# Medical Staff Professional Liability Application

This application is intended for use by eligible medical staff members applying for coverage in the Universal International Insurance Ltd., professional liability insurance program. Applications must be completed prior to review. Applications will not be processed without supporting documentation such as claims histories and prior policy declaration pages.

*Universal International Insurance, Ltd. is not licensed by the State of Michigan. In case of Insolvency, payment of claims are not guaranteed*

## SECTION A: GENERAL INFORMATION (All Participats)

Applicant Name: ______________________

DEA No.: ______________ Social Security No.: ______________

| 500 Kirts Blvd. | Troy | M | 48084 |
|---|---|---|---|
| Primary Office Address | City | State | Zip Code |
| | | | |
| Residence Address | City | State | Zip Code |

Office Phone: (248) 824-6000 Residence Phone: ______________

Office Fax: (248) 824-6001 Cellular Phone: ______________

Contact Person: ______________ Beeper: ______________

Medical License I.D. Numbers: State License I.D. Number

______________ / ______________

______________ / ______________

Applicant's Date of Birth: ____ / ____ / ____

## SECTION B: EDUCATION/TRAINING/STAFF AFFILIATION/STAFF MEMBERSHIP (All Applicants)

| | Location | Degree | Completion Date |
|---|---|---|---|
| Medical School: | | | / / |
| Internship: | | | / / |
| | | | / / |
| Residency: | | | / / |
| | | | / / |
| Additional Training: | | | / / |
| Sub-specialty Training: | | | / / |

American Board Certified: Yes ☐ No☐ Educational Council for Foreign Medical Graduate Certified: Yes ☐ No☐

Hospital Privileges -- Primary Hospital (50% or more):

| Hospital | Percentage of Work |
|---|---|
| | |

Hospital Privileges -- Secondary Hospital:

| Hospital | Percentage of Work |
|---|---|
| | |

Hospital Courtesy Privileges:

| *Hospital* | *Location* |
|---|---|
| | |
| | |

## SECTION C - COVERAGE HISTORY AND COVERAGE REQUESTED (All Applicants)

Are you currently a participant in a hospital sponsored professional medical liability program? **Yes** ☐ **No** ☑
*If yes, please indicate the program name:* ____________ Yearly contribution: $ ____________

Does this policy include separate coverage for office activities? **Yes** ☐ **No** ☑
*If yes, please indicate the current premium for this coverage:* $ ____________

Do you have separate coverage for other hospital activities outside of the above stated hospital? **Yes** ☐ **No** ☑
*If yes, please indicate the current premium for this coverage:* $ ____________

Does the sum of the amounts listed above equal the total paid per year for liability coverage? **Yes** ☐ **No** ☑
*If no, please explain:* ____________

**PRIOR COVERAGE** ***This section must be completed starting with periods of coverage prior to your current policy.***

Insurer: ____________
Type of Coverage: ____________
Dates of Coverage: / / to / /
Yearly Premium: $ ____________
Limits of Liability: ____________
Retroactive Date: / /

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Dates of Coverage: / / to / /
Yearly Premium: $ ____________
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Retroactive Date: / /

Insurer: ____________
Type of Coverage: ____________
Dates of Coverage: / / to / /
Yearly Premium: $ ____________
Limits of Liability: ____________
Retroactive Date: / /

**CURRENT COVERAGE** **(Please attach a copy of your policy's current declarations page.)**

Insurer: ____________
Type of Coverage: ____________
Dates of Coverage: / / to / /
Yearly Premium: $ ____________
Estimated Renewal Premium: $ ____________
Limits of Liability: ____________
Retroactive Date: / /

**Is your current insurer canceling or failing to renew your current policy?** **Yes** ☐ **No** ☐
**If yes, please explain:** ____________

Do you have another professional liability policy covering activities other than for those currently being requested? **Yes** ☐ **No** ☐
**If yes, please explain:** ____________

Are you currently or have you been a chief, department head or medical director of any hospital, clinic or other medical facili **Yes** ☐ **No** ☐
**If yes, list the clinic or hospital's name, your responsibilities and dates of service:**

____________

## SECTION C - *Continued* (All Applicants)

**REQUESTED COVERAGE**

Type of Coverage Requested: Claims Made

Limits of Liability: ☐ $500,000/1.5MM ☑ 250,000/750,000 (Florida / Texas only)

Effective Date Requested : / / at 12:01 a.m.

**Retroactive Date Requested:** / /

## SECTION D - PHYSICIAN INFORMATION (All applicants)

Medical or Surgical Specialty: ______ Percent of Practice: ______

Sub-Specialty: ______ Percent of Practice: ______

Major and Minor Surgeries per Year: Major: N/A Minor: N/A Assists: N/A

Total Patients Treated per Week: ______ Deliveries per Year: N/A

Do you perform robotic surgery? **Yes** ☐ **No** ☑

***If yes, please include on an additional sheet the types of procedures performed and the number performed during the last twelve mont***

Do you or any other employee provide medical services over the internet or through telemedicine? **Yes** ☐ **No** ☑

***If yes, please include on an additional sheet the type of consultations, the method of communication, and the location of the recipients of the services.***

Hours Devoted to Emergency Room Treatment per Month: N/A

***If ER treatment is covered by a separate insurer, please provide proof of coverage.***

Number of hours you are on-call per week: N/A

Number of hours worked in a clinic or practice setting per we N/A

Number of hours charting after office hours per week: N/A

Number of hours the practice or clinic is open per week: N/A

Number of hours performing surgery per week: N/A

**Total Hours Per Week:** ______

Part-Time Coverage Request (20 hours/week or less): **Yes** _ **No** _

***Failure to maintain an average of 20 hours per week or less may result in***

How many years have you been practicing part-time: N/A

**If the requested part-time coverage is supplemental, provide a declarations page from your primary or additional insurer.**

## SECTION E - PRACTICE, CORPORATION OR PARTNERSHIP INFORMATION (All applicants)

Partnership ☐

Individual Unincorporated ☐

Individual Incorporated ☐

Owner of Professional Corporation ☐

Employee: ☑ Employer: Visiting Physicians Association, PC

Independent Contractor: ☐ Contractor: ______

Professional Corporation Coverage Requested: **Yes** ☑ **No** ☐

If yes, provide the Corporation's legal name: Visiting Physicians Association, PC

List all stockholders, partners, and employee physicians: N/A

| Name | Carrier | Specialty | Liability Limits |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## SECTION F: CLAIMS HISTORY FOR PHYSICIAN (All Applicants)

- Have you ever had a claim for alleged malpractice made against you or been sued for medical professional liability?

**Yes** ☐ **No** ☐

***(When applicable, a 10-year claims history generated by your prior insurer(s) must accompany this application)***

**If yes, complete the attached "Claim History" form.** REPORT ALL CLAIMS

- Has any claim or suit for alleged malpractice been made against you that has **NOT** been reported to a prior insurer?

**Yes** ☐ **No** ☐

**If yes, complete the attached "Claim History" form.**

- Are you aware of any acts, errors, omissions, or circumstances which may result in a malpractice claim or suit being made or brought against you?

**Yes** ☐ **No** ☐

**If yes, complete the attached "Claim History" form.**

- Have you ever had a grievance filed against you with your County or State Medical Society?

**Yes** ☐ **No** ☐

If yes, please explain: ______________________________

- Have you ever had medical professional liability insurance refused, cancelled, or non-renewed?

**Yes** ☐ **No** ☐

If yes, please explain: ______________________________

- Have you ever been convicted for an act committed in violation of any law or ordinance?

**Yes** ☐ **No** ☐

If yes, please explain: ______________________________

- Have you ever failed any medical licensing or specialty organization examination?

**Yes** ☐ **No** ☐

If yes, please explain: ______________________________

- Have you ever been treated for alcoholism or drug addition or undergone personal psychiatric treatment or has any administrative agency, hospital, or professional association requested or required that you be evaluated for any alleged mental condition and/or drug addiction?

**Yes** ☐ **No** ☐

If yes, please explain: ______________________________

- Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?

**Yes** ☐ **No** ☐

If yes, please explain: ______________________________

## SECTION G: ADDITIONAL QUESTIONS (All Applicants)

- Do you cover the informed consent process with your patient and have him or her sign an in-house informed consent form before surgery or treatment? **Yes** ☐ **No** ☐
- Do you receive information about new medications from sources other than pharmaceutical representatives? **Yes** ☐ **No** ☐
- Do you ever prescribe medication with which you are unfamiliar with all of its contraindications? **Yes** ☐ **No** ☐
- Are there any surgical procedures in your specialty that you feel uncomfortable performing? **Yes** ☐ **No** ☐
- Do you establish coverage for your patients when you go out of town? **Yes** ☐ **No** ☐
- Do you give patients at least 5 minutes to ask questions during an office visit? **Yes** ☐ **No** ☐
- Are you involved in prenatal or neonatal care? **Yes** ☐ **No** ☐
- Do you believe that your patients feel important and valued by you as a doctor? **Yes** ☐ **No** ☐
- Do you empathize with your patients? **Yes** ☐ **No** ☐
- Is there any criteria used in your diagnosis of patients that is impaired by any hospital policies? **Yes** ☐ **No** ☐
- Do you request consultations in a majority of your medical cases? **Yes** ☐ **No** ☐
- Do you strive to maintain communication with other physicians in your specialty? **Yes** ☐ **No** ☐
- Are you satisfied with the monetary reimbursement of your specialty? **Yes** ☐ **No** ☐
- Do you feel that you are on-call too many days of the year? **Yes** ☐ **No** ☐
- Do you find your personal life satisfying? **Yes** ☐ **No** ☐
- Do you feel there is a proper balance between your personal and professional life? **Yes** ☐ **No** ☐
- Do you have any chronic physical or mental illnesses? **Yes** ☐ **No** ☐

**If yes, please explain the type of illness:**

Notice to Applicant: The coverage applied for is solely as stated in the policy, which provides coverage on an annual basis or as stated in the policy.
Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information
Warranty: I warrant to the Insurer, Universal International Insurance Ltd., that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence be acceptance of this application by issuance of a policy. I authorize the release of claim

Name of Applicant (please print)

Signature of Applicant

Date

***Signing this application does not bind the Applicant or the Insurer to complete the insurance.***
***Applications must be completed prior to review. Applications will not be processed without supporting documentation***

## SUPPLEMENTAL CLAIMS HISTORY FOR PHYSICIANS:

***Complete a separate form for each claim.***

Patient's Name: ______________________ Age: __________

Incident Date: __________

Incident Status:

Pending __________
Dismissed from case without payment __________
Settlement __________
Judgment __________

Your Status is

__________ Sole Defendant
__________ Co-Defendant with __________________
__________ Other

Were the settlement terms confidential? Yes ☐ No ☐
Total Amount of Settlement/Judgment: __________
Amount Paid on Your Behalf: __________

Date Suit Filed: __________

Case Number: __________ Court: __________

Name and Address of Insurance Carrier at the time of Incident: __________

Name of Additional Defendant(s): __________

Explain in Detail the Plaintiff's Allegation:

Explain in Detail Your Defenses to these Allegations:

***What measures have you taken in order to help avoid a reoccurrence of this type of incident?:***

Patient's Condition Post-Incident:

Whom May We consult for Further Legal Information about the Suit: