

<b>ADMIRAL INSURANCE COMPANY</b>	<b>PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)</b>
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1. **Full Name of Applicant:** \_\_\_\_\_
  2. **Principal Office Address:** \_\_\_\_\_  
**County:** \_\_\_\_\_
  3. **Home Address:** \_\_\_\_\_  
\_\_\_\_\_
  4. **Social Security #:** \_\_\_\_\_ **DEA #:** \_\_\_\_\_
  5. **List the States and License Numbers where you practice:** \_\_\_\_\_  
\_\_\_\_\_
  6. **Date of Birth:** \_\_\_\_\_ **Place of Birth:** \_\_\_\_\_
  7. **Are you a U.S. Citizen?** \_\_\_\_ Yes \_\_\_\_ No **If NO, please indicate your status and date of entry into the United States:** \_\_\_\_\_
  8. **What is your medical or surgical specialty:** \_\_\_\_\_  
**What percentage of your practice is dedicated to this specialty?** \_\_\_\_\_
  9. **What is your sub-specialty:** \_\_\_\_\_  
**What percentage of your practice is dedicated to this specialty?** \_\_\_\_\_
  10. **Do you limit your practice to the above specialties?** \_\_\_\_ Yes \_\_\_\_ No **If No, what other specialties do you practice? Provide details.** \_\_\_\_\_  
\_\_\_\_\_
  11. **Are you American Board certified?** \_\_\_\_ Yes \_\_\_\_ No  
**Medical Specialty:** \_\_\_\_\_ **Date Certified:** \_\_\_\_\_  
**Medical Specialty:** \_\_\_\_\_ **Date Certified:** \_\_\_\_\_
  12. **Type of Practice (check all that apply)**  
 Individual                       Employee                       Member of Multi-person Corp or Assoc  
 Individual Corporation                       Partnership                       Other \_\_\_\_\_
  13. **What is your total annual revenue?**                       \$100,000 or less                       \$250,001-\$499,999  
 \$100,001 - \$250,000                       \$500,000 or more
  14. **Please provide the names of all facilities that you practice at and your interest in each facility.**  
Name of Clinic or Facility and Location                      Interest (Owner, Partner, Employee?)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- \*Attach a separate attachment if necessary.
15. **Are you seeking coverage for your work at all of the above facilities?** \_\_\_\_ Yes \_\_\_\_ No **If No, please list those facilities for which you do not require coverage and explain why coverage isn't needed.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  16. **Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.**

	<u>Employed</u>	<u>Contracted</u>	<u>Carry their own Med Mal policy?</u>
Physicians	_____	_____	___ Yes ___ No
Physicians Assistants	_____	_____	___ Yes ___ No
Nurse Practitioners	_____	_____	___ Yes ___ No
Surgical Technicians	_____	_____	___ Yes ___ No
CRNA's	_____	_____	___ Yes ___ No
Chiropractors	_____	_____	___ Yes ___ No
RN's	_____	_____	___ Yes ___ No
LPN's, Nurse Aides	_____	_____	___ Yes ___ No
Other: _____	_____	_____	___ Yes ___ No
Other: _____	_____	_____	___ Yes ___ No

\*Please attach copies of dec pages on above professionals that carry their own malpractice policies.

17. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  
 \_\_\_ Yes \_\_\_ No **If NO, please attach explanation.**

18. List the hospitals at which you are currently a staff member: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

19. Briefly describe the type and extent of your hospital privileges: \_\_\_\_\_  
 \_\_\_\_\_

20. Are you the Chief or Head of a hospital department? \_\_\_ Yes \_\_\_ No **If YES, which department(s):**  
 \_\_\_\_\_

21. Are you the medical director of a nursing home or assisted living facility? If so, please provide the name of the facility:  
 \_\_\_\_\_

22. Are you the medical director of any other facilities? If so, please provide the names of each facility:  
 \_\_\_\_\_  
 \_\_\_\_\_

23. From what Medical School did you graduate? \_\_\_\_\_  
 City, State and Country of Medical School \_\_\_\_\_  
 Degree: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_  
 If foreign medical school graduate, are you certified by the Educational Council for Medical School Graduates? \_\_\_ Yes \_\_\_ No. If YES, state the year: \_\_\_\_\_

24. Internship? \_\_\_ Yes \_\_\_ No **If Yes, complete the following:**  
 Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
 Type: \_\_\_\_\_ Completed? \_\_\_ Yes \_\_\_ No

25. Residency? \_\_\_ Yes \_\_\_ No **If YES, complete the following for each:**  
 Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
 Type: \_\_\_\_\_ Completed? \_\_\_ Yes \_\_\_ No  
 Location: \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_  
 Type: \_\_\_\_\_ Completed? \_\_\_ Yes \_\_\_ No

26. Where have you practiced your profession since completion of training:  
 In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

27. Additional Medical Training? \_\_\_\_ Yes \_\_\_\_ No If Yes, provide details including type, location, and date of training: \_\_\_\_\_  
\_\_\_\_\_

28. Have you participated in any continuing medical education program(s) within the past five years? \_\_\_\_ Yes \_\_\_\_ No If YES, please provide details: \_\_\_\_\_  
\_\_\_\_\_

29. Indicate memberships in professional societies: \_\_\_\_\_  
\_\_\_\_\_

30. Do you perform one or more of the following:	Yes	No
A. Endoscopic Procedures, other than sigmoidoscopy or proctoscopy. If Yes, describe: _____ _____	_____	_____
B. Catheterization, other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel. If Yes, describe: _____ _____	_____	_____
C. Arteriography, lymphangiography, myelography or phenmoencephalography?	_____	_____
D. Interventional radiology-percutaneous transluminal angioplasty or embolization?	_____	_____
E. Radiation therapy, including radium implants? If Yes, describe: _____	_____	_____
F. Chemobrasion or dermabrasion?	_____	_____
G. Hair Transplantation or Suturing of Hairpieces?	_____	_____
H. Mohs Micrographic surgery? If YES, describe: _____ _____	_____	_____
I. Acupuncture? If YES, describe: _____	_____	_____
J. Prenatal care and normal deliveries? If YES, Do you perform home deliveries? _____ Do you only perform prenatal care? _____ Do you supervise nurse midwives? If YES, when do you refer: _____ weeks gestation _____	_____ _____ _____	_____ _____ _____
K. Dilation and curettage?	_____	_____
L. Needle Biopsies? If YES, describe: _____	_____	_____
M. Electroshock therapy or hypnosis? If YES, describe: _____ _____	_____	_____
N. Radial keratotomy, excimer laser PRK, LASIK or any other surgical vision correction procedure?	_____	_____

Do you perform any of the following? (continued) Yes No

- |            |  |            |           |
|------------|--|------------|-----------|
| <b>O.</b>  | Surgery, other than incision of boils and superficial abscesses or suturing skin and superficial fascia?<br>If Yes, please attach a list of all surgical procedures.   | _____      | _____     |
| <b>P.</b>  | Non-spontaneous, induced abortions? If YES,<br>What is maximum trimester? _____  | _____      | _____     |
| <b>Q.</b>  | Vasectomies or reversal of vasectomies?  | _____      | _____     |
| <b>R.</b>  | Hysterectomies? If YES, do you perform laparoscopic hysterectomies?  | _____      | _____     |
| <b>S.</b>  | Cholecystectomies? If YES, do you perform laparoscopic cholecystectomies?<br>If YES, how many performed as of this date: _____   | _____      | _____     |
| <b>T.</b>  | Tonsillectomies and/or Adenoidectomies?  | _____      | _____     |
| <b>U.</b>  | Caesarian sections?  | _____      | _____     |
| <b>V.</b>  | Spinal Surgery? If you also perform chemonucleolysis, check here: _____ and/or percutaneous lumbar disectomy, check here: _____  | _____      | _____     |
| <b>W.</b>  | Administration of general, spinal or caudal block anesthesia?  | _____      | _____     |
| <b>X.</b>  | Open reduction of fractures?   | _____      | _____     |
| <b>Y.</b>  | Organ transplantation? If YES, describe: _____<br>_____  | _____      | _____     |
| <b>Z.</b>  | Sex Change Operations?   | _____      | _____     |
| <b>AA.</b> | Weight Reduction Surgery including gastric bypass or other stomach banding procedures? If YES, which procedures? _____<br>_____  | _____      | _____     |
| <b>BB.</b> | Experimental research, surgical research, or experimental therapy in human patients? If YES, describe: _____   | _____      | _____     |
| <b>CC.</b> | Cosmetic/Plastic Surgery? If YES, complete the following:<br>Do you perform breast augmentation? _____<br>Do you perform breast reductions? _____<br>Do you perform liposuction? If YES, what is the maximum amount of cc's removed? _____<br>Do you perform fat recycling? If YES, in what parts of the body? _____<br>Do you perform vaginoplasty or labiaplasty? _____<br>Do you use silicone implants? If Yes, in which parts of the body: _____<br>Do you perform Botox injections? If Yes, in which parts of the body: _____ | _____      | _____     |
| <b>DD.</b> | Penile lengthening or enhancement procedures?  | _____      | _____     |
|            | <b>Do you perform any of the following? (continued)</b>  | <b>Yes</b> | <b>No</b> |

EE. Do you perform Pain Management Procedures? \_\_\_\_\_  
 If so, please indicate the procedures you perform: \_\_\_\_\_

**CATEGORY A:**

- Acupuncture \_\_\_\_\_
- Botox Injections \_\_\_\_\_
- Medication Only \_\_\_\_\_
- Massage/Osteopathic Manipulation – No Anesthesia \_\_\_\_\_
- Medicinal Marijuana – Prescription Only – No Dispensing \_\_\_\_\_

**CATEGORY B:**

- Facet Joint Blocks \_\_\_\_\_
- Lesioning \_\_\_\_\_
- Percutaneous Discectomy \_\_\_\_\_
- Percutaneous Endoscopic Nerve Root Decompression \_\_\_\_\_
- Peripheral Nerve Block \_\_\_\_\_
- Radio Frequency Nerve Ablation \_\_\_\_\_
- Rapid Opiate Detoxification \_\_\_\_\_
- Selective Nerve Root Block \_\_\_\_\_
- Sympathetic Blocks \_\_\_\_\_
- Trigger Point Injections \_\_\_\_\_
- Schedule I or Schedule II Prescription Medications \_\_\_\_\_

**CATEGORY C:**

- Dorsal Column Stimulator Implants/Reprogramming \_\_\_\_\_
- Epidural or Spinal Catheters \_\_\_\_\_
- Intradiscal Electrothermal Therapy \_\_\_\_\_
- Peripheral Nerve Stimulation \_\_\_\_\_
- Spinal Infusion Implants/Pumps; Removal, Refilling/Reprogramming \_\_\_\_\_
- Spinal Manipulation under General Anesthesia \_\_\_\_\_
- Vertebroplasty \_\_\_\_\_
- Discectomy \_\_\_\_\_

FF. Any other surgical procedures not shown above? \_\_\_\_\_  
 Please describe. \_\_\_\_\_

**\*PLEASE ATTACH A LIST OF ALL SURGICAL PROCEDURES YOU PERFORM**

31. Do you perform surgery in your office? \_\_\_\_ Yes \_\_\_\_ No If YES, please list. \_\_\_\_\_  
 \_\_\_\_\_

32. Do you perform surgery in other non-hospital facilities? \_\_\_\_ Yes \_\_\_\_ No (If YES, what type of facility and list the surgical procedures: \_\_\_\_\_  
 \_\_\_\_\_

33. In the course of surgery does a Board Certified Anesthesiologist provide the anesthesia? \_\_\_\_ Yes \_\_\_\_ No  
 If No, please provide details. \_\_\_\_\_  
 \_\_\_\_\_

34. Do you do any hospital emergency room work? \_\_\_\_ Yes \_\_\_\_ No If YES, Is the emergency room care:  
 Only for your own patients? \_\_\_\_ Yes \_\_\_\_ No  
 Required for staff privileges? \_\_\_\_ Yes \_\_\_\_ No  
 How many hours per month: \_\_\_\_\_  
 Does the hospital cover you for malpractice while you work in the emergency room? \_\_\_\_ Yes \_\_\_\_ No  
 Are you requesting coverage for your emergency room work? \_\_\_\_ Yes \_\_\_\_ No

35. Do you assist in surgery:  
 On your own patients? \_\_\_\_ Yes \_\_\_\_ No  
 On patients of others? \_\_\_\_ Yes \_\_\_\_ No

36. If your practice includes plastic surgery, specify the percentage of your practice devoted to:  
 \_\_\_\_% Traumatic Surgery \_\_\_\_% Cosmetic/ Elective Surgery

37. If your practice includes weight reduction/control (other than by diet and exercise), specify the percentage of patients that are exclusively weight control: \_\_\_\_%.  
 Do you prescribe any weight control drugs? \_\_\_\_ Yes \_\_\_\_ No If YES, list drugs prescribed. \_\_\_\_\_

Do you dispense supplements for weight control? \_\_\_\_ Yes \_\_\_\_ No If Yes, list supplements dispensed. \_\_\_\_\_

Do you use injections for weight control? \_\_\_\_ Yes \_\_\_\_ No If YES, list drugs injected: \_\_\_\_\_

38. Have you or any of your employees: (If yes, attach details.)	Yes	No
A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Attach a copy of Complaint and Consent Order document if applicable.	_____	_____
B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
C. 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 you be evaluated for an alleged mental condition and/or alcohol or drug addiction?	_____	_____
D. Ever had any state profession license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____
E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?	_____	_____
F. Ever failed any medical licensing or specialty organization examination?	_____	_____
G. Do you have any chronic illnesses or defects? If Yes, please describe. _____	_____	_____

39. Do you supervise any individuals other than your own employees? \_\_\_\_ Yes \_\_\_\_ No If YES, please provide detailed explanation of your responsibilities, relationship and whether or not these individuals have their own medical malpractice coverage: \_\_\_\_\_

40. Are you under contract to any individual, firm or corporation other than your own? \_\_\_\_ Yes \_\_\_\_ No  
If YES, attach explanation including details of responsibilities. If this contract contains a hold harmless agreement then attach a copy of the contract language.
41. Are you in the employ of, or under contract to any governmental entity? \_\_\_\_ Yes \_\_\_\_ No If YES, please provide details and outline your duties. \_\_\_\_\_  
 \_\_\_\_\_
42. Do you offer professional advice to the public such as through a website, radio or TV broadcasts, newsletters, etc? \_\_\_\_ Yes \_\_\_\_ No If YES, please provide details. \_\_\_\_\_  
 \_\_\_\_\_
43. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? \_\_\_\_ Yes \_\_\_\_ No If YES, please provide details and attach copies of all advertising brochures.  
 \_\_\_\_\_  
 \_\_\_\_\_
44. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? \_\_\_\_ Yes \_\_\_\_ No If YES, please provide details. \_\_\_\_\_  
 \_\_\_\_\_
45. Average Weekly Patient Load: \_\_\_\_\_ Total Patients Annually: \_\_\_\_\_  
 Total surgeries performed annually: \_\_\_\_\_
46. Average number of hours worked per week: \_\_\_\_\_
47. Do you anticipate any changes in your practice? \_\_\_\_ Yes \_\_\_\_ No If YES, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
48. List the prior medical malpractice insurance carried for each of the past 5 years beginning with most current:
- | <u>INSURANCE COMPANY</u> | <u>LIMITS OF LIABILITY</u> | <u>POLICY PERIOD</u> | <u>PREMIUM</u> | <u>RETRO DATE</u> |
|--------------------------|----------------------------|----------------------|----------------|-------------------|
| _____                    | _____                      | _____                | _____          | _____             |
| _____                    | _____                      | _____                | _____          | _____             |
| _____                    | _____                      | _____                | _____          | _____             |
- \*Attach a copy of the declarations page of your most recent policy.
49. Do you own, operate or provide professional services for, or at, any health care facility or business enterprise not already clearly described in this application? \_\_\_\_ Yes \_\_\_\_ No If YES, please describe: \_\_\_\_\_  
 \_\_\_\_\_
50. Has any claim or suit for alleged malpractice been brought against you? \_\_\_\_ Yes \_\_\_\_ No  
 If YES, how many total claims or incidents: \_\_\_\_\_  
 Please complete the Supplemental Claim Information Form attached to this application for each and every claim. Also, please attach 10 years of currently valued company loss runs.
51. 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, please complete the Supplemental Claim Information Form attached to this application for each and every claim.
52. 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, please provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.

**The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.**

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

**Please attach the following documents to this application:**

- **C.V. or resume**
- **Five years of currently valued company loss runs**
- **Copies of any disciplinary actions, stipulation orders or probation documents**
- **Copies of declarations pages for all employees or contractors that carry their own med mal**
- **Copy of applicant's most current declarations page**

**SUPPLEMENTAL CLAIM INFORMATION FORM**  
*(Complete one form for each claim)*

1. Name of applicant/named insured: \_\_\_\_\_  
\_\_\_\_\_
2. Name of other parties or defendants named in suit: \_\_\_\_\_  
\_\_\_\_\_
3. Date of alleged error or occurrence, or contact date: \_\_\_\_\_
4. Date claim was made: \_\_\_\_\_
5. Name of claimant: \_\_\_\_\_
6. Name of Insurance Company handling your claim: \_\_\_\_\_
7. Present status of claim or final disposition: \_\_\_\_\_  
\_\_\_\_\_  
Circle One:            **CLOSED**                            **OPEN**
8. Defense costs paid to date inclusive of any deductible: \_\_\_\_\_
9. If closed, total loss paid, inclusive of any deductible: \_\_\_\_\_
10. If claim is open or pending, what are the insurers reserves?  
    Defense: \_\_\_\_\_                            Loss: \_\_\_\_\_
11. Description of case and events including allegations and assessment of liability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Claimants last settlement demand: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature