



CAMP MED

Casualty & Indemnity Company, Inc. of Maryland

Tel: 800/831-9506 • Fax: 703/242-3815

P.O. Box 2408
Vienna, VA 22183

**Application for Physicians & Surgeons
Professional Liability Insurance
(Claims Made Basis)**

Applicant's Instructions:

1. Answer all questions. If the answer requires detail, please attach a separate sheet. If a question is not applicable, state NOT APPLICABLE.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
4. Please do not complete application earlier than **45** days before the proposed effective date of coverage.
5. If you have a Curriculum Vitae (C.V.), please attach to application and check here _____.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full Name of Applicant (Include professional degree) _____

b. Principal business address: _____

Please attach list of additional locations.

c. Business Phone: () _____ Home Phone: () _____

d. Date of Birth: _____ Place of Birth: _____

e. Social Security Number: _____

f. Are you a US Citizen? ___ Yes ___ No. If no, please indicate your status and the date of entry into the US.

g. Limits of liability requested:

\$ _____ each claim \$ _____ aggregate \$ _____ deductible

Effective Date (12:01AM): _____

h. Solo Practitioner (uninc.) Solo Practitioner (inc.) Professional Corporation Professional Association

Partnership Employee of _____
Give name of Employer

i. If you practice other than as an employee OR an unincorporated solo practitioner ONLY:

- (i) Please list the names of ALL your partners, your employees, or members of your professional association or corporation who practice medicine.
- (ii) Formal corporate, association, partnership or business name.
- (iii) Please attach a copy of your letterhead.

j. Please list the states in which you practice and provide your respective license numbers:

<u>State</u>	<u>License Number</u>
_____	_____
_____	_____
_____	_____
_____	_____

Applicant's Name: _____

k. Please list the hospitals where you are currently on staff and indicate the percentage of work at each hospital:

<u>Hospital</u>	<u>Percentage of Work</u>
_____	_____
_____	_____
_____	_____

l. Briefly describe the type and extent of your hospital privileges: _____

m. Are you "chief of" or "head" of any hospital department? ____ Yes ____ No

n. Do you or the firm indicated in question 1 (i) above own (either wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? ____ Yes ____ No. If yes, please provide a detailed explanation specifically including the name, location, size and number of beds.

2. APPLICANT EDUCATION

a. Please provide the name and address of the medical school(s) that you attended, indicating the degree(s) received and the year they were attained: _____

b. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? ____ Yes ____ No. If yes, please state the year of your certification and describe your medical degree.

c. Did you complete any residency programs? ____ Yes ____ No. If yes, please provide a detailed explanation specifically including the type of residency program, the dates of each program, and the location and facility where they were served.

d. Have you received any additional medical training? ____ Yes ____ No. If yes, please provide an explanation specifically detailing the type of medical training, where the training was received, and the time period in which it was obtained.

e. Are you American Board certified? ____ Yes ____ No. If yes, please indicate the medical specialty in which you are certified, your date of certification and any recertification dates.

f. Please provide a detailed summary of where you have practiced your profession since completing your training.

g. Are you a member of any professional societies? ____ Yes ____ No. If yes, please provide information regarding your membership(s).

h. Have you participated in any continuing medical education program(s) within the past five (5) years? ____ Yes ____ No. If yes, please provide a detailed explanation.

i. Do you or the firm named in Question 1(i) above own, operate, or provide professional services for any health care facility or business enterprise not already clearly described in this application? ____ Yes ____ No. If yes, please attach a detailed explanation.

3. APPLICANT PRACTICE

a. What is your medical or surgical specialty: _____

b. Do you limit your practice to the above specialty? ____ Yes ____ No

c. Do you have a sub-specialty? ____ Yes ____ No. If yes, please provide a detailed explanation.

Applicant's Name: _____

d. Do you perform one of or more of the following procedures? Please check all that apply and provide a detailed explanation for all items checked including the name and location of the offices, hospitals, or centers where the procedures are performed.

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Endoscopic procedures (other than Sigmoidoscopy or proctoscopy) | <input type="checkbox"/> Chemabrasion |
| <input type="checkbox"/> Catheterization (other than swan-ganz, umbilical cord, urethral catheterization, or arterial line in a peripheral vessel) | <input type="checkbox"/> Dermabrasion |
| <input type="checkbox"/> Dilatation and Curettage | <input type="checkbox"/> Hair transplants or suturing of hairpieces |
| <input type="checkbox"/> Needle biopsies | <input type="checkbox"/> Mohr micrographic surgery |
| <input type="checkbox"/> Electroshock therapy or hypnosis | <input type="checkbox"/> Acupuncture (for analgesia) or acupuncture anesthesia |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Prenatal care and normal deliveries |
| <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Home deliveries |
| <input type="checkbox"/> Myelography | <input type="checkbox"/> Supervise midwives |
| <input type="checkbox"/> Phenmoencephalography | <input type="checkbox"/> Radial keratotomy |
| <input type="checkbox"/> Interventional radiology | <input type="checkbox"/> Hexagonal keratotomy |
| <input type="checkbox"/> Percutaneous transluminal angioplasty or embolization | <input type="checkbox"/> Any minimal incision surgery |
| <input type="checkbox"/> Radiation therapy (including radium transplants) | <input type="checkbox"/> Surgery (other than incision of boils and superficial abscess or suturing skin and superficial fascia) |
| <input type="checkbox"/> Cosmetic plastic surgery (cosmetic body contouring implants, injections and/or blepharopigmentation) | <input type="checkbox"/> Non-spontaneous abortions (1 st or 2 nd trimester) |
| <input type="checkbox"/> Open reduction of fractures | <input type="checkbox"/> Sterilization procedures |
| <input type="checkbox"/> Hysterectomies | <input type="checkbox"/> Spinal surgery (including chemonucleolysis and/or percutaneous lumbar discectomy) |
| <input type="checkbox"/> Laparoscopic hystertomies | <input type="checkbox"/> Administer Anesthesia (general spinal or caudal block) |
| <input type="checkbox"/> Tonsillectomies | <input type="checkbox"/> Cholecystectomies |
| <input type="checkbox"/> Adenoidectomies | <input type="checkbox"/> Laparoscopic cholecystectomies |
| <input type="checkbox"/> Weight reduction surgery | <input type="checkbox"/> Caesarian sections |
| <input type="checkbox"/> Experimental research, surgical research, or experimental therapy in human patients | <input type="checkbox"/> Organ transplantations |
| <input type="checkbox"/> Sex change operations | <input type="checkbox"/> Other surgery _____ |

- e. Do you perform surgery in your office? Yes No. If yes, please describe the surgical procedure.
- f. Do you perform surgery in non-hospital facilities? Yes No. If yes, please indicate the facility and describe the surgical procedure.
- g. Is general anesthesia administered for any of the surgeries performed in Questions 3(e) and 3(f)? Yes No. If yes, please indicate whether the anesthesia is administered by you or by an anesthesiologist.
- h. Do you assist in surgery either on your own patients or on the patients of others? Yes No.
- i. Do you perform any hospital emergency room care? Yes No. If yes, please provide a detailed explanation specifically indicating the approximate hours per month spent in emergency room care, whether it is a requirement for staff privileges, and whether this care is for only your own patients.
- j. Does your practice include plastic surgery? Yes No. If yes, what percentage of the practice is devoted to traumatic surgery and cosmetic surgery.
- k. Does your practice include weight reduction or control (other than by diet-exercise)? Yes No. If yes, please provide a detailed explanation including the percentage of patients that are specifically weight control patients, whether you dispense any drugs and the names of the drugs, and whether you use injections for weight control and a list of the drugs injected.

Applicant's Name: _____

1. (i) Please list the number and type of professional employees in your practice. If NONE, state none.

_____ Physicians (other than yourself)	_____ Surgeon's Assistants *
_____ Nurse Practitioners *	_____ Physician's Assistants *
_____ Nurse Anesthetists	_____ Other _____

* Describe duties in detail, including extent supervised, on separate sheet

(ii) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ___ Yes ___ No If no, please attach a detailed explanation.

m. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hour walk-in clinic or birthing center? ___ Yes ___ No. If yes, please provide a detailed explanation, including the location of the center.

n. What is your average patient load? _____ Please provide information for number of patients weekly and number of patients annually. _____

o. What is the average number of hours devoted to your practice each week? _____

p. Do you anticipate any changes in your practice within the next year? ___ Yes ___ No. If yes, please explain.

q. What is the approximate gross annual income from your practice? (Please check one).

<input type="checkbox"/> less than \$50,000	<input type="checkbox"/> \$50,000 to \$99,999	<input type="checkbox"/> \$100,000 to \$149,999
<input type="checkbox"/> \$150,000 to \$199,999	<input type="checkbox"/> \$200,000 or more (please estimate)	<input type="checkbox"/> Other _____

r. Please list prior professional liability insurance carried for each of the past five (5) years. If NONE, state none.

Insurance Co.	Policy #	Limits of Liability	Premium	Inception MM/DD/YY	Expiration MM/DD/YY	Was this a Claim Made Policy For		Retro Date
						Yes	No	
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

s. Do you supervise any individuals other than your own employees? ___ Yes ___ No. If yes, please provide a detailed explanation of their responsibilities and the relationship to the entity which employees these individuals.

t. Please indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	X-ray Technicians
_____	Laboratory Technicians	_____	Other _____

4. APPLICANT AFFILIATIONS

a. Are you in the employ of any individual, firm or corporation other than your own? ___ Yes ___ No. If yes, please provide a detailed explanation including details of your responsibilities.

Applicant's Name: _____

- b. Are you under contract to any individual, firm or corporation other than your own? Yes No. If yes, please provide a detailed explanation including details of your responsibilities. (If your contract contains a hold-harmless agreement, a copy of the contract must be attached to this application.)
- c. Are you in the employ of, or under contract to, any governmental entity? Yes No. If yes, please provide a detailed explanation including details of your responsibilities.
- d. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? Yes No. If yes, please submit a copy of your advertisement.
- e. Are you associated with any agency or organization that engages in advertising for, or solicitation of, patients? Yes No. If yes, please submit a copy of ALL advertisements.

5. CLAIMS

(Attach a detailed explanation for any "yes" answers.)

- a. Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Yes No. Attach a copy of the Complaint and Consent Order, if applicable.
- b. Have you ever been convicted for an act committed in violation of any law or ordinance? Yes No
- c. Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required that you be evaluated for any alleged mental condition and/or alcohol or drug addiction? Yes No
- d. Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No
- e. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? Yes No
- f. Have you ever failed any medical licensing or specialty organization examination? Yes No
- g. Do you have any chronic physical illness or defect? Yes No
- h. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? Yes No. If yes, complete a Supplemental Claim Information form.
- i. Has any claim or suit for alleged malpractice been brought against you? Yes No. If yes, complete a Supplemental Claim Information form.
- j. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? Yes No. If yes, complete a Supplemental Claim Information form.

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy.

Applicant's Name: _____

I hereby authorize the release of claim information from any prior insurer to Campania Insurance Agency, Inc.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

Application MUST be currently signed and dated to be considered for quotation.