Fill out Form, Download and
email to: rtrenchard@hcradv.com

Healthcare Risk
ADVISORS

Age Management, Stem Cell And Aesthetic Medicine

APPLICATION FOR COVERAGE – PHYSICIANS AND SURGEONS

This application is for claims made coverage. Please read the policy carefully.

1. Personal Information			
Full Name	First:		
	Middle:		
	Last:		___MD ___DO
	Date of Birth:	Social Security Number:	
Specialt(y/ies) for which you are requesting coverage:			
2. Address			
Office Address	Street:		
	City:	State:	Zip:
	Office Phone:	Office Fax:	
	Office Email:		
	Website(s):		
Home Address	Street:		
	City:	State:	Zip:
	Home Phone:	Cell Phone:	
	Email address:		
	Which is best way to contact you? ___Home ___Office ___Cell Phone		
3. Corporation Information			
Name of Corporation (if applicable):			
FEIN Number:			
Type of Corporation: ___Individual/Solo Corporation ___Partner/Shareholder/Employee			
Is there any other name under which you practice (i.e. DBA)?:			
Is your corporation requesting coverage? ___Yes ___No If yes, Shared or Separate Limits:			
Do you or your corporation have a website(s):			
4. Limits of Liability			
Texas Only:	___$200,000/$600,000	___$500,000/$1,000,000	___$1,000,000/$3,000,000
Florida Only:	___$250,000/$750,000	___$500,000/$1,500,000	
Pennsylvania Only:	___$500,000/$1,500,000		
Remainder of States:	___$1,000,000/$3,000,000		
Requested **Effective Date:**		Requested **Retroactive Date:**	
Are you purchasing tail coverage from your current carrier? ___Yes ___No If yes, please provide a copy.			

5. Medical Licensure		
State:	State:	State:
License #:	License #:	License #
Expiration Date:	Expiration Date:	Expiration Date:
DEA License #:		
Have you ever had your license revoked, refused, suspended or denied? ___Yes ___No If yes, give details:		

6. Certification			
Are you American Board Certified? ___Yes ___No	Eligible – until when?		
Name of Specialty Board(s):		Year:	Recertified:
Are you certified in: ___ACLS	Year:	Recertified:	
___ATLS	Year:	Recertified:	
___PALS	Year:	Recertified:	

7. Education/Training *(Please complete section or attach copy of most current CV)*		
Medical School:		
Location:		
Date Admitted:	Date Completed:	Degree:
Are you a Foreign Medical School Graduate? ___Yes ___No	If yes, please provide a copy of your USMLE.	
Internship - Facility:		
Location:		
Date Admitted:	Date Completed:	Specialty:
Residency - Facility:		
Location:		
Date Admitted:	Date Completed:	Specialty:
Residency - Facility:		
Location:		
Date Admitted:	Date Completed:	Specialty:
Fellowship - Facility:		
Location:		
Date Admitted:	Date Completed:	Specialty:
Fellowship - Facility:		
Location:		
Date Admitted:	Date Completed:	Specialty:
Please explain any gap in training:		
Are you entering private practice for the first time following your residency, training, military services or an academic position? ___Yes ___No		

8. Current Practice and Practice History			
Current Practice Primary Specialty:		Percentage of Practice:	
Secondary Specialty:		Percentage of Practice:	
Average number of hours worked per week?			
Average number of patients seen per week?			
Average number of Stem Cell Procedures per week?			
Average number of PRP Procedures per week?			
Percentage of practice outside of an office location; please provide details:			
Have there been significant changes in your practice in the past five-years (i.e. changes in specialty, addition or deletion of procedures)? ___Yes ___No If yes, please explain:			
Practice Locations - Please provide ten (10) years of practice history from most recent, attach additional page if necessary:			
Current Practice Locations:			
Location 1:		From:	To:
Location 2:		From:	To:
Location 3:		From:	To:
Location 4:		From:	To:
Location 5:		From:	To:
Location 6:		From:	To:
Location 7:		From:	To:
Location 8:		From:	To:
Location 9:		From:	To:
Location 10:		From:	To:
Have you ever had medical professional liability insurance declined, canceled, surcharged, nonrenewed, or issued with a deductible or other reduction in coverage? *(Not Applicable for Missouri Applicants.)* ___Yes ___No If yes, please describe:			
Do you treat celebrities or professional athletes? ___Yes ___No If yes, please describe:			
Does your practice include care at a prison, correctional facility or for inmates? ___Yes ___No If yes, please note total percentage of your practice and addresses of the facilities:			

8. Current Practice and Practice History (continued)

Do you see patients in a Nursing Home? ___Yes ___No
If yes, please note total percentage of your practice and addresses of the facilities:

Do you practice as a Hospitalist? ___Yes ___No
If yes, please note total percentage and addresses of the facilities:

Do you have another practice for which you carry separate coverage or coverage is provided for you? ___Yes ___No
If yes, please attach a copy of a declarations page or certificate of insurance.

Did you practice with other physicians in an employer-employee relationship, implied or formal partnership, professional association or Medical Corporation during the period for which you are requesting prior acts coverage? ___Yes ___No
If yes, please list the full name of the entity(ies)/physician(s) with whom you practiced and the period of each such association.

Name of Entity Name of Physician Dates: Form - To

_____

_____

_____

_____

9. Medical Staff

Do you employ/contract/supervise any of the following personnel? Indicate the number of the following non-physician healthcare providers utilized by you or your group? ___Employ ___Contract ___Supervise ___N/A

Please indicate the number of staff below:

CRNA		CNM		Laboratory Technician	
Other Physicians		Nurse Practitioner		Occupational Therapist	
Optician		Interns		Optometrist	
Orthodontist		Pharmacist		Residents	
Physical Therapist		Physician's Assistant		Podiatrist	
Fellows		Psychologist		Respiratory Therapist	
Speech Therapist		Social Worker		Audiologist/Udiologist	
X-Ray Technician		Other (please explain):			

Are you requesting the above to be covered? ___Yes ___No
If yes, should the ancillary be covered on a shared or separate limit of liability?

Are any of the above ancillary staff independent contractors? ___Yes ___No
If yes, please provide declarations page or certificate of insurance.

Do any of the ancillary staff have his/her own coverage? ___Yes ___No
If yes, please provide declarations page or certificate of insurance.

10. Additional Professional Information

Please provide a complete explanation for each question answered "Yes".

A. Has membership in any Professional Association or Society ever been refused, revoked or limited in any way? ___Yes ___No

B. Have you ever had a complaint filed, been censured or had a private reprimand with a County or State Medical Society? ___Yes ___No

C. Have you ever been treated for alcoholism, narcotic addiction or mental impairment? ___Yes ___No
If yes, please provide details of rehabilitation program including dates of treatment.

D. Have you ever been indicted, charged or convicted of a felony other than a minor traffic violation?
___Yes ___No

E. Do you work as an emergency room physician, other than for maintaining hospital privileges? ___Yes ___No
If yes, do you have separate coverage for this exposure? ___Yes ___No

F. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director or attending physician at any of the following?

___Hospital ___Sanitarium ___Nursing Home ___Surgi-Center
___Clinic ___Laboratory ___Blood Bank ___Prepaid Health Plan
___HMO ___Other Medical Facility

If you checked any of the above, please list the names of the facility and your affiliation with them:

Name	Affiliation	Who Provides Coverage for this	Limits

Do you practice medicine at the above institutions? ___Yes ___No
If yes, are you looking for coverage for this exposure? ___Yes ___No

G. Do you ever enter into arbitration or similar agreements with your patients? ___Yes ___No
If yes, please attach a copy of the agreement(s).

EXPLANATION OF QUESTION(S) ANSWERED 'YES'

11. Hospital Privileges Currently Held

Hospital Name	Location	Privileges

Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily?
___Yes ___No
If yes, please give details:

Have your hospital privileges been expanded in the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or you Specialty Board?
___Yes ___No
If yes, please explain:

12. Medical Procedures

Please check the appropriate box, indicating the extent of surgery you perform:

___ No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing or minor lacerations

___ Minor Surgery includes most procedures performed under local anesthesia

___ Assisting in Major Surgery on your own patients _____# Annually

___ Assisting in Major Surgery on patients other than your own _____# Annually

___ Major Surgery includes all procedures done under general, spinal or caudal anesthesia, and specifically includes tonsillectomy, appendectomy, D&C cesarean section, abortion and open reduction of fractures

Please check the procedures which you preform for which you are requesting coverage.
Please check any procedure you have performed in the last three years.

___ Abortion (indicate trimesters)
___ 1st___ 2nd___ 3rd

___ Acupuncture or Acupressure

___ Adenoidectomy / Tonsillectomy

___ Aesthetic Procedures - please list:

_____

_____

_____

___ Anesthesia
level___ 3___ 4 ___ 5

___ Angiography, Angioplasty, Arteriography

___ Appendectomy

___ Banding Hemorrhoids

___ Bronchoscopy

___ Cardiac Catheterization
___ Left Heart ___Right Heart

___ Cesarean Section _____# per yr

___ Chelation Therapy

___ Chemabrasion/Dermabrasion

___ Clinical Trails

___ Cosmetic Plastic Surgery or Procedures (elective) - please list:

_____

_____

_____

___ Cryosurgery

___ D&C

___ Endoscopic Procedures - please list:

_____

_____

_____

___ ERCP

___ Experimental Surgery - please list:

_____

_____

_____

___ Fertility/Infertility Treatment - please list:

_____

_____

_____

___ Bariatrics - please list:

_____

_____

_____

___ Hemorrhoidectomy

___ Hernias

___ Hysterectomy

___ Insertion of IUD

___ Laparoscopy - please list:

_____

_____

_____

___ Laser used in Therapy or Surgery - please list:

_____

_____

_____

___ Liposuction, SAL

___ Nerve Block

___ Obstetrical Deliveries at other than a licensed Acute Care Hospital

___ Pre-Natal Care
(indicate trimesters)
___ 1st___ 2nd___ 3rd

___ Pain Management (other than oral analgesics)

___ PRP Treatment

___ Laser Eye Surgery

___ Radiation Therapy

___ Reconstructive Plastic Surgery

___ Robotics Surgery

___ Shock Therapy (ECT)

___ Spinal and epidural anesthesia

___ **STEM Cell Treatment**

___ Surgical Hair Replacement

___ Telemedicine

___ Thoracic Surgery

___ Trauma Surgery

___ Tubal Ligation

___ Vascular Surgery

___ VBACS _____# per yr

___ Use of Blood or Blood By-Products that have not been tested for HIV

___ Sex reassignment or transgender surgery

___ X-Ray

13. Previous Insurance - Please provide ten (10) years of previous insurance information

Current Carrier	Effective Date:_____	Limit of Liability:_____
	Expiration Date:_____	Type of Coverage:_____
	Retroactive Date:_____	Premium:_____
Prior Carrier	Effective Date:_____	Limit of Liability:_____
	Expiration Date:_____	Type of Coverage:_____
	Retroactive Date:_____	Premium:_____
Prior Carrier	Effective Date:_____	Limit of Liability:_____
	Expiration Date:_____	Type of Coverage:_____
	Retroactive Date:_____	Premium:_____
Prior Carrier	Effective Date:_____	Limit of Liability:_____
	Expiration Date:_____	Type of Coverage:_____
	Retroactive Date:_____	Premium:_____

14. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ___Yes ___No

If yes, please complete a claim supplemental for each claim and provide prior carriers loss history.

Total Number of Claims:_____ Open/Reserved:_____ Closed:_____

Any change in your practice as a result of claims?

Warranty*

These warranties* are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy. Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by The Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by Underwriters. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

* Some state laws permit the statements on the application to be only representations. If the policy will be issued in one of these states, your statements will be representations and not warranties.

Acknowledged and Agreed:

_____

Applicant Signature Date

Signing this application does not bind Underwriters to complete the insurance. All information requested in this application is considered material and important. If Underwriters agree to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

Fraud Warnings:

Notice to Alabama Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Notice to Alaska Applicants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to California Applicants: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Notice to Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Applicants: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Applicants: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Warnings continued:

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In addition, if an insured or applicant misstates, misrepresents, omits or conceals information, and we rely on such misstatement, misrepresentation, omission or concealment and it is proven to be material to the policy or fraudulent, we may take action, including denying coverage for a claim or other covered event or rescinding, cancelling, or nonrenewing the policy or coverage.

Notice to Pennsylvania Applicants: 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.

Notice to Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Tennessee Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Washington Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Notice to West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

_____

Signature Date

_____

Printed Name Date

This application is not valid without your complete signature, date, printed name, and title above.