**Issuing Company:**



**The Medical Protective Company**

**Fort Wayne, Indiana**

**HOSPITAL PHYSICIANS (SHORT FORM) APPLICATION**

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| **INSTRUCTIONS** |

1. Please answer all questions. If a question is not applicable, print, “n/a”.
2. This application must be completed and signed by an authorized officer of the applicant.
3. If additional space is needed, please use the Supplemental Information section at the end of the application and refer to the question or an additional form.

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| **I. APPLICANT INFORMATION** |

Applicant Name

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| **II. COVERAGE** |

1. **On the chart below, please indicate the coverages, limits and deductibles requested:**

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| **Coverage**  Coverage is provided on a limited duty and scope basis unless otherwise requested. | **Requested Per Events Limits** | **Requested Aggregate Limits** | **Occurrence or Claims-Made** | **Retro Date**  **(if applicable)** | **Shared or Separate Limits** | **Deductible or Self-Insured Retention (SIR) Limit** |
| **Professional Liability Employed or Contracted Physicians** (Physician, Surgeons, Residents, Interns, Fellows, Dentists and Oral Surgeons) |  |  | Occurrence  Claims-Made |  | Shared Limits  Separate Limits | Ded  SIR |

**B. The Indiana Patient Compensation Fund (“Fund”) retroactive date if different than the retroactive date identified above.**    /    /

MM DD YYYY

**C. Is the applicant aware of any gaps in Fund coverage?** Yes No

If yes, please provide exact dates and explain:

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| **III. EXPOSURES** |

**PHYSICIAN/SURGEON**

1. **Please provide the information below for each physician, surgeon, resident, intern, fellow, dentist and oral surgeon for whom coverage is to be provided under this policy. If additional space is needed, please provide in spreadsheet format or on an additional piece of paper and include all information requested in the Schedule of Medical Professionals, below.**

**Please complete the Claim/Suit Information section to provide the previous 10 years loss history for each physician.**

Coverage is provided on a shared limit limited duty and scope basis unless otherwise requested. If coverage is requested for: (1) separate limits, (2) duties outside limited duty and scope, (3) state Fund/PCF compliance, or (4) prior acts, please complete the Hospital Physician Application for each. Coverage is designed to provide retroactive dates equal to the hire date of the applicant unless otherwise requested.

**Contracted independent physicians cannot share limits of liability with the hospital. Please clearly indicate on the table below, if/for whom the facility is requesting coverage for separate limit.**

Employee Status: (C)ontract; (E)mployed; (F)aculty; (R)esident

Limits: (SH) Shares limits with the facility, restricted to the named insured’s operations.

(SE) Separate limits, restricted to the named insured’s operations.

If the applicant has continued exposure from departed physicians, please include in the table below.

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| **SCHEDULE OF MEDICAL PROFESSIONALS—PHYSICIANS, SURGEONS, DENTISTS AND ORAL SURGEONS** | | | | | | | | | | | | | | |
| **Name of Medical Professional**  **Last Name, First Name, Middle Name** | **Stat-**  **us**  **(C)**  **(E)**  **(F)**  **(R)** | **State** | **County** | **Specialty ISO- Code-List all that apply. (Please see ISO Code Reference)** | **Retro Date** | **Hire Date** | **Termin-**  **ation**  **Date (if**  **applic-**  **able)** | **Number of hours per week if less than 40** | **License**  **#** | **Limits**  **(SH)**  **(SE)** | **Fund Retro Date, if different** | **Any Gaps in Fund Coverage?**  **\*** | **List any other states of practice** | **If any other states of practice, requested limits** |
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\*If yes for any physician, please provide an explanation with exact dates.

**D. Do any of the active physicians for whom coverage is being requested, perform the following procedures as part of, or in addition to, their primary specialty:**

Broncho-esophagoglgy  Yes  No If yes, please specify which physician(s):

Surgery-endocrinology  Yes  No If yes, please specify which physician(s):

Surgery-neoplastic  Yes  No If yes, please specify which physician(s):

Surgery-nephrology  Yes  No If yes, please specify which physician(s):

Laparoscopy  Yes  No If yes, please specify which physician(s):

Colonoscopy  Yes  No If yes, please specify which physician(s):

Needle Biopsy  Yes  No If yes, please specify which physician(s):

Resident – Non-Moonlighting  Yes  No If yes, please specify which physician(s):

Resident – Moonlighting  Yes  No If yes, please specify which physician(s):

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| **III. Exposures (continued)** |

**E. Are any of the physicians for whom coverage is being requested, being covered for the residency or fellowship?**  YES  NO

If yes, please specify which physician(s):

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| **IV. ISO Code Reference** |

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| Specialty | ISO Code | |
| M.D. | D.O. |
| Abdominal Surgery | 80166 | 84166 |
| Allergy—No surgery | 80254 | 84254 |
| Anesthesiology | 80151 | 84151 |
| Colon & Rectal Surgery | 80115 | 84115 |
| Cardiology (including Swan-Ganz) - No surgery | 80255 | 84255 |
| Cardiology (including Left Heart Catheterization, Epicardial Pacemakers, Electrophysiological Studies [left heart]) | 80422 | 84422 |
| Cardiology (Right Catheterization only) | 80281 | 84281 |
| Cardiovascular Surgery | 80150 | 84150 |
| Cosmetic Surgery | 80136 | 84136 |
| Dermatology—No surgery | 80256 | 84256 |
| Dermatology—Performing any of the following procedures: Liposuction, Tumescent Technique only, Deep Chemical Peels | 80282 | 84282 |
| Dermatology—Mini Facelifts with Laser, assisting in major surgery—own patients | 80294 | 84294 |
| Emergency Medicine (including major surgery) | 80157 | 84157 |
| Endocrinology—No surgery | 80238 | 84238 |
| Family/General Practice—No surgery/No obstetrics | 80420 | 84420 |
| Family/General Practice—Performing any of the following procedures: Vasectomies—own patients only; Lumbar  Epidural Steroid Nerve Blocks | 80421 | 84421 |
| Family/General Practice—Performing any of the following procedures: Prenatal practice with delivery or to term; no delivery, Tubal Ligations, Colonoscopy | 80273 | 84273 |
| Family/General Practice—including deliveries | 80273 | 84273 |
| General Surgery—No bariatric | 80143 | 84143 |
| General Surgery—Bariatric | 80148 | 84148 |
| Forensic Medicine—No surgery | 80240 | 84240 |
| Gastroenterology—No surgery | 80241 | 84241 |
| Gastroenterology—Performing any of the following procedures: Colonoscopy, Endoscopic Biopsy, Upper GI Endoscopy - ERCP, Gastrostomy (PEG tube replacement), Upper GI Endoscopy - Duodenoscopy | 80274 | 84274 |
| Geriatrics—No surgery | 80243 | 84243 |
| Gynecology—No surgery | 80244 | 84244 |
| Gynecology—Major surgery | 80167 | 84167 |
| Hand Surgery | 80169 | 84169 |
| Head & Neck Surgery | 80170 | 84170 |
| Hematology/Oncology—No surgery | 80245 | 84245 |
| Infectious Disease-No surgery | 80246 | 84246 |
| Internal Medicine—No surgery | 80257 | 84257 |
| Internal Medicine—Performing any of the following procedures: Gastrointestinal Endoscopy, Colonoscopy, Endoscopic Biopsy | 80284 | 84284 |
| Neonatology—No surgery | 80471 | 84471 |
| Nephrology—No surgery | 80260 | 84260 |
| Neurology—No surgery | 80261 | 84261 |
| Neurology—Performing any of the following procedures: Lumbar Epidural Steroid-Nerve Blocks, Myelography,  Angiography, Arteriography | 80288 | 84288 |
| Neurosurgery– Neurosurgeons (Craniotomy, Laminectomy, Spinal Fusions) | 80152 | 84152 |
| Nuclear Medicine—No surgery | 80262 | 84262 |
| Nutrition—No surgery | 80248 | 84248 |
| Obstetrics/Gynecology | 80153 | 84153 |
| Occupational Medicine—No surgery | 80233 | 84233 |
| Ophthalmology—No surgery | 80263 | 84263 |
| Ophthalmology—Performing any of the following procedures: Ectropion/Entropian repair, Excision of growths in area of eyes and lids | 80289 | 84289 |
| Ophthalmology—Performing any of the following procedures: Cataract Surgery, Blepharoplasty, Lasik/Refractive Surgery | 80114 | 84114 |
| Orthopedic Surgery—Exclude back | 80176 | 84176 |
| Orthopedic Surgery—Include back | 80154 | 84154 |
| Otorhinolaryngology—No surgery | 80265 | 84265 |
| Otorhinolaryngology—Performing any of the following procedures: Endoscopic Biopsy, Lymph Node Excision, Hair Transplants (Follicular Unit Transplantation) | 80291 | 84291 |
| Otorhinolaryngology—Assisting in surgery on other than own patients | 80117 | 84117 |
| Otorhinolaryngology—Performing any of the following procedures: Rhinoplasty, Reconstructive Blepharoplasty,  Tonsillectomy & Adenoidectomy, Reconstructive Cleft Plate surgery, Mastoidectomy | 80159 | 84159 |
| Pain Management | 80295 | 84295 |
| Pathology—No surgery | 80266 | 84266 |
| Pediatrics—No surgery | 80267 | 84267 |

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| **IV. ISO Code Reference (continued)** |

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| Specialty | ISO Code | |
| M.D. | D.O. |
| Pediatrics—Performing any of the following procedures: Colonoscopy, Upper GI Endoscopy - ERCP, Upper GI  Endoscopy - Esophagoscopy | 80293 | 84293 |
| Physiatry-No surgery | 80235 | 84235 |
| Plastic Surgery | 80156 | 84156 |
| Psychiatry—No surgery (including child) | 80249 | 84249 |
| Radiology—Diagnostic (including Teleradiology) | 80280 | 84280 |
| Radiology—Therapy | 80425 | 84425 |
| Radiology—(including Mammography) | 80472 | 844272 |
| Rheumatology—No surgery | 80252 | 84252 |
| Thoracic Surgery | 80144 | 84144 |
| Traumatic Surgery | 80171 | 84171 |
| Urgent Care—No surgery/No ER | 80102 | 84102 |
| Urology | 80145 | 84145 |
| Vascular Surgery | 80146 | 84146 |

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| **V. CLAIM/SUIT INFORMATION** |

For **each physician** complete this form for **each claim**.

Please complete the questions below for all **(1) Open and; (2) Closed claims covering the past ten (10) years**. All claims must be first dollar/ ground up, and if possible, sent electronically. Only provide the claims information on those claims which are not being handled directly by The Medical Protective Company.

Note: Additional documentation (office/hospital records) may be requested at the underwriting department’s discretion. All fields must be completed.

**Claim Number:**

**A. Patient/Claimant Name:** **Age:**

**B. Date of treatment and/or surgery, which led to the allegations against the applicant:**    

MM YYYY

**C. Date claim/incident notice received:**    

MM YYYY

**D. Has this claim/incident been reported to the applicant’s current or former insurer?**  YES  NO

If Yes, provide the date the claim was reported to the applicant’s current or former insurer:    

*Please provide a copy of the report(s).* MM YYYY

**E. Name of doctor(s), healthcare provider(s) or other hospital(s) if any, involved in the claim or suit:**

**F. Defending insurance carrier name:**

**G. Was a suit filed?**  YES  NO

**H. Indicate case or reserve value established by carrier, if known:** $

**I. Disposition or current status of claim or suit:**  OPEN  CLOSED

**If closed**, date of closing/settlement or award:    

MM YYYY

**If closed**, was payment made?  YES  NO

If No, was claim or suit withdrawn?  YES  NO

If Yes, indicate total amount of settlement or award: $

Was this matter closed with the applicant’s consent?  YES  NO

**If open**, has settlement been offered?  YES  NO

**If open**, has trial date been set?  YES  NO

Trial date:    

MM YYYY

**J. Nature of allegations in the claim or suit:**

Condition treated:

Treatment provided:

Alleged negligence:

Alleged injury:

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| **V. CLAIM/SUIT INFORMATION (continued)** |

**K. Please provide a narrative description of the medical facts: (must include, at a minimum, the type of treatment and/or surgery including the applicant’s level of involvement).**

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| **VI. IMPORTANT NOTICE** |

This insurance may contain claims-made and reported coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date which are reported to the Company during the policy period or any applicable extended reporting period. Please read and review the policy carefully.

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| **VII. FRAUD NOTICE** |

**MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:**

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 ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT

INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, WHICH MAY INCLUDE Initial Here

VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

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| **VIII. PLEASE READ AND SIGN** |

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity’s behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company’s receipt of the applicant’s acceptance of the Company’s quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

**This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.**

           

Signature of Officer or Authorized Representative Title Date

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| **IX. SUPPLEMENTAL INFORMATION** |