

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] 815-4803 • Underwriting [405] 815-4801 • Toll Free [866] 867-4566 • [405] 815-4900

FAX: (405) 815-4900

**VOLUNTEER PHYSICIANS PROFESSIONAL LIABILITY
 INSURANCE APPLICATION**

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

SECTION 1 - GENERAL INFORMATION		
Name of Applicant:		Degree or Title:
Address:		
City/State/Zip Code:		
Billing/Mailing Address (if different):		
Home Address:		
NPID#:		Home Phone:
Office Phone:	Fax:	E-Mail:
Web Site:	Soc. Sec. No.:	
Date of Birth:	Place of Birth:	Sex:
Contact Person:		

Please provide on a separate sheet of paper any other names by which you have been known, specifying the dates during which the name was used.

SECTION 2 - COVERAGE INFORMATION					
Requested Limits of Liability:					
<input type="checkbox"/> \$100,000 / \$300,000		<input type="checkbox"/> \$200,000 / \$600,000			
	Insurance Company	Policy Type	Policy Period	Retroactive Date	
Current Year:					
Present Carrier: Please attach a copy of your current policy, including the Declarations Page and all endorsements. If you are presently insured under a Group Policy, attach a copy of your Certificate of Insurance.					
1 st year prior:					
2 nd year prior:					
3 rd year prior:					
4 th year prior:					
5 th year prior:					
Have you ever been denied professional liability insurance or has your coverage ever been non-renewed or cancelled? If "Yes", please explain on a separate sheet.				Yes	No
Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage?				Yes	No
Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument?				Yes	No

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING

	Name and Location of School and/or Hospital	Degree and/or Specialty	Start Date	Completion Date (or Expected)
Medical School:				
Internship:				
Residency:				
Residency:				
Fellowship:				
How many continuing education credits (CME's) have you completed altogether the past 3 years?				

SECTION 4 - CERTIFICATION / LICENSURE / ASSOCIATION

Are you Board Certified?			<u>Yes</u>	<u>No</u>
Name of Specialty Board:				
Date Certified:		Latest Recertification Date:		
Name of Specialty Board (if dual or sub-specialty certified):				
Date Certified:		Latest Recertification Date:		
Professional Degree:				
Medical License No.:				
State:		Expiration Date:		
Medicare No.:	Medicaid No.:		DEA No.:	
Name of Partnership or Professional Corporation:				
Has your medical license in any state ever been suspended, revoked, denied, or limited? If "Yes", please explain on a separate sheet.			<u>Yes</u>	<u>No</u>
Are you currently under investigation by any state licensing board or agency? If "Yes", please explain on a separate sheet.			<u>Yes</u>	<u>No</u>
Are you licensed in other states? Yes _____ No _____ State _____ Lic. # _____				
Are you an active member of the Oklahoma State Medical Association? If "No," is your application for membership pending? If your answer to both questions is "No," you will need to contact the Oklahoma State Medical Association and either join the association or sign an Insurance Affiliate Agreement if you are a new applicant. (405) 843-9571			<u>Yes</u>	<u>No</u>
Are you an active member of the Oklahoma Osteopathic Association?			<u>Yes</u>	<u>No</u>
Have any of the following ever been denied, revoked, suspended, reduced, limited, canceled, sanctioned, placed on probation, not renewed, or relinquished for disciplinary reasons?				
Oklahoma Bureau of Narcotics and Dangerous Drugs (BNDD) or other state narcotics registration			<u>Yes</u>	<u>No</u>
Academic appointment			<u>Yes</u>	<u>No</u>
Membership on any hospital or healthcare facility medical staff			<u>Yes</u>	<u>No</u>
Clinical privileges, prerogatives, or rights on any medical staff			<u>Yes</u>	<u>No</u>
Membership in other healthcare organizations or facilities			<u>Yes</u>	<u>No</u>
Professional society membership or fellowship			<u>Yes</u>	<u>No</u>
Any other type of professional reprimand or sanction			<u>Yes</u>	<u>No</u>

Educational Commission for Foreign Medical Graduates (ECFMG) certification	Yes	No
Participation in the Medicare or Medicaid program or other government health benefits program	Yes	No
Please list Medical Society Affiliations:		

SECTION 5 - HOSPITAL PRIVILEGES AND FREE CLINIC ASSOCIATION		
Please indicate the name and location (city and state) of each hospital where you now hold staff privileges:		
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 a separate sheet.	Yes	No
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 a separate sheet.	Yes	No

SECTION 6 - PRIOR PRACTICE		
Do you currently have any medical and/or psychiatric problem including alcohol and/or drug dependence?	Yes	No
Have you ever been treated for psychiatric, drug or alcohol-related problem?	Yes	No
Have you ever been institutionalized during the past five years?	Yes	No
Do you have any continuing health problems requiring current therapy?	Yes	No
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	No
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	No
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	No
Most recent physical examination date: _____ Significant Findings: _____		
Has your employment at a health care organization ever been terminated?	Yes	No
Have you ever been charged of a crime other than a minor traffic offense?	Yes	No

Are there any felony charges pending against you?	Yes	No
Have you ever withdrawn your application for appointment, reappointment, and/or clinic privileges or resigned from the medical staff or surrendered your clinical privileges while under investigation or before a recommendation or decision by a hospital's or health care facility's medical executive or governing board was rendered?	Yes	No
Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)?	Yes	No
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	No
Are you employed by the State of Oklahoma? If "Yes", indicate percent of time involved in private practice.	Yes	No
Are you employed by the United States Military Service?	Yes	No
Do you treat prison or jail inmates?	Yes	No
Has your practice been reduced because of any of the following? (Check all that apply)		
<input type="checkbox"/> Semi-retirement		
<input type="checkbox"/> Disability		
<input type="checkbox"/> Majority of practice is conducted in a teaching role which is insured elsewhere		
<input type="checkbox"/> Majority of practice is insured through another entity such as an employer		
<input type="checkbox"/> Pregnancy or dependent care		
<input type="checkbox"/> Maintenance of another practice in bordering state that is insured elsewhere		
List Clinic(s) and/or Hospital(s) for which coverage is needed. If additional space is needed, please attach separate sheet.		
Name/Address:		
Number of hours worked per week at the above location:		
Specialty practiced at the above location:		
List all other clinics for which coverage is NOT needed. If additional space is needed, please attach separate sheet.		
Name/Address:		
Number of hours worked per week at the above location:		
Specify practiced at the above location:		
Insurance carrier providing coverage at the above location:		

SECTION 7 - SPECIALTY CLASSIFICATION

What is your present Specialty?		Sub-specialty?
Please check which ONE of the following best describes your practice:		
<input type="checkbox"/> Aerospace Medicine	<input type="checkbox"/> Neurology	<input type="checkbox"/> SURGERY: endocrinology
<input type="checkbox"/> Allergy	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> SURGERY: gastroenterology
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Nutrition	<input type="checkbox"/> SURGERY: general
<input type="checkbox"/> Bronco-Esophagology	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> SURGERY: general practice or family practice-not primarily engaged in major surgery
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> SURGERY: geriatrics
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Otology	<input type="checkbox"/> SURGERY: gynecology
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Otorhinolaryngology	<input type="checkbox"/> SURGERY: hand
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Pain Management	<input type="checkbox"/> SURGERY: head and neck
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Pathology	<input type="checkbox"/> SURGERY: laryngology
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> SURGERY: neoplastic
<input type="checkbox"/> Forensic Medicine	<input type="checkbox"/> Pharmacology-clinical	<input type="checkbox"/> SURGERY: nephrology
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Physiatry	<input type="checkbox"/> SURGERY: neurology
<input type="checkbox"/> General Practice	<input type="checkbox"/> Physical Medicine and Rehabilitation	<input type="checkbox"/> SURGERY: obstetrics
<input type="checkbox"/> General Preventive Medicine	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> SURGERY: obstetrics-gynecology
<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Psychoanalysis	<input type="checkbox"/> SURGERY: ophthalmology
<input type="checkbox"/> Gynecology	<input type="checkbox"/> Psychosomatic Medicine	<input type="checkbox"/> SURGERY: orthopedic - back
<input type="checkbox"/> Hematology	<input type="checkbox"/> Public Health	<input type="checkbox"/> SURGERY: orthopedic - no back
<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Pulmonary Diseases	<input type="checkbox"/> SURGERY: otology

Hypnosis		Radiology - Diagnostic		SURGERY: Otorhinolaryngology
Infectious Disease		Retired		SURGERY: plastic
Intensive Care Medicine		Rheumatology		SURGERY: rhinology
Internal Medicine		Rhinology		SURGERY: thoracic
Laryngology		SURGERY: abdominal		SURGERY: traumatic
Legal Medicine		SURGERY: cardiac		SURGERY: urological
Neoplastic Diseases		SURGERY: cardiovascular disease		SURGERY: vascular
Nephrology		SURGERY: colon and rectal		
Other (please identify):				

SECTION 8 - CLAIMS HISTORY							
Use the following as a guideline for providing an explanation of claims as requested on the application. This form may be reproduced if necessary.							
Please provide information for the following: Each professional liability action against you during the past ten (10) years. Each settlement or decision for the Plaintiff that has occurred on your behalf during the past ten (10) years.							
Case No: _____							
Insurance Carrier's Name _____							
Date of Incident: _____							
Date Filed: _____ Date Closed: _____							
What was/is your status in the case?							
<input type="checkbox"/> Primary Defendant		<input type="checkbox"/> Co-defendant		<input type="checkbox"/> Other (explain)			
<input type="checkbox"/> Pending		<input type="checkbox"/> Found for Defendant		<input type="checkbox"/> Found for Plaintiff			
If pending, when was the last contact with the Plaintiff's attorney?							
If damages were paid, either by settlement or court award, what was the amount?							
Attributed to your involvement: \$				Paid by All Parties?			
Claim No.	Patient Initials	Insurance Company	Date of Medical Incident	Date Reported	Date Claim Was Closed	Amount Paid (on your behalf)	
Have there been or are there currently pending, any malpractice claims, settlements, judgments or arbitration proceedings involving your professional practice? If "Yes", include a list and status (settled, dropped, pending), and explain the nature of the allegation(s).						Yes	No
Please explain in detail on a separate piece of paper: What is/was 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 _____ _____ Identify any other parties named in the suit. _____ _____							

SECTION 9 - 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 Association's 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.

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.

COPIES OF REQUIRED DOCUMENTS

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

Attached	Item
	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
	Current Federal DEA Registration Certificate
	Curriculum Vitae
	Copy of your current policy, including the Declarations page, and all endorsements. If you are insured under a Group policy, include a copy of your current Certificate of Insurance.
	Copy of claims history/loss reports from current and previous carriers for the past ten (10) years.
	Information Packet on the clinics you plan to offer your services.

ADDITIONAL INFORMATION

This section is furnished for your convenience in completing questions or providing additional information. Please provide separate sheet(s) as necessary to fully answer all questions.

As appropriate, note section number and question number that you are addressing.
