PHYSICIANS LIABILITY INSURANCE COMPANY
P.O. BOX 1838, OKLAHOMA CITY, OK 73101-1838

Submit to:

Scott Selman | Rich & Cartmill | PhysicianMalpracticeQuote.com
2738 E 51st St Ste 400
Tulsa, OK 74105
Fax: 918-744-8429

PHYSICIANS PROFESSIONAL LIABILITY INSURANCE APPLICATION

THIS FORM PROVIDES CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

☐ **Individual Policy** or **Add to a Group Policy** ☐ ***Group's policy #*** _____

Name of Group _____

SECTION 1 - GENERAL INFORMATION

1. Name of Applicant:			2. SSN:
3. Indicate other names by which you have been known. Specify the dates during which the name was used:			
4. M. D. ☐ D. O. ☐	5. Sex:	6. Place of Birth:	7. Date of Birth:
8. Office Address:			
9. Contact Person:			
10. Billing address (***if different than Office Address***) :			
11. Home Phone:		12. Office Phone:	13. Fax:
14. E-mail:		15. Web Site:	
16. Home Address:			
17. I hereby name as my insurance agent: Rich & Cartmill			

SECTION 2 - COVERAGE INFORMATION

1. Requested Effective Date: _____ 2. Requested Retroactive Date: _____

3. Requested Limits of Liability:

☐ $100,000 / $300,000 ☐ $500,000 / $1 million ☐ $1 million / $1 million
☐ $1 million / $3 million ☐ $2 million / $2 million ☐ $2 million / $4 million

4. Insurance history

Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current Year:				
1st year prior:				
2nd year prior:				
3rd year prior:				
4th year prior:				
5th year prior:				

5. Have you ever been denied professional liability insurance or has your coverage ever been non-renewed or cancelled? If "Yes", provide details on Section 15. Yes☐ No☐

6. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? If "Yes", provide details on Section 15. Yes☐ No☐

7. Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 15. Yes☐ No☐

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING

SCHOOL OR FACILITY	NAME AND LOCATION OF SCHOOL AND/OR HOSPITAL	DEGREE OR SPECIALTY	START DATE	COMPLETION DATE
Medical School:				
Internship:				
Residency:				
Residency:				
Fellowship:				
How many continuing education credits (CME's) have you completed during the past 3 years?				

SECTION 4 – LICENSURE – CERTIFICATION - ASSOCIATION

1. Oklahoma Medical License #: 2. Expiration Date:
3. Are you licensed in other states? Yes☐ No☐ State: _____ License #:_____ State: _____ License #:_____
4. Are you Board Certified? Yes☐ No☐
   If yes, name of specialty board:
5. Second Specialty Board: Date Certified:
6. Third Specialty Board: Date Certified:
7. Has your medical license in any state ever been suspended, revoked, denied, or limited? Yes☐ No☐
   If "Yes", provide details on Section 15.
8. Are you currently under investigation by any state licensing board or agency? Yes☐ No☐
   If "Yes", please explain on Section 15.
9. Medicare#: 10. Medicaid#: 12. OBN#:
13. Are you an active member of the Oklahoma State Medical Association (OSMA)? Yes☐ No☐
    A discount is applied to policies issued to OSMA members that are insured on full time basis (discount does not apply to part-time policies). If you are interested in joining the OSMA, please contact the OSMA Membership Coordinator at (405) 843-9571.
14. If you are a Doctor of Osteopathy: are you an active member of the Oklahoma Osteopathic Association? Yes☐ No☐
15. Please list any Medical Society Affiliations:

SECTION 5 – INSTITUTIONAL PRACTICE

1. Indicate the name and location (city and state) of each hospital where you currently hold staff privileges:

	NAME	LOCATION
a.	_____	_____
b.	_____	_____
c.	_____	_____

2. Has any hospital ever taken action to deny, suspend, revoke, or restrict your medical staff privileges, or your application or reapplication for medical staff privileges? Yes☐ No☐
   If "Yes", identify hospital, date, and reasons on Section 15.
3. Have you ever resigned from a hospital staff while under investigation, or to avoid possible disciplinary action? If "Yes", identify hospital, date, and give reasons on Section 15. Yes☐ No☐

SECTION 5 – INSTITUTIONAL PRACTICE (continued)

4. Has any of the following ever been denied, revoked, suspended, reduced, limited, canceled, sanctioned, placed on probation, not renewed, or relinquished for disciplinary reasons? Yes☐ No☐

   a. Oklahoma Bureau of Narcotics (OBN) or other state narcotics registration Yes☐ No☐

   b. Academic appointment Yes☐ No☐

   c. Membership on any hospital or healthcare facility medical staff Yes☐ No☐

   d. Clinical privileges, prerogatives, or rights on any medical staff Yes☐ No☐

   e. Membership in other healthcare organizations or facilities Yes☐ No☐

   f. Professional society membership or fellowship Yes☐ No☐

   g. Any other type of professional reprimand or sanction Yes☐ No☐

   h. Educational Commission for Foreign Medical Graduates (ECFMG) certification Yes☐ No☐

   i. Participation in the Medicare/Medicaid program or other government health benefits program Yes☐ No☐

SECTION 6 – CLASSIFICATION – PRACTICE

1. Check the box(es) that best describe your practice

☐ No Surgery - Includes incision of boils and superficial abscesses, or suturing of skin or superficial fascia.

☐ Minor Surgery - Any operation that involves a surgical incision into the dermis, epidermis and superficial fascia or suturing of skin or superficial fascia and does not enter below the superficial fascia or any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis.

☐ Major Surgery – Includes any operation done under general anesthesia, or any operation that presents a distinct hazard to life such as removal of tumors, reduction of open fractures, amputations, abortions, tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, abortions, vasectomies, the removal of any gland or organ, plastic or cosmetic surgery.

2. Has there been any change in your practice in the last five (5) years? Yes☐ No☐
   If "Yes", provide details on Section 15.

3. Do you plan to take additional residencies or change specialties? Yes☐ No☐
   If "Yes", provide details on Section 15.

4. Do you participate in clinical trials? Yes☐ No☐
   If "Yes", indicate what percentage of *your practice* is dedicated to clinical trials: _____
   Indicate the percentage that clinical trials represent of your *total gross receipts*: _____

5. Does your practice include locations outside Oklahoma? Yes☐ No☐
   If "Yes", indicate locations: _____
   _____

SECTION 7 – MEDICAL SPECIALTY

1. What is your present Specialty? | 2. Sub-specialty?

3. Please check the box that best describes your practice:

Aerospace Medicine	Nuclear Medicine	MAJOR SURGERY (continued):
Allergy	Nutrition	**Colon and Rectal**
Anesthesiology	Occupational Medicine	**Endocrinology**
Bronco-Esophagology	Ophthalmology	**Gastroenterology**
Cardiovascular Disease	Otology	**GP/FP not primarily engaged in major surgery**
Dermatology	Otorhinolaryngology	
Diabetes	Pain Management	**Geriatrics**
Emergency Medicine	Pathology	**Gynecology**
Endocrinology	Pediatrics	**Hand**
Family Practice (FP)	Pharmacology-clinical	**Head and Neck**
Forensic Medicine	Physiatry	**Laryngology**
Gastroenterology	Physical Medicine and Rehabilitation	**Neoplastic**
General Practice (GP)	Psychiatry	**Nephrology**
General Preventive Medicine	Psychoanalysis	**Neurology**
Geriatrics	Psychosomatic Medicine	**Obstetrics**
Gynecology	Public Health	**OB/GYN**
Hematology	Pulmonary Diseases	**Ophthalmology**
Hospitalist	Radiology – Interventional* (list procedures in Section 15)	**Orthopedic –including back**
Hypnosis	Radiology - Diagnostic	**Orthopedic – no back**
Infectious Disease	Retired	**Otology**
Intensive Care Medicine	Rheumatology	**Otorhinolaryngology**
Internal Medicine	Rhinology	**Plastic**
Laryngology		**Rhinology**
Legal Medicine	**MAJOR SURGERY:**	**Thoracic**
Neoplastic Diseases	**Abdominal**	**Traumatic**
Nephrology	**Cardiac**	**Urological**
Neurology	**Cardiovascular**	**Vascular**
Other (please identify):		

SECTION 8 – MEDICAL and SURGICAL PROCEDURES

Please check off "Yes" or "No" for each procedure or activity that you performed in the past year or will perform in the coming year. Indicate the number of procedures performed in the past year, and also indicate if you anticipate any significant changes for the coming year.

1. Minor surgery (on a regularly scheduled basis).	Yes	No	# in past year	Changes?
2. Minor surgery (on an emergency basis only).	Yes	No	# in past year	Changes?
3. Assisting in major surgical procedures on your own patients.	Yes	No	# in past year	Changes?
4. Major Surgery includes but not limited to: Tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, abortions, vasectomies and other procedures performed under general anesthesia.	Yes	No	# in past year	Changes?
5. Assisting in major surgical procedures on other than your own patients.	Yes	No	# in past year	Changes?
6. Normal obstetrical procedures	Yes	No	# in past year	Changes?
7. Obstetrical procedures, which are considered to be major surgery: C-Sections, D&C, etc.	Yes	No	# in past year	Changes?

SECTION 8 - MEDICAL and SURGICAL PROCEDURES (continued)				
8. Plastic surgery-reconstructive? (Medically necessary following surgery or trauma).	Yes	No	# in past year	Changes?
9. Plastic/Cosmetic surgery - elective? (not medically necessary)	Yes	No	# in past year	Changes?
10. Non-surgical cosmetic procedures (Dermabrasion, Botox injections, permanent micro-pigmentation, thread lifts, mesotherapy, etc.)	Yes	No	# in past year	Changes?
11. Administering general anesthesia?	Yes	No	# in past year	Changes?
12. Acupuncture	Yes	No	# in past year	Changes?
13. Angiography – venous	Yes	No	# in past year	Changes?
14. Angiography – arterial	Yes	No	# in past year	Changes?
15. Colonoscopy	Yes	No	# in past year	Changes?
16. Cryosurgery – other than use on benign or non-malignant dermatological lesions or cervix	Yes	No	# in past year	Changes?
17. Discograms	Yes	No	# in past year	Changes?
18. Endoscopic retrograde cholangiopancreatography	Yes	No	# in past year	Changes?
19. Heart Catheterization - with or without coronary angiography	Yes	No	# in past year	Changes?
20. Occasional emergency insertion of central venous recording catheters and temporary pacemakers (Swan Ganz)	Yes	No	# in past year	Changes?
21. Laparoscopy (Peritoneoscopy)	Yes	No	# in past year	Changes?
22. Laser- used in surgery	Yes	No	# in past year	Changes?
23. Lymphangiography	Yes	No	# in past year	Changes?
24. Myelography	Yes	No	# in past year	Changes?
25. Needle biopsy - including lung and prostate	Yes	No	# in past year	Changes?
26. Needle biopsy - including liver, kidney, or bone marrow biopsy	Yes	No	# in past year	Changes?
27. Phlebography	Yes	No	# in past year	Changes?
28. Pneumatic or mechanical esophageal dilation (not with bougle or olive)	Yes	No	# in past year	Changes?
29. Pneumoencephalography	Yes	No	# in past year	Changes?
30. Radiation therapy	Yes	No	# in past year	Changes?
31. Radiopaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae	Yes	No	# in past year	Changes?
32. Electro-Convulsive Shock Therapy (ECT)	Yes	No	# in past year	Changes?
33. Vascular embolization	Yes	No	# in past year	Changes?
34. Chelation therapy	Yes	No	# in past year	Changes?

SECTION 8 - MEDICAL AND SURGICAL PROCEDURES (continued)				
35. Micro or blepharopigmentation (permanent eyelash enhancement)	Yes	No	# in past year	Changes?
36. Bariatric surgery, indicate procedures:	Yes	No	# in past year	Changes?
37. Liposuction	Yes	No	# in past year	Changes?
38. Hair Transplants	Yes	No	# in past year	Changes?
39. Angioplasty	Yes	No	# in past year	Changes?
40. Circumcisions	Yes	No	# in past year	Changes?
41. Breast augmentation	Yes	No	# in past year	Changes?
42. Deliver babies	Yes	No	# in past year	Changes?
43. Surgery on the spine	Yes	No	# in past year	Changes?
44. Does your practice include *non-invasive* pain management?	Yes	No	# in past year	Changes?
45. Does your practice include *invasive* pain management? If "Yes", list procedures in Section 15.	Yes	No	# in past year	Changes?
46. Do you practice at an emergency department of a hospital or healthcare facility?	Yes	No	# in past year	Changes?
47. Are you employed in an Urgicare or Emergicare Center?	Yes	No	# in past year	Changes?
48. Do you perform office-based surgery in your professional office?	Yes	No	# in past year	Changes?
49. Are you using anesthesia including conscious sedation in your office?	Yes	No	# in past year	Changes?

SECTION 9 - Underwriting		
1. Have you ever been treated for, or do you currently have any medical and/or psychiatric problem including alcohol and/or drug dependence?	Yes☐	No☐
2. Have you been institutionalized during the past five years, or do you have a continuing health condition that requires therapy? If "Yes", provide details on Section 15	Yes☐	No☐
3. Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation according to accepted standards of professional performance and without posing a direct threat to patients?	Yes☐	No☐
4. Are you currently engaged in the illegal use of drugs, or the misuse of legal drugs? (If you are making application to a government entity, you have the right to elect not to answer this question, if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution).	Yes☐	No☐
5. Is your physical or mental health such that it may impair your ability to practice within the scope of the privileges for which you have applied?	Yes☐	No☐

SECTION 9 - UNDERWRITING (continued)

6. Date of the most recent physical exam: _____
7. Significant Findings:

8. Have you ever been charged of a crime other than a minor traffic offense? Yes☐ No☐

9. Are there any felony charges pending against you? Yes☐ No☐

10. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges, resigned from the medical staff, or surrendered your clinical privileges while under investigation or before a recommendation or decision was rendered by a hospital or health care facility's medical executive or governing board? Yes☐ No☐

11. Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)? Yes☐ No☐

12. Has your employment at a health care organization ever been terminated? Yes☐ No☐

13. Have you ever been terminated, rejected, limited, or been excluded or refused membership in a managed care organization (HMO, PPO, PHO, etc.) for a stated reason? Yes☐ No☐

14. Do you contract with any PPO, HMO or other organization involved in contract medicine? Yes☐ No☐
If "Yes", please provide the names of the healthcare plans below:

_____

_____

_____

Does the contract include an indemnity (hold harmless) agreement? Yes☐ No☐

15. Estimate of percentage of practice that involved PPO or HMO patients_____

16. Are you employed by the State of Oklahoma or any of its counties or local government office? Yes☐ No☐
If "Yes", indicate percent of time involved in private practice:

17. Are you employed by the Indian Health Services or similar organization? Yes☐ No☐
If "Yes", indicate percent of time involved in private practice:

18. Are you employed by the United States Military Service? Yes☐ No☐

19. Do you treat prisoners or jail inmates? Yes☐ No☐
If "Yes", indicate name of penal/correctional facility:

20. Has your practice been reduced because of any of the following: (Check all that may apply)
Semi-retirement ☐ Disability ☐ Pregnancy or dependent care ☐
Majority of practice conducted in a teaching role which is insured elsewhere ☐
Majority of practice insured through another entity such as an employer ☐
Maintenance of another practice insured elsewhere ☐

21. List all locations where you will practice and for which practice coverage is being applied for under this application.
Name/Address:
Hours worked per week: _____ Medical specialty:_____
Refer to Section 15 for additional space.

22. List all other locations where you will practice and for which practice coverage is NOT being applied for under this application.
Name/Address:
Hours worked per week: _____ Medical specialty:_____
Insurance carrier providing coverage at the above location:
Refer to Section 15 for additional space

SECTION 9 - UNDERWRITING (continued)

23. Do you participate in telemedicine? Yes☐ No☐

If "Yes" indicate in Section 15, in which states and what percentage of your practice is dedicated to telemedicine. For the purpose of this question, telemedicine is defined as the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient as a result of transmission of the patient's data by electronic means. Telemedicine does not include an informal consultation provided without the expectation of, or compensation, not does it include services described above which are rendered in a bona fide emergency.

24. Do you prescribe narcotics using pre-printed pads? Yes☐ No☐
If you answer "Yes", please provide a sample/specimen copy of the prescription.

25. If you are a radiologist or pathologist: do you or will you read, interpret, or diagnose films, slides, or specimens taken of patients who reside outside the state of Oklahoma? Yes☐ No☐

If "Yes", please indicate the state or foreign country where the patient resides:

SECTION 10 - PROFESSIONAL PARTNERSHIP, CORPORATION, or ASSOCIATION

1. Do you operate as a Professional : Partnership ☐ Corporation ☐ Association ☐
2. Does the professional partnership, corporation, or association with which you are currently affiliated carry separate professional liability coverage? Yes☐ No☐
3. Do you want your professional partnership/corporation/association covered under your policy, sharing the limits of liability, at no additional charge? Yes☐ No☐
4. Do you want separate limits of liability for your partnership/corporation/association, for an additional premium?. Yes☐ No☐
5. Do you own or have ownership interest in a health care facility? Yes☐ No☐
If "Yes", provide details on Section 15.

If you are requesting coverage for your professional partnership, corporation or association, please include the organization's information. Refer to Section 15 for a list of the information required.

SECTION 11 - EMPLOYEES

1. Do you, or your partnership/corporation/association employ any of the following?

Physicians	☐	Surgeons	☐	Physician Assistants	☐	CRNA's	☐
Nurse Practitioners	☐	Midwives	☐	RN's	☐	LPN's	☐
Podiatrist	☐						

Technicians:

EEG/EKG	☐	Laboratory	☐	Operating Room	☐
Physicial therapist	☐	Perfusionist	☐	Phlebotomist	☐
Radiation	☐	Radiology	☐	Respiratory	☐
X-ray	☐				

2. Complete a separate PLICO application (Physicians or Ancillary Medical Personnel) for each of the above professionals for whom individual limits of liability are desired.
3. Approximately what percent of the time do you use: Anesthesiologists: _____ CRNA's: _____
4. Do you regularly supervise more than one CRNA at the same time? Yes☐ No☐
If "Yes", how many:

SECTION 12 – CLAIMS HISTORY/ REPORT

1. Have you been involved in a professional liability claim/suit in the past ten (10) years? Yes☐ No☐

2. Have all claims/suits/incidents been reported to your current/prior professional liability carrier? Yes☐ No☐
   If "No", please explain on Section 15.

3. ***Complete the following questionnaire for all claims or incidents in which you have been directly or indirectly involved. We require ten (10) year claim or incident history/report from your current in surer with a recent valuation date, even if you have not had any claims/suits.***

Claim #	Patient's Initials	Insurance Company	Date of Loss	Date Reported	Date Closed	*Award's Amount

*Attributed to your involvement: $_____ *Paid by All Parties $ _____

What is/was your status in the case?

☐Primary Defendant ☐Co-defendant ☐Other (explain)_____

If the claim or suit is pending, when was the last contact with the Plaintiff's attorney? _____

What is/was the alleged harm to the patient? _____

_____

_____

_____

What were the allegations made against you? _____

_____

_____

_____

Describe the patient's illness and related effects of the alleged harm _____

_____

_____

Describe any other details you believe are pertinent to the case _____

_____

_____

_____

Name of other parties named in the suit: _____

_____

_____

SECTION 13 - WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted.

I UNDERSTAND that the statements and answers herein will be relied upon by Physicians Liability Insurance Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE any professional societies, prior, or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to PLICO, or to the Oklahoma State Medical Association (Association) upon the request of either. I authorize the use of a copy of this authorization in place of the original.

In order to facilitate the risk management program, I authorize **PLICO** to provide the Association with any records and information concerning claims arising under any policy or insurance issued in connection with this application.

I declare that to the best of my knowledge and belief I have reported all known incidents, claims, and suits to my previous or current carrier(s), and that I have no knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit, and no knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last 10 years that have not been reported to the applicable insurance company or risk transfer entity (self-insured retention plan).

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

Signature_____ Date_____

OKLAHOMA FRAUD 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.

SECTION 14 - COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following documents with this application.

Attach	Documentation
	Individual Applicants: attach a copy of your current policy, including the Declarations Page and all endorsements. Group Applicants: attach a copy of your Certificate of Insurance.
	Current Federal DEA Registration Certificate
	Curriculum Vitae (C.V.)
	Ten (10) years claims history/report, recently prepared, from all previous insurance companies other than PLICO (even if you have not had any claims).
	For partnership, corporate, or association coverage include: ☐ Copy of the Articles of Incorporation ☐ List of Principals or Shareholders ☐ List of all ancillary medical personnel, indicate duties and medical license ☐ Brief description of operations, if other than those consistent with your medical practice or specialty ☐ Copy of the latest Oklahoma Employers Security Commission report (OES – 3) ☐ W-9 form (IRS) ☐ 1099 (IRS)

SECTION 15 – ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please, make as many copies of this page as it may be required to fully answer all questions. As appropriate, note Section number and question number being addressed:

Section/ Question #