

THE PHYSICIANS TRUST

P.O. Box 40318 · Baton Rouge, LA 70835-0318
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Physicians and Surgeons Professional Liability Application

IMPORTANT: EACH AND EVERY QUESTION OF THIS APPLICATION IS MATERIAL AND MUST BE COMPLETED IN DETAIL. IF A QUESTION DOES NOT APPLY TO YOU, PLEASE INDICATE SUCH. IF YOU NEED EXTRA SPACE, USE THE EXTRA SPACE PROVIDED ON PAGE 9 OF THIS APPLICATION.

A. PRACTICE INFORMATION

1. Practice Name: _____ Inc. PC OA PLC PLLC LLP LLC
Other (Explain on Supplemental Form)

2. Mailing Address:

Address **City** **State** **Zip**

3. Principal Office Address: (If other than above)

Address **City** **State** **Zip**

4. Are there other office locations not listed above? Yes No
(If YES, please indicate on Supplemental Form)

5. Office Telephone: (_____) _____ - _____ 6. Office Fax: (_____) _____ - _____

7. Business Manager or Contact Person: _____

8. E-Mail Address: _____

9. Requested Policy Effective Date: ____/____/____ (12:01 a.m. Standard Time)

10. Limits of Liability Desired*: Each Medical Incident \$100,000/\$300,000 \$1,000,000/\$3,000,000
* Enrollment in the LA Patient's Compensation Fund (LPCF) is required

11. Deductible: None \$5,000 \$10,000 \$25,000 \$50,000
(A Letter of Credit letter may be required for the higher deductible limits)

12. Type of Practice: Individual Intern/Resident Employee
 Independent Contractor Owner Professional Corporation
 Professional Association Partner Other

13. What is the retroactive date for the corporation/partnership: ____/____/____ (Date first covered under Claims-Made Policy)
14. Is a separate limit of liability desired for the corporation/partnership? Yes No
15. Do you employ or supervise any of the following classifications of employees or independent contractors?

Classification	Certified		Number Employed	Number Contracted	# of Patients Seen Weekly	Are Separate Limits Desired?	
	Yes	No				Yes	No
Physician Assistants	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
Surgical Assistants	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
Nurse Practitioners	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
Nurse Midwives	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
Nurse Anesthetists	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
Physician Extenders	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

NOTE: These employees must complete an application. Please notify us if one has not been provided. Provide a copy of certificate of insurance for independent contractors.

16. Please complete the following for all physicians or surgeons employed by or under contract to the practice. Include physicians working part-time or that are members of a PLC, LLC, or LLP that are to be covered by this policy.

Name	Status	Hours Worked Per Week (If part-time)	Coverage to be provided under this policy (Y/N)
	E C P M		Yes <input type="checkbox"/> No <input type="checkbox"/>
	E C P M		Yes <input type="checkbox"/> No <input type="checkbox"/>
	E C P M		Yes <input type="checkbox"/> No <input type="checkbox"/>
	E C P M		Yes <input type="checkbox"/> No <input type="checkbox"/>

Status: E=Employed C=Contractor P=Part-time M=Member of LLP, LLC or PLC

17. Are all partners or members of the partnership, corporation, association, Limited Liability Corporation or limited liability partnership to be covered by this policy? Yes No
(If NO, please explain on Supplemental Form)

E. INSURANCE HISTORY

1. Provide details of coverage for the past five years, including moonlighting positions during residency, but excluding your residency program: (Provide copy of your current declarations page, if claims-made must reflect retro date).

Carrier	(Limits) Each Incident	(Eff. Dates)			Policy Type Claims-made or Occurrence
		Aggregate	From	To	
			/	/	
			/	/	
			/	/	
			/	/	
			/	/	
			/	/	

2. If prior coverage is Claims-Made, has a Reporting Endorsement (Tail Coverage) been purchased? Yes No
(If YES, please attach a copy) (If No, please explain any gaps in coverage on the Supplemental Form)
3. Have you ever been without coverage since beginning practice? Yes No
(If YES, please explain on Supplemental Form)
4. Has any similar insurance ever been declined, cancelled, non-renewed, or subjected to special conditions or limitations? Yes No
(If YES, please explain on Supplemental Form)
5. Do you have other professional liability insurance for work that you are performing elsewhere? Yes No
(If YES, please explain on Supplemental Form)

F. INDIVIDUAL PRACTICE INFORMATION

1. Specialty: _____ % practice: _____
(If Specialty is Anesthesiology, Emergency Medicine, General Surgery, Orthopedic Surgery or Radiology, please complete Section "H" Specialty Information).
 Sub-Specialty: _____ % practice: _____
2. Average weekly patient load: _____ 3. Average monthly practice hours for this policy: _____
4. Do you currently participate in the Louisiana Patient's Compensation Fund? Yes No
5. List all locations and dates where you have practiced medicine since graduation from medical school, including moonlighting positions: (Provide copy of your current curriculum vitae).

Practice Name	City/State	Specialty	Dates	
			From	To
			/	/
			/	/
			/	/
			/	/

G. MEDICAL PROCEDURES - CHECK ALL PROCEDURES THAT YOU PERFORM:

IF YOU DO NOT PERFORM ANY OF THE PROCEDURES LISTED BELOW, PLEASE CHECK HERE

OFFICE	HOSPITAL	OTHER	PROCEDURE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abortion (Do you perform elective abortions of uncomplicated viable pregnancies?) Yes <input type="checkbox"/> No <input type="checkbox"/> (Which trimester?) (#per year)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acupuncture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amniocentesis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angiography – Cardiac <input type="checkbox"/> - Peripheral <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty – Cardiac <input type="checkbox"/> - Peripheral <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthroscopic Procedures (Attach summary of training)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blepharoplasty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Botox Injections – Cosmetic <input type="checkbox"/> - Physiatry <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Surgery (Do you perform implants?) Yes <input type="checkbox"/> No <input type="checkbox"/> (Number per year)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchoscope
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Catheterization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chelation Therapy - Lead Removal <input type="checkbox"/> - Arteriosclerotic Heart Disease <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circumcisions (other than newborns)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cryosurgery (other than use on benign, malignant or pre-malignant dermatological lesions)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colonoscopy - With anesthesia <input type="checkbox"/> - Parenteral sedation <input type="checkbox"/> - Conscious sedation <input type="checkbox"/> - Without conscious sedation <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Plastic Surgery – Elective <input type="checkbox"/> - Traumatic <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dermabrasion (Indicate % of time devoted to this procedure) %
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D&C's
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Electroconvulsive Therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ERCP (Endoscopic Retrograde Cholangioancreatography)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GI Endoscopy - With anesthesia <input type="checkbox"/> - Parenteral sedation <input type="checkbox"/> - Conscious sedation <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair Transplants - Scalp Excision/Transplants Yes <input type="checkbox"/> No <input type="checkbox"/> - Plug Technique/Mingraph Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kyphoplasty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopic Procedure(s) – Diagnostic <input type="checkbox"/> -Therapeutic <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liposuction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lithotripsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar Puncture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphangiography
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myelography
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needle Biopsy (including lung, prostate, liver & kidney)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrical Deliveries: Caesarian Sections Per Year # Vaginal Per Year #
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occipital Nerve Blocks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Pacemaker Insertions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phenol Facial Peels
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placement of access lines for dialysis, chemotherapy & CVP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumoencephalography
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sigmoidoscopy - With anesthesia <input type="checkbox"/> - Parenteral sedation <input type="checkbox"/> - Conscious sedation <input type="checkbox"/> - Without Conscious sedation <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swan-Ganz Catheterization (Annual number performed #)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Pacemaker Insertions (Annual number performed #)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TURPS (Transurethral Resection of Prostate)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertebroplasty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision Correction Surgery: Type (s) Performed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss Surgical Procedures (Annual number performed #) (Specify Type)

- ASSISTING IN MAJOR SURGERY ON OWN PATIENTS
- ASSISTING IN MAJOR SURGERY ON OTHER THAN OWN PATIENTS
- ANY PROCEDURE NOT USUAL OR CUSTOMARY TO YOUR SPECIALTY
(Please explain on Supplemental Form)
- ANY PROCEDURE OR TREATMENT USING OFF LABEL PRODUCTS NOT APPROVED BY THE FDA
(Please explain on Supplemental Form)
- ANY ADDITIONAL PROCEDURES THAT YOU PERFORM OR ANY PROCEDURE NOT LISTED ABOVE
(Please list on Supplemental Form)
- FOLLOW YOUR OWN PATIENTS POST-OPERATIVELY

2. Has any licensing authority or hospital conducted or are they currently conducting an investigation relating to the nature of your practice, or to the restriction or limitation of your license or privileges of which you are aware? Yes No
3. Has your Medicare or Medicaid license ever been revoked, suspended, placed on probation or voluntarily surrendered? Yes No
4. Have you ever been indicted, charged, arrested (other than for motor vehicle violations **excluding DWI's or DUI's**) or convicted of any offense, crime or misdemeanor in any state or federal jurisdiction? Yes No
5. Have you ever been diagnosed for any disease or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency, or HIV/AIDS, which may affect your ability to render services as a healthcare provider? Yes No
6. Have you ever received treatment or medication, or, are you currently under treatment or medication, for any disease, or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency, or HIV/AIDS, which may affect your ability to render services as a healthcare provider? Yes No
7. Do you average fewer than 20 hours of Category I CME units annually in your specialty(ies)? Yes No
8. Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s) *not* previously disclosed in this application? Yes No
9. Have there been any changes in your practice or specialty in the past five years? Yes No
10. Are you engaged in any "moonlighting" activity or other health care related activity apart from your practice (*including any Emergency Room coverage*)? Yes No
11. Do you participate in the practice of Telemedicine?
(If YES, please fill out a Telemedicine Questionnaire)
For the purpose of this question, "Telemedicine" means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual patient as a result of a transmission of individual patient data by electronic means. Electronic means includes, but is not limited to, real-time video, interactions, store and forward technology, and the exchange of information via web site, electronic mail, or on-line chat rooms. Telemedicine does not include informal consultation provided without compensation or expectation of compensation, routine on-call services, nor does it include those services described above which are rendered in a bona fide emergency. Yes No
12. Do you presently advertise via internet, yellow pages, newspaper, radio, television, etc.? Yes No
(If 'Yes', please provide copies of your advertisement)
13. Do you participate in experimental drug therapy, clinical trials or surgical procedures? Yes No

14. Do you or any of your employees make home health care or nursing home visits? Yes No
(If YES, what % _____)
15. Do you perform any diagnostic or therapeutic procedures which have been introduced to you and/or the medical profession within the past 18 months? Yes No
16. Do you have a non-hospital based surgical facility (surgi-suite) in your office? Yes No
17. Other than local or topical anesthesia, do you administer any anesthetics or parenteral sedation outside of a hospital or surgi-center? Yes No

(If YES, please complete the below information)

18.

Procedure	Sedation Type	What type of emergency equipment and/or emergency procedures are in place in the event there are complications?

K. CLAIMS INFORMATION

In addition to answering the questions below, please provide a claims/loss history from previous carriers.

Have you ever been involved, directly or indirectly, or do you have knowledge of any:

1. Claim, potential claim, suit or incident having potential for a claim, arising out of the rendering or failing to render professional services? Yes No
 From: ___/___/___ to ___/___/___
If YES, how many? _____

PLEASE COMPLETE SUPPLEMENTAL CLAIM INFORMATION FORM FOR EACH CLAIM

2. Claim, potential claim, suit or incident having potential for claim, arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee of the corporation, partnership, or professional association? Yes No
If YES, how many? _____

PLEASE COMPLETE SUPPLEMENTAL CLAIM INFORMATION FORM FOR EACH CLAIM

3. Have all of the above claims or incidents been reported to your present carrier? Yes No

NOTICE AND DECLARATION

In the event this application is accepted by the Trust, and a Certificate of Coverage is issued, Applicant hereby ratifies and confirms the appointment by the Fund’s Board of Trustees of HSLI as Service Agent and acknowledges that the Trust will designate defense counsel for handling the defense of claims for the Trust; and agrees to be bound by the terms and provisions of the Trust Agreement.

The Applicant expressly represents and warrants that the information provided in this application (and attachments) and any subsequent applications are true and correct and that no material facts have been suppressed or misstated. Applicant specifically acknowledges that the Trust has relied on statements contained in this application to issue coverage and establish the amount to charge for the contract, particularly as to claims made and prior acts or retro coverage as to disclosing all incidents occurring in the last two (2) years where Applicant knows or has reason to believe a claim may be made in the next two years. Applicant also acknowledges that any failure to disclose material facts affecting coverage, losses and premiums, including incidents that have occurred at the time of this application or subsequent to the completion of the application but prior to the effective date of coverage, but not made until after coverage is instituted may constitute a material misrepresentation or fraud causing the denial of coverage or the rescinding or voiding of the coverage contract.

Applicant understands the submission of this application does not bind the Trust to issue or Applicant or institution to purchase this coverage. By signing below, Applicant grants permission (1) to the Trust to contact third parties and (2) for third parties to release to the Trust information which relates to the issuance and continuation of this coverage. Applicant also understands that knowingly providing false, incomplete or misleading information to the Trust for the purpose of defrauding the Trust may constitute a crime punishable by imprisonment, fines, and/or a denial of coverage.

Applicant acknowledges that, in the event this application is accepted by the Trust and a Certificate of Coverage issued, Applicant and/or institution will remain responsible for any deductible amounts owed even after termination of the coverage, and as a duly authorized representative of Applicant and/or institution, promises on behalf of Applicant and/or institution, to pay all deductible amounts owed under the coverage agreement and should any amounts owed to the Trust under the coverage agreement be turned over to an attorney for collection, that Applicant and/or institution shall be liable for attorney's fees and all costs of collection.

Applicant hereby certifies that they have signed this application with the specific authority of the Board or governing body of the institution. By placing their name on this application, it constitutes an electronic signature which legally binds him/her and the institution to the accuracy of the information inserted within as if they had actually signed the original application.

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Signature of Individual and Authorized Partner or Corporate Representative

Date

Print Name Here

BY MY SIGNATURE, I AM AUTHORIZING A REPRESENTATIVE OF THE PHYSICIANS TRUST TO OBTAIN MY MEDICAL PROFESSIONAL LIABILITY CLAIMS’ HISTORY FROM THE LOUISIANA PATIENT’S COMPENSATION FUND.

SUPPLEMENTAL CLAIM INFORMATION

PLEASE COMPLETE ONE FORM FOR EACH CLAIM. IF SPACE IS INSUFFICIENT TO ANSWER ANY QUESTION FULLY, PLEASE USE THE REVERSE SIDE OR ATTACH A SEPARATE SHEET. PLEASE DO NOT LEAVE ANY BLANKS. COMPLETE INFORMATION IS NECESSARY FOR THE EQUITABLE AND CAREFUL EVALUATION OF YOUR APPLICATION.

1) Name of applicant: _____

2) Name of patient involved in the claim: _____ 2A) Age: _____ 2B) Sex: Male Female

3) Date of incident from which claim resulted or which is likely to result in a claim: ___/___/_____

4) Date claim was made: ___/___/_____ 5) Indicate whether this was a: Claim Suit Incident

6) Allegations made against you:

7) Explain in detail the specifics of the incident which led or may lead to the claim:

8) Present status of claim: Active Dismissed Dropped Closed

9) If claim is closed:

A) What is the total loss paid, including any deductible that may have applied? \$ _____

B) Was this amount paid subsequent to a: Court judgment Out-of-court settlement

10) If claim is pending/open:

A) What is claimant's settlement demand? \$ _____

B) What is defendant's settlement offer? \$ _____

C) What is insurer's loss reserve: \$ _____

D) If in suit, what amount (if any) was asked for in summons? \$ _____

11) Name of the insurance company involved: _____

12) Name(s) of other doctor(s) and hospital(s), if any, involved in the claim or suit:

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same representation and conditions.

Signature of Individual Physician

Date