eKo Specialty Insurance Services, Inc.

www.eKoSpecialty.com

Please e-mail completed and signed application to: eKo@eKoSpecialty.com

Physicians and Surgeons Professional Liability Application

1. **Full Name of Applicant:** _____

2. **Principal Office Address:** _____
_____

3. **Home Address:** _____
_____

4. **Social Security #:** _____ **DEA #:** _____

5. **List the States and License Numbers where you practice:** _____
_____

6. **Date of Birth:** _____ **Place of Birth:** _____

7. **Are you a U.S. Citizen? _____ Yes _____ No If NO, please indicate your status and date of entry into the United States:** _____

8. **What is your medical or surgical specialty:** _____
What percentage of your practice is dedicated to this specialty? _____

9. **What is your sub-specialty:** _____
What percentage of your practice is dedicated to this specialty? _____

10. **Do you limit your practice to the above specialties? _____ Yes _____ No If No, what other specialties do you practice? Provide details.** _____
_____

11. **Are you American Board certified? _____ Yes _____ No**
Medical Specialty: _____ **Date Certified:** _____
Medical Specialty: _____ **Date Certified:** _____

12. **Type of Practice (check all that apply)**
_____ Individual _____ Employee _____ Member of Multi-person Corp or Assoc
_____ Individual Corporation _____ Partnership _____ Other _____

13. **What is your total annual revenue?** **____ $100,000 or less** **____$250,001-$499,999**
____ $100,001 - $250,000 **____$500,000 or more**

14. **Please provide the names of all facilities that you practice at and your interest in each facility.**

Name of Clinic or Facility and Location	**Interest (Owner, Partner, Employee?)**

***Attach a separate attachment if necessary.**

15. **Are you seeking coverage for your work at all of the above facilities? _____ Yes _____ No If No, please list those facilities for which you do not require coverage and explain why coverage isn't needed.** _____
_____
_____

16. Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.

	Employed	Contracted	Carry their own Med Mal policy?
Physicians Assistants	_____	_____	____ Yes ____ No
Nurse Practitioners	_____	_____	____ Yes ____ No
Surgical Technicians	_____	_____	____ Yes ____ No
CRNA's	_____	_____	____ Yes ____ No
Chiropractors	_____	_____	____ Yes ____ No
Nurse Practitioners	_____	_____	____ Yes ____ No
RN's	_____	_____	____ Yes ____ No
LPN's, Nurse Aides	_____	_____	____ Yes ____ No
Other: _____	_____	_____	____ Yes ____ No
Other: _____	_____	_____	____ Yes ____ No

***Please attach copies of dec pages on above professionals that carry their own malpractice policies.**

17. Are all of the above individuals licensed in accordance with applicable state and federal regulations?
_____ Yes _____ No <u>If NO, please attach explanation.</u>

18. List the hospitals at which you are currently a staff member: _____
_____
_____

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

20. Are you the Chief or Head of a hospital department? _____ Yes _____ No If YES, which department(s):
_____

21. From what Medical School did you graduate? _____
City, State and Country of Medical School _____
Degree: _____ Year of Graduation: _____
If foreign medical school graduate, are you certified by the Educational Council for Medical School Graduates? _____ Yes _____ No. If YES, state the year: _____

22. Internship? _____ Yes _____ No If Yes, complete the following:
Location: _____ Dates: From _____ To _____
Type: _____ Completed? _____ Yes _____ No

23. Residency? _____ Yes _____ No If YES, complete the following for each:
Location: _____ Dates: From _____ To _____
Type: _____ Completed? _____ Yes _____ No
Location: _____ Dates: From _____ To _____
Type: _____ Completed? _____ Yes _____ No

24. Where have you practiced your profession since completion of training:
In _____ From _____ To _____
In _____ From _____ To _____
In _____ From _____ To _____

25. Additional Medical Training? _____ Yes _____ No If Yes, provide details including type, location, and date of training: _____
_____

26. Have you participated in any continuing medical education program(s) within the past five years?
_____ Yes _____ No If YES, please provide details: _____
_____

27. **Indicate memberships in professional societies:** _____
_____
_____

		Yes	No
28.	**Do you perform one or more of the following:**		
A.	**Endoscopic Procedures, other than sigmoidoscopy or proctoscopy. If Yes, describe:** _____ _____	_____	_____
B.	**Catheterization, other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel. If Yes, describe:** _____ _____	_____	_____
C.	**Arteriography, lymphangiography, myelography or phenmoencephalography?**	_____	_____
D.	**Interventional radiology-percutaneous transluminal angioplasty or embolization?**	_____	_____
E.	**Radiation therapy, including radium implants? If Yes, describe:** _____	_____	_____
F.	**Chemobrasion or dermabrasion?**	_____	_____
G.	**Hair Transplantation or Suturing of Hairpieces?**	_____	_____
H.	**Mohs Micrographic surgery? If YES, describe:** _____	_____	_____
I.	**Acupuncture? If YES, describe:** _____	_____	_____
J.	**Prenatal care and normal deliveries? If YES,** **Do you perform home deliveries?** **Do you only perform prenatal care?** **Do you supervise nurse midwives? If YES, when do you refer:** _____ **weeks gestation**	_____ _____ _____ _____	_____ _____ _____ _____
K.	**Dilation and curettage?**	_____	_____
L.	**Needle Biopsies? If YES, describe:** _____	_____	_____
M.	**Electroshock therapy or hypnosis? If YES, describe:** _____	_____	_____
N.	**Radial keratotomy, excimer laser PRK, LASIK or any other surgical vision correction procedure?**	_____	_____
O.	**Surgery, other than incision of boils and superficial abscesses or suturing skin and superficial fascia? If Yes, please attach a list of all surgical procedures.**	_____	_____
P.	**Non-spontaneous, induced abortions? If YES, What is maximum trimester?**_____	_____	_____
Q.	**Vasectomies or reversal of vasectomies?**	_____	_____

Do you perform any of the following? (continued)		Yes	No
R.	**Hysterectomies? If YES, do you perform laparoscopic hysterectomies?**	_____ _____	_____ _____
S.	**Cholecystectomies? If YES, do you perform laparoscopic cholecystectomies?** **If YES, how many performed as of this date: _____**	_____ _____	_____ _____
T.	**Tonsillectomies and/or Adenoidectomies?**	_____	_____
U.	**Caesarian sections?**	_____	_____
V.	**Spinal Surgery? If you also perform chemonucleolysis, check here: ____ and/or percutaneous lumbar disectomy, check here: _____**	_____	_____
W.	**Administration of general, spinal or caudal block anesthesia?**	_____	_____
X.	**Open reduction of fractures?**	_____	_____
Y.	**Organ transplantation? If YES, describe: _____** **_____**	_____	_____
Z.	**Sex Change Operations?**	_____	_____
AA.	**Weight Reduction Surgery including gastric bypass or other stomach banding procedures? If YES, which procedures? _____** **_____**	_____	_____
BB.	**Experimental research, surgical research, or experimental therapy in human patients? If YES, describe:_____**	_____	_____
CC.	**Cosmetic/Plastic Surgery? If YES, complete the following:** **Do you perform breast augmentation?** **Do you perform breast reductions?** **Do you perform liposuction? If YES, what is the maximum amount of cc's removed? _____** **Do you perform fat recycling? If YES, in what parts of the body? _____** **Do you perform vaginoplasty or labiaplasty?** **Do you use silicone implants? If Yes, in which parts of the body: _____** **Do you perform Botox injections? If Yes, in which parts of the body: _____**	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
DD.	**Penile lengthening or enhancement procedures?**	_____	_____
EE.	**Any other surgical procedures not shown above? Please describe._____** **_____**	_____	_____

***PLEASE ATTACH A LIST OF ALL SURGICAL PROCEDURES YOU PERFORM**

29. Do you perform surgery in your office? _____ Yes _____ No If YES, please list. _____

_____

_____

30. **Do you perform surgery in other non-hospital facilities? _____ Yes _____ No (If YES, what type of facility and list the surgical procedures: _____**
_____

31. **In the course of surgery does a Board Certified Anesthesiologist provide the anesthesia? _____ Yes _____ No If No, please provide details. _____**
_____

32. **Do you do any hospital emergency room work? _____ Yes _____ No If YES, Is the emergency room care:**
Only for your own patients? _____ Yes _____ No
Required for staff privileges? _____ Yes _____ No
How many hours per month: _____
Does the hospital cover you for malpractice while you work in the emergency room? _____ Yes _____ No
Are you requesting coverage for your emergency room work? _____ Yes _____ No

33. **Do you assist in surgery:**
On your own patients? _____ Yes _____ No
On patients of others? _____ Yes _____ No

34. **If your practice includes plastic surgery, specify the percentage of your practice devoted to:**
_____% Traumatic Surgery _____% Cosmetic/Elective Surgery

35. **If your practice includes weight reduction/control (other than by diet and exercise), specify the percentage of patients that are exclusively weight control: _____%.**
Do you prescribe any weight control drugs? _____ Yes _____ No If YES, list drugs prescribed. _____
_____
_____
Do you dispense supplements for weight control? _____ Yes _____ No If Yes, list supplements dispensed. ___
_____
_____
Do you use injections for weight control? _____ Yes _____ No If YES, list drugs injected:_____
_____

36.	**Have you or any of your employees:**	**Yes**	**No**
A.	**Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Attach a copy of Complaint and Consent Order document if applicable.**	_____	_____
B.	**Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?**	_____	_____
C.	**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 you be evaluated for an alleged mental condition and/or alcohol or drug addiction?**	_____	_____
D.	**Ever had any state profession license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?**	_____	_____
E.	**Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?**	_____	_____

Have your or any of your employees? (continued)		YES	NO
F.	Ever failed any medical licensing or specialty organization examination?	_____	_____
G.	Do you have any chronic illnesses or defects? If Yes, please describe. _____	_____	_____

37. Do you supervise any individuals other than your own employees? _____ Yes _____ No If YES, please provide detailed explanation of your responsibilities, relationship and whether or not these individuals have their own medical malpractice coverage: _____

_____

_____

38. Are you under contract to any individual, firm or corporation other than your own? _____ Yes _____ No **If YES, attach explanation including details of responsibilities. If this contract contains a hold harmless agreement then attach a copy of the contract language.**

39. Are you in the employ of, or under contract to any governmental entity? _____ Yes _____ No If YES, please provide details and outline your duties._____

_____

40. Do you offer professional advice to the public such as through a website, radio or TV broadcasts, newsletters, etc? _____ Yes _____ No If YES, please provide details. _____

_____

41. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? _____ Yes _____ No If YES, please provide details and attach copies of all advertising brochures.

_____

_____

42. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? _____ Yes _____ No If YES, please provide details. _____

_____

43. Average Weekly Patient Load: _____ Total Patients Annually: _____
Total surgeries performed annually: _____

44. Average number of hours worked per week: _____

45. Do you anticipate any changes in your practice? _____ Yes _____ No If YES, please describe: _____

_____

_____

46. List the prior medical malpractice insurance carried for each of the past 5 years beginning with most current:

INSURANCE COMPANY	LIMITS OF LIABILITY	POLICY PERIOD	PREMIUM	RETRO DATE

*Attach a copy of the declarations page of your most recent policy.

47. Do you own, operate or provide professional services for, or at, any health care facility or business enterprise not already clearly described in this application? _____ Yes _____ No If YES, please describe: _____

_____

48. Has any claim or suit for alleged malpractice been brought against you?_____ Yes _____ No
If YES, how many total claims or incidents: _____
Please complete the Supplemental Claim Information Form attached to this application for each and every claim. Also, please attach five years of currently valued company loss runs.

49. 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, please complete the Supplemental Claim Information Form attached to this application for each and every claim.

50. 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, please provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

_____ _____
Signature of Applicant **Date**

Please attach the following documents to this application:

- **C.V. or resume**
- **Five years of currently valued company loss runs**
- **Copies of any disciplinary actions, stipulation orders or probation documents**
- **Copies of declarations pages for all employees or contractors that carry their own med mal**
- **Copy of applicant's most current declarations page**

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

1. **Name of applicant/named insured:** _____
   _____
2. **Name of other parties or defendants named in suit:** _____
   _____
   _____
3. **Data of alleged error or occurrence, or contact date:** _____
4. **Data claim was made:** _____
5. **Name of claimant:** _____
6. **Name of Insurance Company handling your claim:** _____
7. **Present status of claim or final disposition:** _____
   _____
   _____
   Circle One: CLOSED OPEN
8. **Defense costs paid to date inclusive of any deductible:** _____
9. **If closed, total loss paid, inclusive of any deductible:** _____
10. **If claim is open or pending, what are the insurers reserves?**
    Defense: _____ **Loss:** _____
11. **Description of case and events including allegations and assessment of liability:** _____
    _____
    _____
    _____
    _____
    _____
12. **Claimants last settlement demand:** _____

_____ _____
Date **Signature**