

PENNSYLVANIA

Application for Professional Liability Insurance

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

Requested Effective Date: ___/___/___

SECTION 1

Personal and Demographic Information

Name: _____

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently under review, investigation or subject to an order issued by any state or federal licensing board or agency?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any hospital ever taken action to reprimand, deny, suspend, revoke or restrict your hospital privileges or your reapplication for privileges?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever resigned from hospital privileges while under investigation or to avoid possible disciplinary action?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 5 years, have you been diagnosed or treated for any substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Have you ever practiced in Pennsylvania without participating in the MCARE Fund? 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.)

Limits of Liability requested (each medical incident/aggregate):

- \$500K/\$1.5M MCARE Eligible Physician*
- \$1M/\$3M Not an MCARE Eligible Physician

*MCARE Limits required at \$500K/\$1.5M

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

Name of Organization: _____

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

Note: If coverage is needed for any type of corporation or partnership, 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: _____

***List all counties where you practice in the State of Pennsylvania:**

Number of Employees*

. If shared or 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 _____

Nurse Midwives _____

SECTION 7

Current Practice continued...

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 proceeding 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:_____

SECTION 8

Selected Procedures Information

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

<input type="checkbox"/> Abdominoplasty <input type="checkbox"/> Abortions – Elective – in hospital or surgi-center _____% of total practice <input type="checkbox"/> Abortions – Elective – elsewhere _____% of total practice <input type="checkbox"/> Abortions - Therapeutic _____% of total practice <input type="checkbox"/> Anesthesia General/Spinal/Caudal <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Arteriography <input type="checkbox"/> Assisting in Major Surgery – own patients only <input type="checkbox"/> Assisting in Major surgery – own & other than own patients <input type="checkbox"/> Bariatric Surgery – Laparoscopic <input type="checkbox"/> Bariatric Surgery – Non-Laparoscopic <input type="checkbox"/> Blepharopigmentation _____% of total practice <input type="checkbox"/> Blepharoplasty – Cosmetic _____% of total practice <input type="checkbox"/> Blepharoplasty – Reconstruction _____% of total practice <input type="checkbox"/> Botox in office _____% of total practice <input type="checkbox"/> Botox out of office _____% of total practice <input type="checkbox"/> Brachioplasty <input type="checkbox"/> Breast Implants – Cosmetic _____% of total practice <input type="checkbox"/> Breast Implants – Reconstruction _____% of total practice <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Bronchoesophagology <input type="checkbox"/> Buttock Implant <input type="checkbox"/> Calf Implant <input type="checkbox"/> Cataract Surgery _____% of total practice <input type="checkbox"/> Cheek/Chin/ Lip Implant <input type="checkbox"/> Chemical Peels Deep _____% of total practice <input type="checkbox"/> Cleft Lip Surgery – Reconstructive <input type="checkbox"/> Cleft Palate Surgery – Reconstructive <input type="checkbox"/> ECT Electroconvulsive Therapy <input type="checkbox"/> Embolization <input type="checkbox"/> Face Lift <input type="checkbox"/> HVLA- Cervical Spine – Patient < 18 <input type="checkbox"/> Intrathecal Pump Insertion <input type="checkbox"/> Joint Replacement – Shoulder _____% of total practice <input type="checkbox"/> Joint Replacement – Hip _____% of total practice <input type="checkbox"/> Joint Replacement - Knee _____% of total practice	<input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Lasik surgery _____% of total practice <input type="checkbox"/> Liposuction _____% of total practice <input type="checkbox"/> Mammogram with CAD <input type="checkbox"/> Mammogram without CAD <input type="checkbox"/> Nerve Block Injection <input type="checkbox"/> Pneumoencephalography <input type="checkbox"/> Prenatal/ Gynecology <input type="checkbox"/> Prenatal Practice 1 st and 2 nd Trimester <input type="checkbox"/> Prenatal Practice – to term no delivery <input type="checkbox"/> Prenatal Practice – to term with delivery <input type="checkbox"/> Vaginal Delivery – _____performed per year <input type="checkbox"/> VBAC Delivery – _____performed per year <input type="checkbox"/> C-Section Delivery - _____performed per year <input type="checkbox"/> Prolotherapy <input type="checkbox"/> Radial Laser Keratotomy <input type="checkbox"/> Radiation/X-Ray Therapy <input type="checkbox"/> Rhinoplasty _____% of total practice <input type="checkbox"/> Robotic Surgery _____% of total practice <input type="checkbox"/> Sigmoidoscopy – 60 cm or less <input type="checkbox"/> Sigmoidoscopy – greater than 60 cm <input type="checkbox"/> Silicone Injections _____% of total practice <input type="checkbox"/> Thigh Lift <input type="checkbox"/> Trigger Point Injection <input type="checkbox"/> Weight Control Medication _____% of total practice <hr/> <input type="checkbox"/> Telemedicine <input type="checkbox"/> Pathology <input type="checkbox"/> Radiology State where principal practice is located: _____ State(s) where medical service is delivered remotely/electronically: _____ _____ _____
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<p>Please indicate the percentage of your total practice performing the following surgical activities:</p> <input type="checkbox"/> % Cardiac <input type="checkbox"/> % Dermatology <input type="checkbox"/> % Gynecology <input type="checkbox"/> % Hand <input type="checkbox"/> % Neurosurgery <input type="checkbox"/> % Obstetrics	<input type="checkbox"/> % Ophthalmology <input type="checkbox"/> % Orthopedic – Including Spine <input type="checkbox"/> % Orthopedic – No Spine <input type="checkbox"/> % Otolaryngology without Facial <input type="checkbox"/> % Otolaryngology with Facial <input type="checkbox"/> % Plastic Cosmetic	<input type="checkbox"/> % Plastic Reconstructive <input type="checkbox"/> % Thoracic <input type="checkbox"/> % Trauma <input type="checkbox"/> % Urology <input type="checkbox"/> % Vascular <input type="checkbox"/> % Other
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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 or anyone in your practice received any requests for patient records from an attorney? Yes No

Have you or anyone in your practice reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any previous insurers?

Yes No

Are there any other medical incidents, adverse outcomes, or other circumstances known to you or anyone in your practice that might give rise to a claim in the future or has anyone in the practice received a request for patient records from an attorney for which a claim has not been made?

Yes No

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

SECTION 10

Claim History continued...

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 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 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. _____

SECTION 10

Claim History continued...

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 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 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.

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 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 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: _____