

THE PHYSICIANS TRUST

P.O. Box 40138 Baton Rouge, LA 70835
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Telephone (225) 368-3888 Fax (225) 272-1823

SUPPLEMENTAL ENTITY APPLICATION

CLAIMS-MADE COVERAGE FOR PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND OTHER ORGANIZATIONS ON PROFESSIONAL LIABILITY COVERAGE FORMS

(Complete one supplement for each organization)

Attach copy of Articles of Incorporation, Partnership Agreement or documents setting up entity listed in #1.

1. Legal Name of Entity: _____

2. Entity Business Address (Street, City, State, Zip Code): _____ 3. Parish _____

4. Desired Effective Date of Coverage: ___/___/___ 5. Current Form of Insurance (Check One): Claims-Made Occurrence

6. Current Carrier: _____ If claims-made, was reporting endorsement purchased from current carrier? Yes No

Are you requesting prior acts coverage? Yes No Retroactive date used by current carrier: ___/___/___

7. Are all entities and health care providers currently enrolled in the Louisiana Patient's Compensation Fund? Yes No
If no, give details on non-enrolled entities/providers in comments section of this application

8. Type of Practice: Professional Corporation Partnership LLC Corporation Joint Venture
 Professional Association Other: _____

9. Description of Operations:
 Private Doctor's Office Doctor's office with diagnostic equipment (describe) Outpatient Surgery Urgent Care
 Physician owned & operated lab (owner use only) Physician owned & operated lab (used by other than doctor/owner patients)
 Other – Please Describe: _____

9a. Are there any services or business operations conducted outside of Louisiana? Yes-describe in comments section No

10. Number of owners: _____ Number of Partners: _____

Who are Owners & Partners insured with? _____

11. Employed or contracted physicians/surgeons with the above-named entity (exclude owner/partners):

Name:	Insurance Company:	Specialty:

*Attach current certificate of insurance from professional liability carrier

12. # of employed/contracted licensed physician assistants & general surgeon assistants: _____ Are all insured with LHA Trusts? If no, * Yes No

Number of employed or contracted nurse anesthetists: _____ Yes No

Number of employed or contracted nurse midwives: _____ Yes No

Number of employed or contracted nurse practitioners: _____ Yes No

Number of other employees of this entity (not listed or counted above): _____ N/A

13. Are there any subsidiaries that provide health care related services? Yes – list below No

Subsidiary Name	Description of Operations	Date Acquired	%Ownership
		/ /	
		/ /	
		/ /	

14. Are these subsidiaries to be included in this coverage? Yes No

15. If subsidiaries are not 100% owned by the parent, provide details of other owners and the percentage owned by each:

16. Does this entity perform utilization review for a fee for others? Yes – please describe No

17. Is this entity currently under contract to supervise or administer any departments within a hospital or other facility, for a HMO or PPO or any government agency program? Yes – please describe: No

18. Is the entity eligible to be licensed to provide medical professional services? Yes – By whom: _____ No

Has a license been granted for the entity? Yes No

19. Are you eligible to be JCAHO Certified? Yes No Are you Certified? Yes No Date of Certification: mm/dd/yyyy

20. Has this entity's license ever been suspended, restricted, revoked, surrendered or has probation ever been invoked?

Yes – Please explain below No

21. Have any claims or suits ever been made or brought against this entity? Yes – (Give dates, allegations & disposition of each claim made) No

Date	Allegations	Disposition
mm/dd/yyyy		
mm/dd/yyyy		
mm/dd/yyyy		

22. Do you have knowledge of any claims which might be made against this entity or activities that might give rise to a claim or suit in the future (include any requests for medical records)? Yes – (Please include a description of each claim or activity) No

23. Comments:

SIGNING THIS INFORMATION SUPPLEMENT DOES NOT BIND THE COMPANY TO ISSUE A POLICY OF INSURANCE. ALL INFORMATION REQUESTED IN THIS SUPPLEMENT IS CONSIDERED MATERIAL AND IMPORTANT. IF THE COMPANY AGREES TO BE BOUND UNDER THE TERMS OF THIS SUPPLEMENT, THE INSURANCE POLICY IS VOID IF THE INSURED HIDES ANY IMPORTANT INFORMATION FROM THE COMPANY, MISLEADS THE COMPANY, OR ATTEMPTS TO DEFRAUD OR TO LIE TO THE COMPANY ABOUT ANY MATTER CONTAINED IN THIS SUPPLEMENT.

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.

Signature of Individual Physician

Title

Date