100 Franklin Corner Road
Lawrenceville, NJ 08648-2104

Application for Professional Liability Insurance

This is an application for insurance and not a binder. No coverage exists until authorized in writing by MDAdvantage. Certain questions may require your further explanation.

Requested Effective Date: ___/___/___

Section 1. Personal and Demographic Information

Name:_____

Gender: ☐ M ☐ F Date of Birth:___/___/___ Last 4 Digits of SSN: _ _ _ _

Practice Name:_____

Practice Manager Name:_____

Office Address:_____

_____

Office Phone:_____ Office Fax:_____

Email Address:_____ Website:_____

Mailing Address: (If different from Office)

_____

_____

_____

Billing Address: (If different from Office)

_____

_____

_____

Section 2. Professional Education

Medical School:_____

City, State where located:_____

Degree:_____ Date Completed:___/___/___

Residency:_____

City, State where located:_____

Specialty:_____ Date Completed:___/___/___

Fellowship:_____

City, State where located:_____

Specialty:_____ Date Completed:___/___/___

Please indicate your first date of practice after completing a residency or fellowship program or service in a federal government-funded healthcare program: ___/___/___

Section 3. Board Certification

In what specialties are you board certified?_____

How many times (if any) in total have you failed specialty or sub-specialty exams?_____

Section 4. Licensure

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

State	License Number	Date of License	% of Total Practice
_____	_____	___/___/___	_____%
_____	_____	___/___/___	_____%
_____	_____	___/___/___	_____%

DEA Registration Number:_____

Licensing Questions	Yes	No
1. Has your medical or dental license in any state ever been suspended, revoked or limited?	☐	☐
2. Are you currently under review, investigation or subject to an order issued 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. Has any hospital ever taken action to reprimand, deny, suspend, revoke or restrict your hospital privileges or your reapplication for privileges?	☐	☐
5. Have you ever resigned from hospital privileges while under investigation or to avoid possible disciplinary action?	☐	☐
6. In the past 5 years, have you been diagnosed or treated for any substance abuse?	☐	☐
7. In the past 5 years, have you been diagnosed or treated for disability, mental illness or illness that has or might affect your ability to practice medicine or surgery?	☐	☐
8. If you answered yes to either question 6 or 7 above, are you being monitored by a Professional Assistance Program approved by the State Board of Medical Examiners?	☐	☐

If you answered "Yes" to any of the above questions, please explain further:

_____

_____

_____

_____

Section 5. Professional Liability Insurance History

List all previous medical professional liability insurance you have had for the past 5 years, beginning with the most current.

Coverage Period:___/___/___ Insurer:_____
Coverage Type:_____ Retroactive Date (If Applicable):___/___/___
Limits Amount:$_____/_____ Tail Purchased (If previous coverage was Claims-Made): ☐ Yes ☐ No

Coverage Period:___/___/___ Insurer:_____
Coverage Type:_____ Retroactive Date (If Applicable):___/___/___
Limits Amount:$___/___ Tail Purchased (If previous coverage was Claims-Made): ☐ Yes ☐ No

Coverage Period:___/___/___ Insurer:_____
Coverage Type:_____ Retroactive Date (If Applicable):___/___/___
Limits Amount:$___/___ Tail Purchased (If previous coverage was Claims-Made): ☐ Yes ☐ No

Have you ever practiced without professional liability insurance? ☐ Yes ☐ No
If yes, please explain:_____

Other than at your request, has your professional liability insurance ever been canceled or non-renewed? ☐ Yes ☐ No
If yes, please explain:_____

Has your application for professional liability insurance ever been declined? ☐ Yes ☐ No
If yes, please explain:_____

Section 6. Type of Coverage

☐ Claims-Made (Coverage does not include extended reporting period (tail) coverage.)
☐ Occurrence (Extended reporting period (tail) coverage is not applicable with this coverage.)
☐ Permanent Protection (Claims-made coverage that includes extended reporting period (tail) coverage.)

Limits of Liability requested (each medical incident/aggregate):
☐ $1M/$3M ☐ $2M/$4M ☐ $3M/$5M ☐ $5M/$7M

Section 7. Current Practice

Practice Organization:
☐ Solo unincorporated ☐ Solo professional corporation ☐ Partner in a partnership
☐ Shareholder and employee in a professional or business corporation
☐ Employee or contractor for a professional corporation, hospital, clinic or similar corporate business entity

*Do you wish to add your solo professional corporation as an additional insured on your policy, sharing your limits of insurance (no additional premium)? ☐ Yes ☐ No

Name of Organization:_____
Number of physicians, dentists or podiatrists in your group:_____

Note: If coverage is needed for any other type of corporation or partnership other than a solo professional corporation or if separate limits of insurance are desired for any corporation, please complete an Application for Corporation/Partnership Insurance. Coverage will not take effect unless an application has been approved by MDAdvantage.

Practice Locations
Practice Name:_____
Practice Address: _____

Practice Name: _____
Practice Address: _____

Practice Name: _____
Practice Address: _____

Number of Employees*
***If this application is approved, the limits of insurance will be shared by the insured provider applying for this insurance and the following allied healthcare employees when a claim is made against both of them. If separate limits of insurance are desired for any employee, an application for Allied Health Care Employees Professional Liability Insurance must be submitted and approved by MDAdvantage.**

Physician Assistants_____ Nurse practitioners_____ Nurses_____
Nurse anesthetists_____ Medical assistants _____ Lab technicians_____
Perfusionists_____ Physical/occupational therapists_____
Other medical employees _____ Non-medical staff _____

NOTE: If coverage is desired for any employed Nurse Midwife, an application for Allied Health Care Employees Professional Liability Insurance must be submitted for each such employee. There will be no coverage for any Nurse Midwife without a completed, returned and approved application.

Nurse Midwives_____

Has any employee of the applicant ever been named in a claim or suit arising from professional services or from managed care services? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, please provide complete details: _____
_____
_____

Your Practice Profile
Specialty you will be practicing while insured by MDAdvantage:_____
Primary practice focus:_____
_____
Average number of practice hours per week:_____

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Section 8. Selected Procedures Information

Please check any of the following procedures that you will perform. Percentages and counts are understood to be approximate.

_____Abdominoplasty
_____Abortions – Elective – in hospital or surgi-center
_____% of total practice
_____Abortions – Elective – elsewhere _____% of total practice
_____Abortions - Therapeutic _____% of total practice
_____Anesthesia General/Spinal/Caudal
_____Angiography
_____Angioplasty
_____Arteriography
_____Assisting in Major Surgery – own patients only
_____Assisting in Major surgery – own & other than own patients
_____Bariatric Surgery – Laparoscopic
_____Bariatric Surgery – Non-Laparoscopic
_____Blepharopigmentation _____% of total practice
_____Blepharoplasty – Cosmetic _____% of total practice
_____Blepharoplasty – Reconstruction _____% of total practice
_____Botox in office _____% of total practice
_____Botox out of office_____% of total practice
_____Brachioplasty
_____Breast Implants – Cosmetic _____% of total practice
_____Breast Implants – Reconstruction _____% of total practice
_____Breast Reduction
_____Bronchoesophagology
_____Buttock Implant
_____Calf Implant
_____Cataract Surgery _____% of total practice
_____Cheek/Chin/ Lip Implant
_____Chemical Peels Deep _____% of total practice
_____Cleft Lip Surgery – Reconstructive
_____Cleft Palate Surgery – Reconstructive
_____ECT Electroconvulsive Therapy
_____Embolization
_____Face Lift
_____HVLA- Cervical Spine – Patient < 18
_____Intrathecal Pump Insertion

_____Joint Replacement – Shoulder_____% of total practice
_____Joint Replacement – Hip_____% of total practice
_____Joint Replacement - Knee_____% of total practice
_____Kyphoplasty
_____Lasik surgery_____% of total practice
_____Liposuction _____% of total practice
_____Mammogram with CAD
_____Mammogram without CAD
_____Nerve Block Injection
_____Pneumoencephalography
_____Prenatal/ Gynecology
_____Prenatal Practice 1st and 2nd Trimester
_____Prenatal Practice – to term no delivery
_____Prenatal Practice – to term with delivery
_____Vaginal Delivery – _____performed per year
_____VBAC Delivery –_____performed per year
_____C-Section Delivery -_____performed per year
_____Prolotherapy
_____Radial Laser Keratotomy
_____Radiation/X-Ray Therapy
_____Rhinoplasty_____% of total practice
_____Robotic Surgery_____% of total practice
_____Sigmoidoscopy – 60 cm or less
_____Sigmoidoscopy – greater than 60 cm
_____Silicone Injections _____% of total practice
_____Thigh Lift
_____Trigger Point Injection
_____Weight Control Medication _____% of total practice

_____

_____Telemedicine _____Pathology _____Radiology

State where principal practice is located:_____
State(s) where medical service is delivered remotely/electronically:

_____
_____
_____
_____

Please indicate the percentage of your total practice performing the following surgical activities:

_____% Cardiac	_____% Ophthalmology	_____% Plastic Reconstructive
_____% Dermatology	_____% Orthopedic – Including Spine	_____% Thoracic
_____% Gynecology	_____% Orthopedic – No Spine	_____% Trauma
_____% Hand	_____% Otolaryngology without Facial	_____% Urology
_____% Neurosurgery	_____% Otolaryngology with Facial	_____% Vascular
_____% Obstetrics	_____% Plastic Cosmetic	_____% Other

Section 9. Other Underwriting Information

Do you hold any position outside your principal medical or surgical practice (e.g., moonlighting in an E.R., serving part-time at a clinic or nursing home, etc.)? ☐ Yes ☐ No

If yes, please provide activity, entity name, location and hours per week: _____

_____

Do you have separate insurance coverage for this exposure? ☐ Yes ☐ No

If yes, please provide insurance carrier name for that coverage: _____

Are you a collaborating physician supporting nurses functioning essentially independently?
☐ Yes ☐ No

If yes, please provide number of nurses involved and number of those nurses that are working within your practice location: _____

Please attach copies of the Joint Protocols that you have in place with all nurses.

Section 10. Claim History

In the past 10 years, has any claim or suit been made against you arising from your practice of medicine or surgery? ☐ Yes ☐ No

Besides any claim or suit made against you, have you received any requests for patient records from an attorney? ☐ Yes ☐ No

Have you reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any previous insurers? ☐ Yes ☐ No

Are you aware of any other medical incidents, adverse outcomes, requests for patient records from an attorney or other circumstances that might give rise to a claim in the future? ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please provide details on the following page.

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☐ Claim ☐ Incident Name of Patient:____________________
Date of Medical Treatment:___/___/___ Name of Carrier:__________
Date Reported to Carrier:___/___/___ Has a suit been filed? ☐ Yes ☐ No
Current Status:____________ Date Closed:___/___/___
Amount paid on your behalf:$______ Amount paid on behalf of all defendants:$______
Is this an incident that you reported to your insurer even though a claim has not been made?
☐ Yes ☐ No
Are these circumstances that you think may result in a claim but have not previously been reported to your insurer? ☐ Yes ☐ No
What medical or surgical treatment led to the alleged injury to the patient? __________

Describe the alleged injury or problem.____________________

☐ Claim ☐ Incident Name of Patient:____________________
Date of Medical Treatment:___/___/___ Name of Carrier:__________
Date Reported to Carrier:___/___/___ Has a suit been filed? ☐ Yes ☐ No
Current Status:____________ Date Closed:___/___/___
Amount paid on your behalf:$______ Amount paid on behalf of all defendants:$______
Is this an incident that you reported to your insurer even though a claim has not been made?
☐ Yes ☐ No
Are these circumstances that you think may result in a claim but have not previously been reported to your insurer? ☐ Yes ☐ No
What medical or surgical treatment led to the alleged injury to the patient? __________

Describe the alleged injury or problem.____________________

☐ Claim ☐ Incident Name of Patient:____________________
Date of Medical Treatment:___/___/___ Name of Carrier:__________
Date Reported to Carrier:___/___/___ Has a suit been filed? ☐ Yes ☐ No
Current Status:____________ Date Closed:___/___/___
Amount paid on your behalf:$______ Amount paid on behalf of all defendants:$______
Is this an incident that you reported to your insurer even though a claim has not been made?
☐ Yes ☐ No
Are these circumstances that you think may result in a claim but have not previously been reported to your insurer? ☐ Yes ☐ No
What medical or surgical treatment led to the alleged injury to the patient? __________

Describe the alleged injury or problem.____________________

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 canceled or otherwise changed, any refund of premium that results from such cancellation or change should be assigned to:

Name of Payor:_____

The Payor agrees to pay any premium for the professional liability insurance policy applied for any renewal or replacement of it. The applicant for this insurance assigns any and all rights to receive any refund or 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 a 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:_____