

IMPORTANT!!!!!!!

PHYSICIANS LIABILITY INSURANCE COMPANY APPLICATION GUIDELINES

In order to expedite the review of applications, we must receive complete information. Please follow these guidelines to assure that your application is complete, and to assure prompt processing:

- All questions must be answered. If a question does not apply, enter “N/A” for that question. **DO NOT LEAVE ANY QUESTION BLANK!**
- Section 2 – Coverage Information (page 1): Previous Insurance Company information for the preceding 5 years must be provided. Proof of insurance from each carrier should accompany the application. If there are previous denials, non-renewals, cancellations, exclusion of specific procedures, or restrictions on the professional liability insurance, please explain on the Additional Information Section, or on a separate sheet of paper.
- *Entity coverage* - for associations, partnerships, corporations, or companies, on shared or separate limits basis, please provide the following documents or information:
 1. Names of all current principals/shareholders of the entity,
 2. Function or operations of the entity, if other than practice management,
 3. Advise if the entity offers ancillary services such as MRI’s, x-rays, medical testing, etc. If so, please provide the number of procedures associated with each type of service.
 4. Copy of the W-9 and 1099(IRS) forms for the entity,
 5. Copy of the OES-3 form with a notation of employee’s position for the entity,
 6. Provide a current Certificate of Insurance for each employed or contracted physicians not insured by PLICO.
- *License restrictions or investigations*– explain any restrictions or investigation in the Additional Information Section, or on a separate sheet of paper.
- *Physicians’ Application Section 9 and Ancillaries’ Application Section 5* – Explain any “Yes” answers in the Additional Information Section, or on a separate sheet of paper.
- *Medical and Surgical Procedures* (Physicians’ Application Section 8) - indicate the procedures that you will perform under this policy/coverage.
- **CLAIMS HISTORY** – issued by all previous insurance carriers must be submitted with every application, even if you are not aware of any claims. It is imperative that we receive complete claims history from every previous carrier for the past 10 year period.



Accounting [405] 815-4824 • Claims [405] 815-4802 • Marketing [405] 815-4814
 Risk Mgt. [405] 815-4814 • Underwriting [405] 815-4801 • Toll Free [866] 867-4566 • [405] 815-4900

FAX: (405) 815-4900

ANCILLARY MEDICAL PERSONNEL PROFESSIONAL LIABILITY INSURANCE APPLICATION

THIS FORM PROVIDES CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

Add to Policy #: _____ Name of Physician or Group _____

SECTION 1 – GENERAL INFORMATION			
1. Name of Applicant:		2. SSN:	
3. Indicate other names by which you have been known. Specify the dates during which the name was used:			
4. Degree or Title:	5. Sex:	6. Place of Birth:	7. Date of Birth:
8. Office Address:			
9. Contact Person:			
10. Home Phone:		11. Office Phone:	12. Fax:
13. E-mail:		14. Web Site:	
15. Home Address:			
16. Name of employer/Supervising Physician and her/his medical specialty:			

SECTION 2 - COVERAGE INFORMATION				
1. Requested Effective Date: _____		2. Requested Retroactive Date: _____		
3. Requested Limits of Liability:				
<input type="checkbox"/> \$100,000 / \$300,000	<input type="checkbox"/> \$500,000 / \$1 million	<input type="checkbox"/> \$1 million / \$1 million		
<input type="checkbox"/> \$1 million / \$3 million	<input type="checkbox"/> \$2 million / \$2 million	<input type="checkbox"/> \$2 million / \$4 million		
Note: the selected limits of liability must not exceed the lowest limits of liability of any physician in the policy.				
4. Insurance history				
Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current Year:				
1 st year prior:				
2 nd year prior:				
3 rd year prior:				
4 th year prior:				
5 th year prior:				
5. Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 9.			Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you ever been denied professional liability insurance or has your coverage ever been non-renewed or canceled? If "Yes", provide details on Section 9.			Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? If "Yes", provide details on Section 9.			Yes <input type="checkbox"/>	No <input type="checkbox"/>

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING

1. Name and location of college or professional school:	Degree and/or Specialty	Start Date	Completion Date (or Expected)
2. Indicate how many continuing education credits have you completed during the past 3 years?			

SECTION 4 – LICENSURE – CERTIFICATION - ASSOCIATION

1. Oklahoma License #:	2. Expiration Date:
3. Are you licensed in other states? Yes <input type="checkbox"/> No <input type="checkbox"/>	State: _____ License #: _____ State: _____ License #: _____
4. Has your license in any state ever been suspended, revoked, denied, or limited? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", provide details on Section 9.	
5. Are you currently under investigation by any state licensing board or agency? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please explain on a separate sheet.	
6. Please list any Professional Society Affiliations:	

SECTION 5 - CURRENT PRACTICE

PROVIDE DETAILS FOR ANY "YES" ANSWER(S) ON SECTION 9

1. Do you currently have any medical and/or psychiatric problem including alcohol and/or drug dependence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever been treated for psychiatric, drug or alcohol-related problem?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you ever been institutionalized during the past five years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you have any continuing health problems requiring current therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do you currently have any condition or circumstance that may prevent or impair you to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Are you currently engaged in the illegal use of drugs? (If you are making application to a government entity, you have the right to elect not to answer this question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Is your physical or mental health such that it may impair your ability to practice within the scope of the privileges for which you have applied?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Has your employment at a health care organization ever been terminated?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Have you ever been charged of a crime other than a minor traffic offense?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Are there any felony charges pending against you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges, or have you resigned from the medical staff, or surrendered your clinical privileges while under investigation or before a recommendation or decision by a hospital's or healthcare facility's medical executive or governing board was rendered?	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 5 - CURRENT PRACTICE (continued)

REFER TO SECTION 9 FOR ADDITIONAL SPACE

12. Are you involved in the treatment of prisoners or jail inmates? Yes No
 If yes, indicate location of practice _____

13. List of locations of employment for which coverage is being requested:

Name/Address: Hours per week worked at this location: Nature of your practice:

1. _____
 2. _____

14. List all other locations of employment for which coverage is NOT being requested.

Name/Address: Hours per week worked at this location: Nature of your practice:

1. _____
 2. _____

15. Do you practice at an Emergency Department of a Hospital or Health care Facility? If yes, indicate name of the hospital or medical facility	<u>Yes</u>	<u>No</u>	<u># in past year</u>	<u>Changes?</u>
16. Are you employed in an Urgi Center or Emergi-care Center? If yes, indicate name of the healthcare facility.	<u>Yes</u>	<u>No</u>	<u># in past year</u>	<u>Changes?</u>
17. Do you perform office based surgery in your professional office?	<u>Yes</u>	<u>No</u>	<u># in past year</u>	<u>Changes?</u>
18. Are you using anesthesia including conscious sedation in your office?	<u>Yes</u>	<u>No</u>	<u># in past year</u>	<u>Changes?</u>

SECTION - 6 –CLAIMS HISTORY/ REPORT

1. Have you been involved in a professional liability claim/suit in the past ten (10) years? Yes No

2. Have all claims/suits/incidents been reported to your current/prior professional liability carrier? Yes No
 If "No", please explain on Section 9 _____

3. Complete the following questionnaire for all claims or incidents in which you have been directly or indirectly involved. We require ten (10) year claim or incident history/report, with a recent valuation date from your current insurer, even if you have not had any claims/suits.

Claim #	Patient's Initials	Insurance Company	Date of Loss	Date Reported	Date Closed	*Award's Amount

*Attributed to your involvement: \$ _____ *Paid by All Parties \$ _____

Indicate your status in the case: Primary Defendant Co-defendant Other (explain) _____

If the claim or suit is pending, when was the last contact with the Plaintiff's attorney? _____

What is/was the alleged harm to the patient? _____

What were the allegations made against you? _____

Describe the patient's illness and related effects of the alleged harm _____

Describe any other details you believe are pertinent to the case _____

Name of other parties named in the suit: _____

SECTION 7 - WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted.

I UNDERSTAND that the statements and answers herein will be relied upon by Physicians Liability Insurance Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE any professional societies, prior, or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to **PLICO** or to the Oklahoma State Medical Association (Association) upon the request of either. I authorize the use of a copy of this authorization in place of the original.

In order to facilitate the risk management program, I authorize **PLICO** to provide the Association with any records and information concerning claims arising under any policy or insurance issued in connection with this application.

I declare that to the best of my knowledge and belief I have:

1. Reported all known claims, suits, and incidents that could result in a medical negligence claim or suit to my previous or current carrier(s) or risk transfer entity (self-insured program),
2. No knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit that has not been reported to my current or previous insurance carrier or risk transfer entity, and
3. No knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last 10 years, that have not been reported to the applicable insurance company or risk transfer entity.

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by **PLICO** in reliance upon such information.

Signature _____ Date _____

OKLAHOMA FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

SECTION - 8 - COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following documents with this application.

Attached	Item
	Copy of Licensure, Certification, Registration or Association membership required for you to practice
	Copy of Job Description
	Copy of expiring insurance policy or certificate of insurance

