

PHYSICIANS LIABILITY INSURANCE COMPANY

Application Guideline

Thank you for your consideration of PLICO for your professional liability insurance needs. Since 1979, PLICO has been the leading choice by Oklahoma physicians for protecting themselves and their practices. Wholly owned by the Oklahoma State Medical Association and directed by a board of peer physicians, PLICO exists solely for the benefit of other physicians and is the largest and longest standing medical professional liability carrier in the state.

Please note the following instructions for the included application. If you have any questions, please do not hesitate to call Ramona Edwards at 405.815.4851 or PLICO Financial, Inc. at 405.815.4880

- All questions must be answered. If a question does not apply, enter “N/A” for that question.
- 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/information:
 1. Copy of the W-9 and 1099 (IRS) forms for the entity,
 2. Copy of the OES-3 form with a notation of employee’s position for the entity,
 3. Copy of the Articles of Incorporation or Formation for the entity,
 4. 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’ Section 9 and Ancillaries’ Section 5* – Explain any “Yes” answers in the Additional Information Section, or on a separate sheet of paper.
- *Medical and Surgical Procedures* (Physicians’ 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] 815-4803
 Underwriting [405] 815-4801 • Toll Free [866] 867-4566 • Main [405] 815-4800

FAX: (405) 815-4900

PHYSICIANS PROFESSIONAL LIABILITY INSURANCE APPLICATION

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

Individual Policy or Add to a Group Policy Group's policy # _____
 Name of 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. M. D. <input type="checkbox"/>	D. O. <input type="checkbox"/>	5. Sex:	6. Place of Birth:
8. Office Address:			7. Date of Birth:
9. Contact Person:			
10. Billing address (if different than Office Address) :			
11. Home Phone:		12. Office Phone:	13. Fax:
14. E-mail:		15. Web Site:	
16. Home Address:			
17. I hereby name as my insurance agent: _____			

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		
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 been denied professional liability insurance or has your coverage ever been non-renewed or cancelled? If "Yes", provide details on Section 15.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? If "Yes", provide details on Section 15.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 15.			Yes <input type="checkbox"/> No <input type="checkbox"/>	

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING

SCHOOL OR FACILITY	NAME AND LOCATION OF SCHOOL AND/OR HOSPITAL	DEGREE OR SPECIALTY	START DATE	COMPLETION DATE
Medical School:				
Internship:				
Residency:				
Residency:				
Fellowship:				

How many continuing education credits (CME's) have you completed during the past 3 years?

SECTION 4 – LICENSURE – CERTIFICATION - ASSOCIATION

1. Oklahoma Medical License #:		2. Expiration Date:	
3. Are you licensed in other states? Yes <input type="checkbox"/> No <input type="checkbox"/>		State: _____ License #: _____	State: _____ License #: _____
4. Are you Board Certified? If yes, name of specialty board:		Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Second Specialty Board:		Date Certified:	
6. Third Specialty Board:		Date Certified:	
7. Has your medical license in any state ever been suspended, revoked, denied, or limited? If "Yes", provide details on Section 15.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Are you currently under investigation by any state licensing board or agency? If "Yes", please explain on Section 15.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Medicare#:	10. Medicaid#:	12. OBN#:	
13. Are you an active member of the Oklahoma State Medical Association (OSMA)? A discount is applied to policies issued to OSMA members that are insured on full time basis (discount does not apply to part-time policies). If you are interested in joining the OSMA, please contact the OSMA Membership Coordinator at (405) 843-9571.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. If you are a Doctor of Osteopathy: are you an active member of the Oklahoma Osteopathic Association?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
15. Please list any Medical Society Affiliations:			

SECTION 5 – INSTITUTIONAL PRACTICE

1. Indicate the name and location (city and state) of each hospital where you currently hold staff privileges:	
NAME	LOCATION
a. _____	_____
b. _____	_____
c. _____	_____
2. Has any hospital ever taken action to deny, suspend, revoke, or restrict your medical staff privileges, or your application or reapplication for medical staff privileges? If "Yes", identify hospital, date, and reasons on Section 15.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Have you ever resigned from a hospital staff while under investigation, or to avoid possible disciplinary action? If "Yes", identify hospital, date, and give reasons on Section 15.	
Yes <input type="checkbox"/> No <input type="checkbox"/>	

SECTION 5 – INSTITUTIONAL PRACTICE (continued)

- | | |
|---|--|
| 4. Has any of the following ever been denied, revoked, suspended, reduced, limited, canceled, sanctioned, placed on probation, not renewed, or relinquished for disciplinary reasons? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| a. Oklahoma Bureau of Narcotics (OBN) or other state narcotics registration | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b. Academic appointment | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. Membership on any hospital or healthcare facility medical staff | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. Clinical privileges, prerogatives, or rights on any medical staff | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| e. Membership in other healthcare organizations or facilities | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| f. Professional society membership or fellowship | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| g. Any other type of professional reprimand or sanction | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| h. Educational Commission for Foreign Medical Graduates (ECFMG) certification | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| i. Participation in the Medicare/Medicaid program or other government health benefits program | Yes <input type="checkbox"/> No <input type="checkbox"/> |

SECTION 6 – CLASSIFICATION – PRACTICE

1. Check the box(es) that best describe 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.
- 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, abortions, vasectomies, the removal of any gland or organ, plastic or cosmetic surgery.
-
2. Has there been any change in your practice in the last five (5) years? Yes No
 If “Yes”, provide details on Section 15.
-
3. Do you plan to take additional residencies or change specialties? Yes No
 If “Yes”, provide details on Section 15.
-
4. Do you participate in clinical trials? Yes No
 If “Yes”, indicate what percentage of *your practice* is dedicated to clinical trials: _____
 Indicate the percentage that clinical trials represent of *your total gross receipts*: _____
-
5. Does your practice include locations outside Oklahoma? Yes No
 If “Yes”, indicate locations: _____

SECTION 7 – MEDICAL SPECIALTY

1. What is your present Specialty?		2. Sub-specialty?	
3. Please check the box that best describes your practice:			
<input type="checkbox"/> Aerospace Medicine	<input type="checkbox"/>	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> MAJOR SURGERY (continued):
<input type="checkbox"/> Allergy	<input type="checkbox"/>	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Colon and Rectal
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/>	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Endocrinology
<input type="checkbox"/> Bronco-Esophagology	<input type="checkbox"/>	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Gastroenterology
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> GP/FP not primarily engaged in major surgery
<input type="checkbox"/> Dermatology	<input type="checkbox"/>	<input type="checkbox"/> Otorhinolaryngology	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Geriatrics
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/> Pathology	<input type="checkbox"/> Gynecology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/>	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Hand
<input type="checkbox"/> Family Practice (FP)	<input type="checkbox"/>	<input type="checkbox"/> Pharmacology-clinical	<input type="checkbox"/> Head and Neck
<input type="checkbox"/> Forensic Medicine	<input type="checkbox"/>	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Laryngology
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/> Physical Medicine and Rehabilitation	<input type="checkbox"/> Neoplastic
<input type="checkbox"/> General Practice (GP)	<input type="checkbox"/>	<input type="checkbox"/> Psychoanalysis	<input type="checkbox"/> Nephrology
<input type="checkbox"/> General Preventive Medicine	<input type="checkbox"/>	<input type="checkbox"/> Psychosomatic Medicine	<input type="checkbox"/> Neurology
<input type="checkbox"/> Geriatrics	<input type="checkbox"/>	<input type="checkbox"/> Public Health	<input type="checkbox"/> Obstetrics
<input type="checkbox"/> Gynecology	<input type="checkbox"/>	<input type="checkbox"/> Pulmonary Diseases	<input type="checkbox"/> OB/GYN
<input type="checkbox"/> Hematology	<input type="checkbox"/>	<input type="checkbox"/> Radiology – Interventional* (list procedures in Section 15)	<input type="checkbox"/> Ophthalmology
<input type="checkbox"/> Hospitalist	<input type="checkbox"/>	<input type="checkbox"/> Radiology - Diagnostic	<input type="checkbox"/> Orthopedic –including back
<input type="checkbox"/> Hypnosis	<input type="checkbox"/>	<input type="checkbox"/> Retired	<input type="checkbox"/> Orthopedic – no back
<input type="checkbox"/> Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Otology
<input type="checkbox"/> Intensive Care Medicine	<input type="checkbox"/>	<input type="checkbox"/> Rhinology	<input type="checkbox"/> Otorhinolaryngology
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/>		<input type="checkbox"/> Plastic
<input type="checkbox"/> Laryngology	<input type="checkbox"/>		<input type="checkbox"/> Rhinology
<input type="checkbox"/> Legal Medicine	<input type="checkbox"/>	<input type="checkbox"/> MAJOR SURGERY:	<input type="checkbox"/> Thoracic
<input type="checkbox"/> Neoplastic Diseases	<input type="checkbox"/>	<input type="checkbox"/> Abdominal	<input type="checkbox"/> Traumatic
<input type="checkbox"/> Nephrology	<input type="checkbox"/>	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Urological
<input type="checkbox"/> Neurology	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Vascular
<input type="checkbox"/> Other (please identify):			

SECTION 8 – MEDICAL and SURGICAL PROCEDURES

Please check off "Yes" or "No" for each procedure or activity that you performed in the past year or will perform in the coming year. Indicate the 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.				

SECTION 8 - MEDICAL and SURGICAL PROCEDURES (continued)

8. Plastic surgery-reconstructive? (Medically necessary following surgery or trauma).	Yes	No	# in past year	Changes?
9. Plastic/Cosmetic surgery - elective? (not medically necessary)	Yes	No	# in past year	Changes?
10. Non-surgical cosmetic procedures (Dermabrasion, Botox injections, permanent micro-pigmentation, thread lifts, mesotherapy, etc.)	Yes	No	# in past year	Changes?
11. Administering general anesthesia?	Yes	No	# in past year	Changes?
12. Acupuncture	Yes	No	# in past year	Changes?
13. Angiography – venous	Yes	No	# in past year	Changes?
14. Angiography – arterial	Yes	No	# in past year	Changes?
15. Colonoscopy	Yes	No	# in past year	Changes?
16. Cryosurgery – other than use on benign or non-malignant dermatological lesions or cervix	Yes	No	# in past year	Changes?
17. Discograms	Yes	No	# in past year	Changes?
18. Endoscopic retrograde cholangiopancreatography	Yes	No	# in past year	Changes?
19. Heart Catheterization - with or without coronary angiography	Yes	No	# in past year	Changes?
20. Occasional emergency insertion of central venous recording catheters and temporary pacemakers (Swan Ganz)	Yes	No	# in past year	Changes?
21. Laparoscopy (Peritoneoscopy)	Yes	No	# in past year	Changes?
22. Laser- used in surgery	Yes	No	# in past year	Changes?
23. Lymphangiography	Yes	No	# in past year	Changes?
24. Myelography	Yes	No	# in past year	Changes?
25. Needle biopsy - including lung and prostate	Yes	No	# in past year	Changes?
26. Needle biopsy - including liver, kidney, or bone marrow biopsy	Yes	No	# in past year	Changes?
27. Phlebography	Yes	No	# in past year	Changes?
28. Pneumatic or mechanical esophageal dilation (not with bougie or olive)	Yes	No	# in past year	Changes?
29. Pneumoencephalography	Yes	No	# in past year	Changes?
30. Radiation therapy	Yes	No	# in past year	Changes?
31. Radiopaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae	Yes	No	# in past year	Changes?
32. Electro-Convulsive Shock Therapy (ECT)	Yes	No	# in past year	Changes?
33. Vascular embolization	Yes	No	# in past year	Changes?
34. Chelation therapy	Yes	No	# in past year	Changes?

SECTION 8 - MEDICAL AND SURGICAL PROCEDURES (continued)

	Yes	No	# in past year	Changes?
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 15.				
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 9 - Underwriting

1. Have you ever been treated for, or 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 been institutionalized during the past five years, or do you have a continuing health condition that requires therapy? If "Yes", provide details on Section 15	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. 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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Are you currently engaged in the illegal use of drugs, or the misuse of legal 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"/>
5. 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"/>

SECTION 9 - UNDERWRITING (continued)

6. Date of the most recent physical exam: _____	
7. Significant Findings:	
8. Have you ever been charged of a crime other than a minor traffic offense?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Are there any felony charges pending against you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges, resigned from the medical staff, or surrendered your clinical privileges while under investigation or before a recommendation or decision was rendered by a hospital or health care facility's medical executive or governing board?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Has your employment at a health care organization ever been terminated?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you ever been terminated, rejected, limited, or been excluded or refused membership in a managed care organization (HMO, PPO, PHO, etc.) for a stated reason?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Do you contract with any PPO, HMO or other organization involved in contract medicine? If "Yes", please provide the names of the healthcare plans below:	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>_____</p> <p>_____</p> <p>_____</p>	
Does the contract include an indemnity (hold harmless) agreement?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Estimate of percentage of practice that involved PPO or HMO patients _____	
16. Are you employed by the State of Oklahoma or any of its counties or local government office? If "Yes", indicate percent of time involved in private practice:	Yes <input type="checkbox"/> No <input type="checkbox"/>
17. Are you employed by the Indian Health Services or similar organization? If "Yes", indicate percent of time involved in private practice:	Yes <input type="checkbox"/> No <input type="checkbox"/>
18. Are you employed by the United States Military Service?	Yes <input type="checkbox"/> No <input type="checkbox"/>
19. Do you treat prisoners or jail inmates? If "Yes", indicate name of penal/correctional facility:	Yes <input type="checkbox"/> No <input type="checkbox"/>
20. Has your practice been reduced because of any of the following: (Check all that may apply)	
Semi-retirement <input type="checkbox"/> Disability <input type="checkbox"/> Pregnancy or dependent care <input type="checkbox"/>	
Majority of practice conducted in a teaching role which is insured elsewhere <input type="checkbox"/>	
Majority of practice insured through another entity such as an employer <input type="checkbox"/>	
Maintenance of another practice insured elsewhere <input type="checkbox"/>	
21. List all locations where you will practice and for which practice coverage is being applied for under this application. Name/Address: Hours worked per week: _____ Medical specialty: _____ Refer to Section 15 for additional space.	
22. List all other locations where you will practice and for which practice coverage is <u>NOT</u> being applied for under this application. Name/Address: Hours worked per week: _____ Medical specialty: _____ Insurance carrier providing coverage at the above location: Refer to Section 15 for additional space	

SECTION 9 - UNDERWRITING (continued)

23. Do you participate in telemedicine? Yes No

If "Yes" indicate in Section 15, in which states and what percentage of your practice is dedicated to telemedicine. For the purpose of this question, telemedicine is defined as the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient as a result of transmission of the patient's data by electronic means. Telemedicine does not include an informal consultation provided without the expectation of, or compensation, nor does it include services described above which are rendered in a bona fide emergency.

24. Do you prescribe narcotics using pre-printed pads? Yes No
 If you answer "Yes", please provide a sample/specimen copy of the prescription.

25. If you are a radiologist or pathologist: do you or will you read, interpret, or diagnose films, slides, or specimens taken of patients who reside outside the state of Oklahoma? Yes No

If "Yes", please indicate the state or foreign country where the patient resides:

SECTION 10 - PROFESSIONAL PARTNERSHIP, CORPORATION, or ASSOCIATION

1. Do you operate as a Professional : Partnership Corporation Association

2. Does the professional partnership, corporation, or association with which you are currently affiliated carry separate professional liability coverage? Yes No

3. Do you want your professional partnership/corporation/association covered under your policy, sharing the limits of liability, at no additional charge? Yes No

4. Do you want separate limits of liability for your partnership/corporation/association, for an additional premium?. Yes No

5. Do you own or have ownership interest in a health care facility? Yes No
 If "Yes", provide details on Section 15.

If you are requesting coverage for your professional partnership, corporation or association, please include the organization's information. Refer to Section 15 for a list of the information required.

SECTION 11 - EMPLOYEES

1. Do you, or your partnership/corporation/association employ any of the following?
 Physicians Surgeons Physician Assistants CRNA's
 Nurse Practitioners Midwives RN's LPN's
 Podiatrist

Technicians:

EEG/EKG <input type="checkbox"/>	Laboratory <input type="checkbox"/>	Operating Room <input type="checkbox"/>
Physical therapist <input type="checkbox"/>	Perfusionist <input type="checkbox"/>	Phlebotomist <input type="checkbox"/>
Radiation <input type="checkbox"/>	Radiology <input type="checkbox"/>	Respiratory <input type="checkbox"/>
X-ray <input type="checkbox"/>		

2. Complete a separate PLICO application (Physicians or Ancillary Medical Personnel) for each of the above professionals for whom individual limits of liability are desired.

3. Approximately what percent of the time do you use: Anesthesiologists: _____ CRNA's: _____

4. Do you regularly supervise more than one CRNA at the same time? Yes No

If "Yes", how many:

SECTION 12 – 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 15.

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 from your current insurer with a recent valuation date, 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 \$ _____

What is/was 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: _____

