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**PHYSICIANS PROFESSIONAL LIABILITY INSURANCE
 Request for Change**

Effective Date of Change: _____ **Policy Number:** _____

SECTION 1 - GENERAL INFORMATION

Name Insured:		Insurance Agent:
Address:		Insured's Phone #:
City/State/Zip Code:		
Web Site:	Fax:	E-Mail:

Has there been any change in your practice in the last 5 years? Yes No
 If "Yes," provide details on Section 8.

SECTION 2 - STATUS CHANGE (Full or Part-Time)

Annual average number of hours worked per week (circle one):

20 hours or less 21 hours to 30 hours 31 hours or more

Has your practice been reduced because of any of the following? (Check all that apply)

Retirement Semi-retirement Disability Pregnancy or dependent care

Teaching or Majority of practice is conducted in a teaching role which is insured elsewhere

Majority of practice is insured through another entity such as an employer

Maintenance of another practice in bordering state that is insured elsewhere

Are you able 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? If "No", provide details on Section 8. Yes No

Are you currently engaged in the abuse of alcohol or illegal use/misuse 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). If "Yes", provide details on Section 8. Yes No

Are there any felony charges pending against you or have you been charged of a crime other than a minor traffic offense? If "Yes", provide details on Section 8. Yes No

Are you employed by the State of Oklahoma? If "Yes", indicate percent of time involved in private practice: Yes No

Do you treat prisoners or jail inmates? If "Yes", provide details on Section 8. Yes No

Does your practice include locations outside Oklahoma? Yes No
 If "Yes", indicate locations: _____

SECTION 3 - SPECIALTY / CLASSIFICATION

1. What is your present Specialty?

2. Sub-specialty?

Please check which ONE of the following best describes your practice:

No Surgery - Includes incision of boils and superficial abscesses, or suturing of skin or superficial fascia.

Minor Surgery - Any operation that involves a surgical incision into the dermis, epidermis and superficial fascia or suturing of skin or superficial fascia and does not enter below the superficial fascia or any body cavity, including but not limited to the cranium, thorax, abdomen or pelvis. Circumcisions, Hospitalists, and physicians assisting in surgery.

Major Surgery – Includes any operation done under general anesthesia, or any operation that presents a distinct hazard to life such as removal of tumors, reduction of open fractures, amputations, abortions, tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, vasectomies, removal of any gland or organ, plastic surgery, and pain management.

3. Please check the box that best describes your specialty:

Aerospace Medicine		Nuclear Medicine		MAJOR SURGERY (continued):
Allergy		Nutrition		Colon and Rectal
Anesthesiology		Occupational Medicine		Endocrinology
Bronco-Esophagology		Ophthalmology		Gastroenterology GP/FP not primarily engaged in major surgery
Cardiovascular Disease		Otology		
Dermatology		Otorhinolaryngology		
Diabetes		Pain Management		Geriatrics
Emergency Medicine		Pathology		Gynecology
Endocrinology		Pediatrics		Hand
Family Practice (FP)		Pharmacology-clinical		Head and Neck
Forensic Medicine		Physiatry		Laryngology
Gastroenterology		Physical Medicine and Rehabilitation		Neoplastic
General Practice (GP)		Psychiatry		Nephrology
General Preventive Medicine		Psychoanalysis		Neurology
Geriatrics		Psychosomatic Medicine		Obstetrics
Gynecology		Public Health		OB/GYN
Hematology		Pulmonary Diseases		Ophthalmology
Hospitalist		Radiology – Interventional* (list procedures in Section 15)		Orthopedic –including back
Hypnosis		Radiology - Diagnostic		Orthopedic – no back
Infectious Disease		Retired		Otology
Intensive Care Medicine		Rheumatology		Otorhinolaryngology
Internal Medicine		Rhinology		Plastic
Laryngology				Rhinology
Legal Medicine		MAJOR SURGERY:		Thoracic
Neoplastic Diseases		Abdominal		Traumatic
Nephrology		Cardiac		Urological
Neurology		Cardiovascular		Vascular
Other (please identify):				

SECTION 4 – MEDICAL PROCEDURES

Please check off "Yes" or "No" for each of the following procedures or activities to indicate which, if any, you perform or engage in. Indicate number of procedures performed in the past year, and also indicate if you anticipate any significant changes for the coming year.

	Yes	No	# in past year	Changes?
1. Minor surgery (on a regularly scheduled basis).				
2. Minor surgery (on an emergency basis only).				
3. Assisting in major surgical procedures on your own patients.				
4. Major Surgery includes but not limited to: Tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, abortions, vasectomies and other procedures performed under general anesthesia.				
5. Assisting in major surgical procedures on other than your own patients.				
6. Normal obstetrical procedures				
7. Obstetrical procedures, which are considered to be major surgery: C-Sections, D&C, etc.				
8. Plastic surgery-reconstructive? (Medically necessary following surgery or trauma).				
9. Plastic/Cosmetic surgery - elective? (not medically necessary)				
10. Non-surgical cosmetic procedures (dermabrasion, Botox injections, permanent micro-pigmentation, thread lifts, mesotherapy, etc.)				
11. Administering general anesthesia?				
12. Acupuncture				
13. Angiography – venous				
14. Angiography – arterial				
15. Colonoscopy				
16. Cryosurgery – other than use on benign or non-malignant dermatological lesions or cervix				
17. Discograms				
18. Endoscopic retrograde cholangiopancreatography				
19. Heart Catheterization - with or without coronary angiography				
20. Occasional emergency insertion of central venous recording catheters and temporary pacemakers (Swan Ganz)				
21. Laparoscopy (Peritoneoscopy)				
22. Laser- used in surgery				
23. Lymphangiography				
24. Myelography				
25. Needle biopsy - including lung and prostate				
26. Needle biopsy - including liver, kidney, or bone marrow biopsy				

SECTION 4 – MEDICAL PROCEDURES (continued)

	Yes	No	# in past year	Changes?
27. Phlebography				
28. Pneumatic or mechanical esophageal dilation (not with bougie or olive)				
29. Pneumoencephalography				
30. Radiation therapy				
31. Radiopaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae				
32. Electro-convulsive Shock Therapy				
33. Vascular embolization				
34. Chelation therapy				
35. Micro or blepharopigmentation (permanent eyelash enhancement)				
36. Bariatric surgery, indicate procedures:				
37. Liposuction				
38. Hair Transplants				
39. Angioplasty				
40. Circumcisions				
41. Breast augmentation				
42. Deliver babies				
43. Surgery on the spine				
44. Does your practice include <i>non-invasive</i> pain management?				
45. Does your practice include <i>invasive</i> pain management? If "Yes", list procedures in Section 8				
46. Do you practice at an emergency department of a hospital or healthcare facility?				
47. Are you employed in an Urgicare or Emergicare Center?				
48. Do you perform office-based surgery in your professional office?				
49. Are you using anesthesia including conscious sedation in your office?				

SECTION 5 - LIMITS OF LIABILITY

Indicate your current limits of liability: _____		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

SECTION 6 - OTHER CHANGES

Indicate other updates or changes that we should make to your policy such as changes of address, contact information, address, etc.: _____

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 declare that to the best of my knowledge and belief I have reported all known incidents, claims, and suits to previous carrier(s) or risk transfer entities (self-insured retention), or to PLICO. I have no knowledge of:

1. Any incident that could result in a medical negligence claim or suit, and/or
2. No knowledge of any pending medical negligence claim or suit, that may be, or has been made or filed against me in the last 10 years that has not been reported to the applicable insurance company, risk transfer entity (SIR), or to PLICO.

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 – ADDITIONAL INFORMATION

This space is furnished for your convenience in completing questions or providing additional information. As appropriate, note Section number and question number being addressed. Please, use additional sheets of paper if necessary to fully answer all questions:

Section/
Question #

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____