

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: _____ / ____ / ____

Insurer: _____
 Type of Coverage: _____

Dates of Coverage: _____ / ____ / ____ to _____ / ____ / ____
 Yearly Premium: \$ _____
 Limits of Liability: _____
 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 facility? **Yes** **No**

If yes, list the clinic or hospital's name, your responsibilities and dates of service:

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 addiction 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:
