If previously covered with National Fire & Marine, please enter the policy number: _ _____

NATIONAL FIRE & MARINE INSURANCE COMPANY

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

Application Instructions

A. If additional space is needed, please add additional pages as necessary. Supplemental Information with a reference to the question.

B. ***Additional documentation may be requested by the company as necessary*.** For example: A copy of your most recent professional liability policy, including all endorsements, Declarations Page, etc.

C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

I. General Information

A.

Last Name

First Name (Full)

Middle Name | Suffix | Date of Birth MM/DD/YYYY | ☐ Male ☐ Female

Social Security Number (Optional) | National Provider Identifier Number

Business Phone | Business Fax | Residence/Cell Phone

Email address:

B. If you have a web address, please provide the website address (URL): _____

C. Residence Address:

Number & Street | Apartment #

City | State | Zip Code

D. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, Telemedicine or Internet Medicine? ☐ Yes ☐ No

(If this is covered by another professional liability insurance policy, complete Section IV., Question H.)

If yes, which state(s): ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

E. States in which you hold a license to practice medicine:

(Exclude state abbreviation from license number.)

Please check the appropriate box to indicate the status of your license.

			Active	Inactive	Temporary	Pending
1. State		License #	☐	☐	☐	☐
2. State		License #	☐	☐	☐	☐
3. State		License #	☐	☐	☐	☐
4. State		License #	☐	☐	☐	☐

III. Practice Information (continued)

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.

****Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.****

F. What is your present specialty? _____ ____ **% of total practice**

What is your sub-specialty? _____ ____ **% of total practice**

G. Are you permanently retired from the practice of clinical medicine? ☐ Yes ☐ No

H. American Board Certified? ☐ Yes ☐ No _____ Specialty Board ____/____ Date most recently certified

_____ Specialty Board ____/____ Date most recently certified

If not American Board Certified, are you board eligible? ☐ Yes ☐ No If yes, when do you plan on taking your boards? ____/____ MM YYYY

If not American Board Certified, have you ever taken a specialty board examination and failed to pass? ☐ Yes ☐ No

If yes, how many times? ____

If yes, please explain: _____

I. Indicate the estimated average weekly numbers, under each of the following categories, for which you require National Fire & Marine coverage.

Hours per week ____ Patients seen per week ____ None ☐ Unscheduled walk-in patients per week ____ None ☐

J. Please check any of the following procedures you will perform:

☐ Abdominoplasty - Tummy Tuck
☐ Abortions- Elective _____% of total practice
☐ Abortions- Therapeutic _____% of total practice
☐ Acupuncture - Therapeutic/Local Anesthetic
☐ Anesthesia General/Spinal/Caudal
☐ Angiography
☐ Angioplasty
☐ Arteriography
☐ Arthroscopy
☐ Assisting in major surgery - own patients only
☐ Assisting in major surgery - own & other than own patients
☐ Bariatric Surgery - Laparoscopic
☐ Bariatric Surgery - Non-Laparoscopic
☐ Biopsy - Endoscopic
☐ Blepharopigmentation - _____ % of total practice
☐ Blepharoplasty - Cosmetic _____ % of total practice
☐ Blepharoplasty - Reconstruction ____ % of total practice
☐ Botox _____ % of total practice
☐ Brachioplasty
☐ Breast Implants - Cosmetic _____ % of total practice
☐ Breast Implants - Reconstruction ___ % of total practice
☐ Breast Reduction - Cosmetic
☐ Bronchoscopy
☐ Bronco-esophagology
☐ Buttock Implants
☐ Calf Implants
☐ Cataract Surgery
☐ Catheterization - Left Heart
☐ Catheterization - Right Heart (other than CVP lines)/ Swan Ganz
☐ Cheek/Chin/Lip Implants
☐ Chelation Therapy
☐ Chemical Peels - Superficial / Medium
☐ Chemical Peels - Deep _____% of total practice
☐ Cleft Lip Surgery - Reconstructive
☐ Cleft Palate Surgery - Reconstructive
☐ Colonoscopy
☐ Cryosurgery (Cervical)
☐ Cryosurgery (non-external lesions)
☐ D & C
Discectomy
☐ Open
☐ Other Than Open
☐ Electromagnetic Therapy
☐ Electroconvulsive/Shock Therapy
☐ Embolization
☐ ERCP
☐ Face Lifts
☐ Face Lifts Mini (done with laser)__% of total practice
☐ Gastrointestinal Endoscopy
☐ Gynecology - Major Surgery
☐ Hair Transplants - Follicular Unit Transplantations
☐ Hair Transplants - Other
☐ HVLA on the cervical spine on patients younger than 18 years of age
☐ Intrathecal Pumps
☐ Kyphoplasty
☐ Laparoscopic Cholecystectomy
☐ Laparoscopy
☐ Laser Surgery
☐ Laser Therapy (Endoscopic)
☐ Laser Therapy (Non-Endoscopic)
☐ Lipoinjection _____% of total practice
Liposuction
☐ Other Than Tumescent Technique
☐ Tumescent Technique Only___% of total practice
☐ Lithotripsy
☐ Lymphangiography
☐ Mammograms
☐ Myelography
Nerve Blocks
☐ Facet
☐ Lumbar Epidural Steroid
☐ Myofascial
☐ Occipital
☐ Paraspinal/Paravertebral
☐ Peripheral
☐ Sciatic
☐ Triggerpoint Injection
☐ Oxidation Therapy
☐ Pacemakers - Epicardial
☐ Pacemakers - Endocardial
☐ Pacemakers - Temporary
☐ Peritoneoscopy
☐ Phlebography
☐ Pneumoencephalography
☐ Polypectomy
Prenatal /Gynecological Practice
☐ Prenatal Practice - 1st & 2nd Trimester
☐ Prenatal Practice - to term, no delivery
☐ Prenatal Practice - to term, and delivery
☐ Normal Deliveries - total per year _____
☐ Cesarean Deliveries - total per year____
☐ Prolotherapy
☐ Radial/Laser Keratotomy
☐ Radiation/X-Ray Therapy
☐ Rectal Ozone Therapy
☐ Rhinoplasty _____% of total practice
☐ Sigmoidoscopy - 60 cm or less
☐ Sigmoidoscopy - greater than 60 cm
☐ Silicone Injections__ % of total practice
Skin Flaps/Grafts
☐ Cosmetic _____% of total practice
☐ Reconstruction __% of total practice
☐ Spinal Cord Stimulators
☐ Thigh Lift
☐ Tubal Ligations
☐ Upper GI Endoscopy
☐ Vasectomies - own patients
☐ Vasectomies - own & other than your own patients
☐ Weight Control Medication
% of total practice
☐ Other Medical Techniques

List Procedures (do not restate your specialty)

_____

III. Practice Information (continued)

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

____ % Cardiac	____ % Orthopedic (including back)	____ % Thoracic
____ % Gynecology	____ % Orthopedic (not including back)	____ % Traumatic
____ % Hand	____ % Otolaryngology	____ % Urology
____ % Neurosurgery	____ % Plastic (cosmetic enhancement only)	____ % Vascular
____ % Obstetrics	____ % Plastic (reconstruction only)	____ % Other (Describe) _____
____		_____

L. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.) ☐ Yes ☐ No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.) ____ hrs

2. On average how many of the above hours are you working in order to fulfill staff privilege requirements? ____ hrs

(If you have emergency room activities which are covered by another professional liability insurance policy, please complete Section IV, Question H.)

IV. Additional Professional Information (continued)

M. Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, are you a(n): ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

N. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date: ____ / ____ (MM / YYYY) _____

O. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date: ____ / ____ (YYYY) _____

P. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date: ____ / ____ (MM / YYYY) _____

. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? ☐ Yes ☐ No
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: _____

_____

Date(s) of treatment(s): **From:** ____ / ____ (MM / YYYY) **To:** ____ / ____ (MM / YYYY) ☐ Currently in treatment

Name of treating physician(s): _____

Address(es): _____

V. Loss Information (Important! Please fully complete.)

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below that has **NOT** been covered by a NF&M policy.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? ____ None ☐

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to, the following:

Amputation Death Loss of major organ function Loss of vision Permanent neurological injury

If **yes**, how many? ____ None ☐

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?

If **yes**, how many? ____ None ☐

VI. Practice Organization Information

Please provide the number of practice organizations of which you are an employee, shareholder/partner or independent contractor: ____

Please provide details below for your primary practice organization. If you indicated more than one organization above, please complete a Practice Organization Supplement for each one.

A. Employment status:

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date joined: ____ / ____ / ____
MM DD YYYY

VII. Coverage Information

A. Requested Coverage Period (12:01 am): **From:** ____ / ____ / ____ **To:** ____ / ____ / ____
Annual policy term will begin and end on the same month and day. MM DD YYYY MM DD YYYY

B. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer: _____

☐ Occurrence ☐ Claims-Made From: ____ / ____ / ____ To: ____ / ____ / ____
MM DD YYYY MM DD YYYY

2. Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: ____ / ____ / ____ To: ____ / ____ / ____
MM DD YYYY MM DD YYYY

3. Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: ____ / ____ / ____ To: ____ / ____ / ____
MM DD YYYY MM DD YYYY

C. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your requested retroactive date.

VIII. Assignment of Right to Cancel Coverage

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? ☐ Yes ☐ No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-800-398-6726 or sending written notice to National Fire & Marine Insurance Company, 3024 Harney Street, Omaha Nebraska, 68131-3095

Initial Here

Name: _____

Street: _____ Suite: _____

City: _____

State: _____ Zip Code: _____ Phone Number: _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

IX. Notices and Agreements

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments **(hereinafter "Attachments")** for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with National Fire & Marine Insurance Company (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me 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. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

_____ Date Signed: ___ / ___ / _____
Applicant's Signature MM DD YYYY

_____
Print Name

If application is being signed by the applicant's agent: By my signature, I hereby represent that the applicant has granted me full authority to execute this application on his or her behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that applicant understands and agrees that such representations are binding upon him or her, even though I am executing this application on the applicant's behalf. I further acknowledge that any material misrepresentation or omission made on this application may form the basis for the company to terminate my agency agreement with cause.

_____ Date Signed: ___ / ___ / _____
Agent's Signature MM DD YYYY

_____
Print Name

NATIONAL FIRE & MARINE INSURANCE COMPANY

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at National Fire & Marine Insurance Company's discretion.

A. Is the matter related to: **A** ☐ **B** ☐ **C** ☐ **from the Loss Information section? (Check only one)**

A. Current or prior claim.

B. Complication, incident, or adverse outcome.

C. Written request for records.

B. Patient/Claimant Information:

Last Name _____ First Name _____ Age _____

C. Date of treatment and/or surgery which led, or could lead, to allegations against you. ___ / ___ (MM / YYYY)

D. Date of notice received, if applicable. ___ / ___ (MM / YYYY)

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer: ___ / ___ (MM / YYYY)

Current or former insurer name: _____

If no, please explain: _____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ _____

If closed:

1. Date of closing: ___ / ___ (MM / YYYY)

2. Was a payment made? ☐ Yes ☐ No

a. If yes, did you consent to the settlement? ☐ Yes ☐ No

b. Total amount of settlement or award: $ _____

c. Total amount of settlement or award paid on your behalf: $ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

_____

_____

_____

_____

_____