Submit to:
Scott Selman | Rich & Cartmill Inc | PhysicianMalpracticeQuote.com
2738 E 51st St Ste 400 Tulsa, OK 74105
Fax: 918-744-8429 Email: sselman@rcins.com

MEDICUS INSURANCE COMPANY

Application for Coverage – Physicians/Surgeons

I. Personal Information

Full Name

_____ ☐ MD ☐ DO
First Middle Last

Date of Birth: _____ Social Security Number: _____

II. Address

Office Address

_____ _____
Street City County State Zip Code

Office Phone: _____ Office Fax: _____ Office E-mail: _____

Website(s): _____

Home Address

_____
Street City County State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Which is best way to contact you? ☐ Home ☐ Office ☐ Cell Phone

III. 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? ☐ Y ☐ N If yes, Shared or Separate Limits _____

Do you or your corporation have a website(s): _____

IV. Limits of Liability

Texas Only:	☐ $200,000/$600,000	☐ $500,000/$1,000,000	☐ $1,000,000/$3,000,000
Kansas Only:	☐ $200,000/$600,000		
Indiana/Nebraska:	☐ $250,000/$750,000	☐ $1,000,000/$3,000,000	
Remainder of States:	☐ $1,000,000/$3,000,000		

Requested **Effective Date**: _____ Requested **Retroactive Date**: _____

Are you purchasing tail coverage from your current carrier? ☐Y ☐N If yes, please provide Medicus with a copy.

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V. Medical Licensure

State: _____ State: _____
License #: _____ License #: _____
Expiration Date: _____ Expiration Date: _____

DEA License Number: _____

Have you ever had your license revoked, limited, refused, suspended or denied? ☐ Y ☐ N
If yes, give details _____
_____
_____
_____

VI. Certification

Are you American Board Certified? ☐ Y ☐ N ☐ Eligible – until when? _____

Name of Specialty Board(s): _____ Year _____ Recertified _____

Have you ever failed to pass a Board Examination? ☐ Y ☐ N
If yes, give details: _____

Are you certified in ☐ ACLS ☐ ATLS ☐ PALS ☐ Other _____
Have you ever been denied certification? ☐ Y ☐ N
If yes, give details: _____

VII. Education/Training

Please complete section or attach copy of most current CV.

Medical School

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: _____

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

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VII. Education/Training (cont'd)

Fellowship

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

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

VIII. 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? _____

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)? ☐ Y ☐ N 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:_____

Historic Practice Locations:

Location 1: _____ From:_____ To:_____
Location 2: _____ From:_____ To:_____
Location 3: _____ From:_____ To:_____
Location 4: _____ From:_____ To:_____
Location 5: _____ From:_____ To:_____

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VIII. Current Practice and Practice History (cont'd)

Do you practice at a prison, correctional facility or on inmates? ☐ Y ☐ N
If yes, what is the total percentage of your practice and where are you practicing? _____

Do you see patients in a Nursing Home? ☐ Y ☐ N
If yes, what is the total percentage of your practice and where are the Nursing Homes located? _____

Do you practice as a Hospitalist? ☐ Y ☐ N
If yes, what is the percentage, and at what hospitals are you practicing as a hospitalist? _____

Do you have another practice for which you carry separate coverage or coverage is provided for you? ☐ Y ☐ N
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? ☐ Y ☐ N
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: From - To

IX. 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

		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		Audilogist/Udiologist		X-Ray Technician	
Other (please explain)							

Are you requesting the above to be covered by Medicus Insurance Company? ☐ Y ☐ N
If yes, should the ancillary be covered on a shared or separate limit of liability? _____

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

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

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X. Additional Professional Information

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

A. Has membership of any Professional Association or Society ever been refused, revoked or limited in any way? ☐ Y ☐ N

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

C. Have you ever been treated for alcoholism, narcotic addiction or mental impairment? ☐ Y ☐ N
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? ☐ Y ☐ N

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

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? ☐ Y ☐ N
If yes, are you looking for coverage for this exposure? ☐ Y ☐ N

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

EXPLANATION OF QUESTION(S) ANSWERED 'YES'

XI. Hospital Privileges Currently Held

Hospital Name	Location	Privileges

Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily? ☐ Y ☐ N
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? ☐ Y ☐ N
If yes, please explain. _____

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XII. 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

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Please check the procedures, which you perform 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
- ☐ Anesthesia - General
- ☐ Angiography, Angioplasty, Arteriography
- ☐ Appendectomy
- ☐ Banding Hemorrhoids
- ☐ Bronchoscopy
- ☐ Cardiac Catheterization ☐ Left Heart ☐ Right Heart
- ☐ Cesarean Section _____# per year
- ☐ Chelation Therapy
- ☐ Chemabrasion/Dermabrasion
- ☐ Cosmetic Plastic Surgery or Procedures (**elective**) Please list
  _____
  _____
  _____
  _____
- ☐ Cryosurgery
- ☐ D&C
- ☐ Endoscopic Procedures - Please list
  _____
  _____
  _____
- ☐ ERCP
- ☐ Experimental Surgery – Please list
  _____
  _____
  _____
  _____
- ☐ Other _____
  _____
- ☐ Fertility/Infertility Treatment
- ☐ Gastric By-Pass/Stapling or Bariatrics
- ☐ Hair Growing or Transplants
- ☐ Hemorrhoidectomy
- ☐ Hernias
- ☐ Hysterectomy
- ☐ Injection or Implants in Breasts
- ☐ Insertion of Intrauterine Contraceptive Devices
- ☐ LAP BAND Procedures ____# per year
- ☐ Laparoscopy – Please list
  _____
  _____
  _____
  _____
- ☐ Laser used in Therapy or Surgery
  Type of Laser used _____
  Please list type of therapy or surgery _____
  _____
  _____
  _____
  _____
- ☐ Liposuction, SAL
- ☐ Needle Biopsy - ☐ Breast ☐ Kidney ☐ Lung ☐ Prostrate ☐ Other
- ☐ Obstetrical Deliveries at other than a licensed Acute Care Hospital _____
  _____
- ☐ Pre-Natal Care (indicate trimesters) ☐ 1st ☐ 2nd ☐ 3rd
- ☐ Pain Management (other than oral analgesics)
  _____
  _____
  _____
  _____
- ☐ Other _____
  _____
- ☐ Radial Keratotomy, LASIK or PRK
- ☐ Radiation Therapy, -X-Ray
- ☐ Reconstructive Plastic Surgery
- ☐ Shock Therapy (ECT)
- ☐ Spinal Anesthesia
- ☐ Swan Ganz
- ☐ Telemedicine – Please list Specialty and where
  _____
  _____
- ☐ Thoracic Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vascular Surgery
- ☐ VBACS _____ # per year
- ☐ Weight Control Medicine – Please list
  _____
  _____
  _____
  _____
  _____
- ☐ Weight Control Surgery – Please list
  _____
  _____
  _____
  _____
- ☐ Administering or Injecting Silicone Fluid
- ☐ Use of Laetrile Therapy
- ☐ Use or Administration of Human Chronic Gonadotropin (HGG) in the treatment of Obesity or Weight Control
- ☐ Use of Blood or Blood By-Products that have not been tested for HIV
- ☐ Sex Change Operations
- ☐ Other _____
  _____

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XIII. 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	_____

XIV. 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? ☐ Y ☐ N

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 Medicus Insurance Company (Company) as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company 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 the Company. 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.

Acknowledged and Agreed:

_____

Applicant Signature Date

Signing this application does not bind the Company to complete the insurance. All information requested in this application is considered material and important. If the Company agrees 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.

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Fraud Warnings:

General Fraud Statement (not applicable in Colorado, Hawaii, Nebraska, Ohio, Oklahoma, Oregon, Utah and Vermont)

Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia insurance benefits may also be denied.

Notice to Colorado Applicants: **This Notice is A Part of Your Application for Professional Liability Insurance**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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 policy holder 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 Hawaii Applicants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he/she 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 any insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Notice to Utah Applicants: For your protection, Utah law requires the following to be included in this application: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state 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 **Title**

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

MEDICUS INSURANCE COMPANY

Medicus Insurance Company
SUPPLEMENT TO APPLICATION
CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ ☐ Male ☐ Female

2. Date of Incident _____ Location of Incident _____
Insurance Carrier _____ Date Reported to Insurer _____

☐ Suit ☐ Demand for Money ☐ Incident Only
☐ Notice of Intent to Sue ☐ Request for Records ☐ Other _____

3. Summary of condition/diagnosis at time of incident

_____
_____
_____
_____
_____

4. Description of treatment rendered, including dates.

_____
_____
_____
_____
_____

5. Allegation

_____
_____
_____
_____
_____

6. Other physicians or entities involved

_____
_____

7. Status/Disposition of Claim:
- ☐ Closed without indemnity payment
- ☐ Settled
- ☐ Judgment/Verdict
  - ☐ For the defense
  - ☐ For the plaintiff

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendant(s)	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

☐ Open—please provide current status and defense strategy: _____

8. Has there been a change in practice as a result of this claim(s)? ☐Yes ☐No
If yes, what has been the change? _____

_____

_____

I understand this information is part of my Application for Physician/Surgeon Medical Professional Liability Insurance.

Please print your name _____

Signature _____ Date _____