Medical Professional Liability Insurance—Claims-Made Physician Application

ProAssurance
Treated Fairly

ProAssurance Indemnity Company, Inc.
1221 South Mopac Expressway, Suite 200 • Austin, TX 78746 • 800.252.3628 • 512.328.0888 • Fax 512.314.4398

With your fully completed, signed and dated application, please submit the following information:

1. Current coverage verification (i.e., declaration page, certificate of insurance).
2. Written verification of the purchase of an extended reporting endorsement (tail) from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Current loss runs from prior insurance companies or explanation as to why they are not available.
5. Copy of curriculum vitae (CV).

1. Personal Information

Name: _____ Degree: _____
FIRST MIDDLE LAST

Social Security Number: _____ Date of Birth: _____ Gender: Male ☐ Female ☐

Email Address: _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Medical License Number(s):	State	License Number	Expiration Date	% of Practice
	_____	_____	_____	_____
	_____	_____	_____	_____

List all State Medical Associations you currently belong to: _____

Please provide additional license information in the space provided at the end of the application.

2. Practice Location

Practice Name: _____ Employment Date: ____/____/____
MONTH DAY YEAR

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____ Website: _____

Mailing Address: _____

Billing Address: _____

Contact Name: _____ Title: _____

Contact Email Address: _____

Please list other practice locations:

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ % of Practice: _____

Practice Name: _____

Practice Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Dates: _____ From: _____ To: _____ % of Practice: _____

Please list additional practice locations in the space provided at the end of the application.

3. Coverage Requested

A. Requested effective date: _____ / _____ / _____
MONTH DAY YEAR

B. Please indicate your desired level of coverage.
Primary Coverage Limits (Limit per Claim/Annual Aggregate Limit): _____ / _____
Excess Coverage Limits (where available): _____

C. Deductible amount (where available): $_____
☐ Indemnity Only ☐ Indemnity & Expense ☐ None

D. Do you desire coverage for a practice entity? Yes ☐ No ☐
If yes, we require a corporate application to be completed.

E. Will you be carrying additional professional liability insurance with another company? Yes ☐ No ☐

4. Prior Acts Coverage

(Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by a ProAssurance Company that your request for Prior Acts Coverage has been approved.)

A. Are you requesting Prior Acts Coverage? If no, please skip to Section 5. Yes ☐ No ☐
Retroactive Date: _____ / _____ / _____
MONTH DAY YEAR

B. During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from your current practice? (e.g., different states, procedures, coverages, etc.). Yes ☐ No ☐
If yes, please describe the changes in your practice, including all applicable dates in the space provided at the end of the application.

5. Education, Training and Certification

A. Please list the name and location of all medical schools attended:

Institution and Location	Dates Attended	Degree Obtained

B. If degree was granted from a foreign medical school, are you ECFMG certified? Yes ☐ No ☐
i. Have you ever failed the ECFMG examination? Yes ☐ No ☐
If yes, please explain in the space provided at the end of the application.

C. Please list all internships, residencies, or fellowships.

Internship

Institution Name: _____
Institution Location: _____
☐ Rotating ☐ Transitional ☐ Straight (Specialty: _____)
Dates Attended: From _____ To _____
MM/DD/YY MM/DD/YY
Did you successfully complete this program? Yes ☐ No ☐
If no, please explain in the space provided at the end of the application.

Residency

Institution Name: _____
Institution Location: _____
Specialty/Department: _____ Dates Attended: From _____ To _____
MM/DD/YY MM/DD/YY
Did you successfully complete this program? Yes ☐ No ☐
If no, please explain in the space provided at the end of the application.

Fellowship

Institution Name: _____

Institution Location: _____

Type of Fellowship: _____ Dates Attended: From _____ (MM/DD/YY) To _____ (MM/DD/YY)

Did you successfully complete this program? Yes ☐ No ☐

If no, please explain in the space provided at the end of the application.

☐ Please indicate here if you attended more than one medical/professional school or participated in additional programs to those listed above and include information in the space provided at the end of the application.

D. Are you board certified? Yes ☐ No ☐

i. If yes, please indicate which board and specialty/subspecialty:

☐ American Board of _____

☐ American Osteopathic Board of _____

ii. If not boarded, when do you plan to take your boards? _____

iii. Are you required to recertify? Yes ☐ No ☐

If yes, please provide date of recertification: _____

iv. Have you ever failed a board certification or recertification examination? Yes ☐ No ☐

If yes, how many times? _____ (Oral) _____ (Written)

E. Please indicate your current life support certification information:

☐ ACLS Certified ☐ BCLS Certified ☐ ATLS Certified ☐ PALS Certified

6. Practice Information

A. What is your present specialty? _____ % of Practice: _____

B. What is your present sub-specialty? _____ % of Practice: _____

C. Have there been any changes in your specialty, procedures, or practice activity within the past five years? Yes ☐ No ☐

If yes, please describe in the space provided at the end of the application.

D. How many patients do you see on average per week? _____

E. How many hours do you practice on average per week? _____

(Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision, and on-call hours involving patient contact, whether direct or by telephone.)

F. Do you practice any of the following?

☐ Ayurvedic Medicine
☐ Chinese Medicine (including Acupuncture)
☐ Holistic Medicine
☐ Homeopathic Medicine
☐ Naturopathic Medicine

G. Do you perform medical or surgical procedures in an office-based surgical suite? Yes ☐ No ☐

H. Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine program? Yes ☐ No ☐

If yes, what percentage of your practice does this constitute? _____%

i. Do you provide these services to patients in states outside your primary practice location? Yes ☐ No ☐

If yes, please provide a list of states: _____

I. Do you provide services to any nursing home or similar facility? Yes ☐ No ☐

If yes, what percentage of your practice do these services constitute? _____%

Please list the name of the facility(ies): _____

J. Do you provide services to any local, state, or federal correctional facility? Yes ☐ No ☐

If yes, what percentage of your practice do these services constitute? _____%

Please list the name of the facility(ies): _____

K. Do you, or will you, staff an emergency department? Yes ☐ No ☐

If yes, is the emergency department work required to maintain hospital staff privileges? Yes ☐ No ☐

i. How many hours per month do you practice in the emergency department? _____