Deductibles**
If insured under a Group Policy, this section (Waiver of Right to Consent to Settle) does not apply. Groups must submit a written request for this quote separately. ☐ **Please check here if you would like to request a quote to waive your right to Consent to Settle of any claim or suit and receive a premium reduction.** **If you choose this option, MDAdvantage has the right to settle any claim or suit against you without requiring your consent.** ☐ **I do not choose to waive my right to consent to settle of any claim or suit.**	☐ **I would like information on a deductible option.**

Solo Practice

If you wish to add your solo entity as an additional insured on your policy, sharing your limits of insurance (no additional premium), please check the box to the right. **We will add the name you indicate in Section 9**. **Note**: If coverage is needed for any other type of corporation, entity or partnership other than a solo entity, please complete an **Application for Professional Liability Insurance (For Corporations or Other Legal Entities)**. Coverage will not take effect unless an application has been approved by MDAdvantage.	Add Solo Corporation? **Yes**	**No**

8. Professional Liability Insurance History

	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior
Insurance Company					
Limits of Insurance					
Type of Policy (**Claims-made / Modified Claims-Made or Occurrence**)					
Policy Period					
Retroactive Date					

	Yes	No
If your previous policy was **claims-made**, did you obtain extended reporting period ("tail") coverage? **If "yes," please enclose a copy**.		
Have you ever practiced without professional liability insurance? If "**yes**," please attach a complete explanation including dates.		
Has your professional liability insurance ever been cancelled or nonrenewed (other than at your request); has your policy premium ever been surcharged or has your application for professional liability insurance ever been declined? **If** "**yes**," **please attach a complete explanation**.		
Note: **If you practice as a general surgeon**, **obstetrician/gynecologist or orthopedic surgeon**, **you must also complete the specialty application on page 10**.		

9. Current Practice

Practice Organization		Name of Employer/Legal Entity	Members of Your Group	
Check which applies:		**Please indicate the name of your employer:**	**Please indicate the number of:**	
Solo unincorporated			Physicians, Dentists or Podiatrists in your group	
Solo entity				
Partner in a partnership			Those insured by or applying to MDAdvantage:	
Shareholder & employee in a professional corporation			(**Note**: **MDAdvantage must insure at least 50% if you also wish to insure your corporation and paramedical employees with MDAdvantage**).	
Employee or contractor for a professional corp., hospital, clinic, etc.				

Practice Profile	**Average Number Per Week**	**Principal Medical or Surgical Practice** Please describe the practice for which this insurance is needed.
Practice hours (total hours – not just patient contact)		
Patient visits, excluding obstetrical deliveries (in office, hospital, etc.)		
Surgeries (major – in hospital)		
Surgeries (major – in surgical centers)		
Obstetrical deliveries		

First Date of Practice: Please indicate your first date of practice (For physicians or dentists entering practice for the first time after completing a residency or fellowship program or service in a government-funded health care program, such as the U.S. Public Health Service or the U.S. Military, as repayment of a medical education funding obligation). **Date**:

10. Underwriting Information

		Yes	No
Other Positions?	Do you hold any positions outside of your principal medical or surgical practice (e.g., moonlighting in an E.R., serving part-time at a clinic or nursing home, working for an H.M.O. or other managed care or insurance company, serving as a Medical Director, etc.)? **If yes**, **please describe below**. **Include for whom you provide these services**.		
Other Procedures?	Do you perform any procedures, techniques or treatment modalities that are not typical to the specialty in which you received your residency and/or fellowship training? **If yes**, **please describe below**.		
	Do you perform any procedures, techniques or treatment modalities that are outside the specialties you are currently practicing as stated on page 1, question 2? **If yes**, **please describe below**.		
Other Practices	Are you a collaborating physician with a qualified nursing professional? If yes, please describe the extent of this practice, including the number of nurses involved, and if the nurses are working within your practice location? Attach copies of the Joint Protocols that you have in place with these individuals.		
Other Coverage	Do you have a position for which no coverage is required, or for which you are insured with another carrier? If yes, indicate activity, entity and location to be excluded and indicate hours worked at this position only:		
Office Systems	Does your practice utilize an electronic medical record system? Does your practice utilize an electronic prescription writer?	------	-------

Please use the space below to give details for any question to which you answered "Yes" (above).
Attach additional sheets as needed.

11. Allied Health Care Employees

This section does not apply to Paramedical & Non-Paramedical Professional Liability Insurance if insured under a Group Policy. Additionally, this section does not apply to any employed Physician, Dentist or Podiatrist.

If this application is approved, the limits of insurance will be shared by the insured provider applying for this insurance and his or her allied health care employees for whose acts or omissions the insured provider is legally responsible. However, this coverage does not apply to any such employee who is required by law to carry separate insurance coverage. **If separate limits of insurance are desired for any employee**, **an application for Allied Health Care Employees Paramedical & Non-Paramedical Professional Liability Insurance** (**Separate Limits**) **must be submitted**.

Paraprofessional Employees

	Check One	
	Yes	**No**
Please indicate if you employ or contract with anyone in any of the following specialties: **Certified Nurse Anesthetists**, **Nurse Midwives**, **Nurse Practitioners, Physician's Assistants, Surgical Assistants, Perfusionists, Emergency Medical Technicians, Optometrist, Cryotechnologists or Psychologists**. If separate limit coverage is sought through MDAdvantage, additional premium will apply. **Note: There is no separate limit coverage for employees in these specialties unless an application is submitted to and approved by MDAdvantage**.		

Paramedical Employees: The employee types listed below do not require separate limits. **If separate limits of insurance are desired for any employee**, **an application for Allied Health Care Employees Paramedical & Non-Paramedical Professional Liability Insurance** (**Separate Limits**) **must be submitted**. Please indicate the **number** of each currently employed by the Applicant.

Type	How Many?	Type	How Many?	Employee Shared Limits
Nurses (R.N.s, L.P.N.s)		Physical or Occupational Therapists		Employee Shared Limits Liability Option: Coverage is available for employees not required by law to carry separate coverage. Check the box below if the shared limits of liability option is desired and complete an Allied Health Care Employees Paramedical & Non-Paramedical Professional Liability Insurance Application. Employee Shared Limits Coverage is desired: ☐
Medical or Dental Assistants		Mental Health Counselors		
X-Ray Technicians		Medical or Lab Technicians (Other Than Emergency Medicine)		
Speech Pathologists		Please indicate the **total number** of non-medical staff members you employ (receptionists, clerical, etc.):		

	Yes	No
Claims: Have any of your allied health care employees ever been named in a claim or suit arising from professional services or from managed care services contracts? If "yes," you must complete the Claim History section on page 7 of this application.		
Adverse Actions: Has any employee of the Applicant ever had any action taken against his or her license by any licensing board or regulatory authority or ever been the subject of any disciplinary action by any hospital or employer? If "yes," you must provide complete details, including circumstances, allegations and outcomes.		

12. Claim History

Note: Your application will not be approved unless you provide complete claim information.

	Yes	No
In the past ten years, has any claim or suit been made against you arising from your practice of medicine or surgery? If yes, please indicate the **number** of claims or suits:		
Besides any claim or suit made against you, have you reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any of your previous insurers?		
Are you aware of any medical incidents, adverse outcomes or other circumstances that you expect to give rise to a claim in the future?		

Claim No. ___ of ____ Name of Patient:

Name of Insurance Carrier:

1. Date of medical/ surgical incident			8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	**Yes**	**No**
2. Date claim reported to your insurer:			9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	No	10. What medical or surgical treatment led to the alleged injury to the patient? (**Note: include CPT code**, **if known**):		
4. Current Status					
Open / Closed / Date Closed			11. Describe the alleged injury or problem that led to the claim made against you.		
5. Amount paid on your behalf					
6. Amount paid on behalf of all defendants					
7. Amount of reserve, if an open claim (if known)					

Claim No. ___ of ____ Name of Patient:

Name of Insurance Carrier:

1. Date of medical/ surgical incident			8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	**Yes**	**No**
2. Date you reported the claim to your insurer:			9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	No	10. What medical or surgical treatment led to the alleged injury to the patient? (**Note: include CPT code**, **if known**):		
4. Current Status					
Open / Closed / Date Closed			11. Describe the alleged injury or problem that led to the claim made against you.		
5. Amount paid on your behalf					
6. Amount paid on behalf of all defendants					
7. Amount of reserve, if known (if claim open)					

12. Claim History (Continued)

Claim No. ___ of ____ Name of Patient:

Name of Insurance Carrier:

1. Date of medical/ surgical incident			8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	**Yes**	**No**
2. Date you reported the claim to your insurer:			9. Are these circumstances that you think may result in a claim but have not previously been reported to your insurer?		
3. Has a suit been filed?	Yes	No	10. What medical or surgical treatment led to the alleged injury to the patient? (**Note: include CPT code, if known**):		
4. Current Status					
Open / Closed / Date Closed			11. Describe the alleged injury or problem that led to the claim made against you.		
5. Amount paid on your behalf					
6. Amount paid on behalf of all defendants					
7. Amount of reserve, if known (if claim open)					

Note: You may be requested to provide information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.

Please use multiple copies of this form if you have had more than three claims.

Procedures

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.	**Yes**	**No**	**How Many?**
1. If you are not an Obstetrician, do you treat patients beyond the first trimester of pregnancy			
2. Prenatal or postnatal care			
3. Any endoscopic procedure			
4. Any laparoscopic surgeries? If yes, please explain procedures and training below.			
5. Any invasive procedure (incision, excision, puncture, tap, etc.) of any organ, including the skin.			
6. Any procedure performed while the patient is under any type of anesthesia (☐ local, ☐ general, ☐ regional, ☐ acupuncture) (**Please check type of anesthesia used**.)			
7. Any procedure involving withdrawal by needle of bodily fluids (other than blood products) such as amniocentesis, lumbar puncture, abdominal tap, etc.)			
8. Biopsy of any type (excisional or needle)			
9. Catheterization (other than urethral)			
10. Weight reduction procedures, treatments or medications			
11. Cervical/vaginal smears			
12. Hair transplants and/or restorations			
13. Any procedure involving injection and/or diagnosis using any radiopaque contrast material			
14. Any imaging procedure that you perform and/or results that you interpret (x-ray, mammogram, etc.)			

Procedures (continued)

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.	Yes	No	How Many?
15. Do you perform intervention procedures?			
16. Laser therapy or surgery			
17. Polyp removal (from any mucous membrane)			
18. Dialysis therapy (hemodialysis or peritoneal dialysis)			
19. Liposuction			
20. Diabetes management			
21. Do you practice invasive cardiology?			
22. ☐ Electrocardiography, ☐ echocardiography, ☐ cardiac stress tests or ☐ implantation of any pacemaker			
23. Participate in clinical trials for any drug company or for any organization acting on behalf of any drug Company			
24. If your specialty is Surgical Assistant, do you also conduct office hours?			
25. Assist at any major surgical procedure as first assistant: (making incisions, excising or handling organs, suturing, etc.)			
26. Assist at any major surgical procedure other than as first assistant			
27. Teach, supervise or proctor medical students, residents or fellows (indicate number of hours per week)			
28. Do you perform any cosmetic surgery such as (☐ botox, ☐ laser hair removal, ☐ laser spider vein removal, ☐ other (comment)			

Please use this space to provide details about any item above to which you provided a "yes" answer. Attach additional sheets as needed. Include sufficient detail so as to avoid delay in processing your application.

Specialty Application:

General Surgery Orthopedic Surgery Pathology Radiology Obstetrics & Gynecology

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.

General Surgery	Yes	No	How Many?
Breast surgery (excision of tumors, etc.)			
Bariatric surgery / gastric bypass surgery / lap band surgery			
Cosmetic procedure (liposuction, abdominoplasty, rhinoplasty, breast reduction or augmentation, etc.)			
Any surgical procedure performed in a non-hospital setting			
Any non-hospital procedure using anesthesia (other than local)			
Any laparoscopic procedure			
Any laser procedure			
Vascular or peripheral vascular surgery			
Transplant surgery (lung, kidney, liver, heart, etc.)			
Any orthopedic procedure			
Any obstetrical or gynecologic procedures, including, but not only, termination of pregnancies, etc.			
Any surgical procedure or treatment method that you have trained for after finishing your residency or fellowship			

Specialty Application: (Continued)

General Surgery Orthopedic Surgery Pathology Radiology Obstetrics & Gynecology

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, that you perform or engage in. Please indicate the approximate number you will perform in the coming year.

Orthopedic Surgery	Yes	No	How Many?
Spine surgery			
Microsurgical procedures			
Hip replacement surgery			
Any surgical procedure outside the scope of your training in orthopedics			

Pathology and Radiology

Pathology Physician:

What percent of work is performed while actually working in the state where you principally practice?	%
While working in the state where you principally practice, in what other state(s) are you providing interpretations?	

Radiologist Physician:

What percent of work is performed while actually working in the state where you principally practice?				%
While working in the state where you principally practice, in what other state(s) are you providing interpretations?				
What percent of your practice is designated to mammography interpretations?				%
Do you use computer aided detection for mammography interpretations?	**Yes**		**No**	

Please use the page 11 to provide details about any question to which you answered "yes." Attach additional sheets as needed.

Obstetrics & Gynecology

	Yes	No
Do you make patient records available to any replacement physician seeing your patients? If no, please comment.		
Are your deliveries performed at hospitals with at least a Level II NICU? If no, please comment on the emergency arrangements that you require?		
Do you refer high-risk pregnancies to a perinatologist? If no, please comment.		
Are your deliveries performed at hospitals that have both 24-hour in-house anesthesia services and 24-hour in-house surgical assistants? If no, please comment.		
Are all ultrasounds performed by a certified ultrasonographer? If no, please comment.		
Are all ultrasounds co-interpreted by a Radiologist? If no, please comment.		
Are all mammographies and other imaging reviewed by a radiologist? If no, please comment.		

Specialty Application: (Continued)

Obstetrics & Gynecology

	Yes	No
Do you perform in-vitro fertilization or other specialty reproductive activities? If yes, please comment.		
Do you employ, supervise, or provide back-up services for a midwife group? If yes, how many midwives:_____ Please comment on the arrangements that are in place.		
Do you perform terminations?		
How many per year?		
Do you only perform elective terminations after the 1st trimester? If yes, please comment.		
Are all terminations performed in a hospital? If no, please comment on where the terminations are performed.		
What percent of your deliveries are by VBAC _____% C-Section _____ %		
Do your hospitals employ Laborists?		
Are you a Laborist?		
Do you participate in regular drills (3-4 times per year) for Shoulder Dystocia?		
Do you participate in regular drills (3-4 times per year) for Emergency C-Section?		
Do you participate in regular drills (3-4 times per year) for Neonatal Resuscitation?		
Do you participate in regular drills (3-4 times per year) for Post Partum Hemorrhage?		

Please use this space to provide additional details about any question to which a comment is requested above. **Include sufficient detail so as to avoid delay in processing your application**.

Certification, Authorization and Signature

I certify that the information in this application is true and correct and I authorize the release and exchange of any information regarding my medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which I am or have been a member and MDAdvantage Insurance Company of New Jersey.

I further agree to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

Notice: 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 the purpose of misleading, information concerning fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature: _____ **Date**: _____

Assignment of Any Return Premium

This section should be completed if the premium for this insurance is paid by someone other than the Applicant.

If the premium for this insurance has been paid and the policy is later cancelled or otherwise changed, any refund of premium that results from such cancellation or change should be assigned to:

Name of the Payor: _____

(employer or other person or entity to whom any refund check should be made payable)

The Payor agrees to pay any premium for the professional liability insurance policy applied for and any renewal or replacement of it. The Applicant for this insurance assigns any and all rights to receive any refund of premium in excess of that earned by MDAdvantage Insurance Company of New Jersey for this insurance to the Payor named above. The Applicant appoints Payor or Payor's successors or assigns as Applicant's Attorney-in-Fact with full authority to cancel or amend the insurance policy applied for and to execute or receive any document, instrument, payment or notice of any kind relating to the insurance policy, except with respect to giving or withholding consent to settle claim or suit as may be provided in the insurance policy applied for.

No other interest in the insurance applied for may be assigned by any party without the written consent of MDAdvantage Insurance Company of New Jersey.

This assignment will remain in effect unless both Payor and Applicant agree in writing to its termination.

Applicant's Signature:_____ **Date**:_____