West Virginia Board of Risk & Insurance Management

HEALTHCARE PROVIDER PROFESSIONAL LIABILITY INSURANCE APPLICATION

Please mark one of the following:

☐ New Business Application Requested effective date m/d/y : _____

☐ Renewal Application Renewal date m/d/y: _____

Name of applicant			
Applicant primary business address (*street, city, state, zip*)			
Applicant secondary address (*street, city, state, zip*)			
Applicant home address (*street, city, state, zip*)			
Business Phone Number	Home Phone Number	Business Fax Number	E-mail Address
County	Social Security No.	Date and place of birth	
D.E.A. License Number	FEIN	Name of current carrier	
Number of years with current carrier	Existing form of Insurance ☐Occurrence ☐Claims-made	Current policy term	Retroactive date used by your existing carrier
If Claims-made did you purchase an extended reporting endorsement from your current carrier? ☐Yes ☐No		Are you applying for prior acts coverage? ☐Yes ☐No	

Type of practice
☐Individual ☐Intern-Resident ☐Employee ☐Independent Contractor ☐Owner ☐Partner ☐Other

Coverage Limit Sought: ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000

List all Professional Corporations, Professional Associations and Partnerships and other health care related services in which you have ownership.

Name	Description of your interest	% of your practice

If employed, name of employer	Name of employer's current carrier

If you employ or contract medical professionals - complete a and b.

a. Number and desired coverage for employed or contracted. If individual coverage has been obtained with another carrier, please provide verification of current coverage:

b.

	Physician assistant/Surgeon assistant	Shared Limits	Separate Limits	Individual Coverage
	Nurse midwives	Shared Limits	Separate Limits	Individual Coverage
	Nurse anesthetists	Shared Limits	Separate Limits	Individual Coverage
	Nurse practitioner	Shared Limits	Separate Limits	Individual Coverage
	Psychologist	Shared Limits	Separate Limits	Individual Coverage

	Perfusionist	Shared Limits	Separate Limits	Individual Coverage
	Chiropractor	Shared Limits	Separate Limits	Individual Coverage
	Certified Nurse Anesthetists	Shared Limits	Separate Limits	Individual Coverage
	Cytotechnologist	Shared Limits	Separate Limits	Individual Coverage
	Optometrist	Shared Limits	Separate Limits	Individual Coverage

b. If you, as an individual, employ or contract other medical professionals to provide services, list them and their professional occupations (i.e., R.N., L.P.N., etc.) [*Use additional sheets as necessary*]

Do you wish for us to include your partnership or professional corporation as a named insured? ☐Yes ☐No
To what professional organizations do you belong? ☐AMA ☐AOA ☐State Medical ☐County Medical ☐Other

Name of medical school attended	Degree	Date Graduated m/d/y
Location of medical school attended		
Medical specialty % of practice	Medical sub-specialty % of practice	
Are you certified by an approved specialty board? ☐Yes ☐No	Name of Specialty Board	
If a foreign medical school graduate, have you obtained an ECFMG Certificate or a Fifth Pathway Certificate? ☐Yes ☐No	Indicate which certification was obtained and year certified: ☐ECFMG ☐Fifth Pathway Year Certified:	
Name and location where internship served	Completed? ☐Yes ☐No	
Name and location where residency served	Completed? ☐Yes ☐No	
Residency completed: Month Year	Specialty in which residency was done.	

Name all places where you have practiced your profession in the last five years. During years

List all states where you are licensed to practice and license numbers.

State	License No.	% of Patients seen, examined or treated in each state

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Indicate percentage of time devoted to the following medical and/or surgical activities:
(*Total should equal 100%)*

%	%	%**Surgery**
_____ Aerospace Medicine	_____ Nephrology	_____ Abdominal
_____ Allergy	_____ Neurology	_____ Cardiac
_____ Anesthesiology	_____ Nuclear Medicine	_____ Cardiovascular
_____ Broncho-Esophagology	_____ Nutrition	_____ Colon & Rectal
_____ Cardiovascular Disease	_____ Obstetrics/Pre-Natal	_____ Dermatology
_____ Dermatology	_____ Occupational Medicine	_____ General
_____ Diabetes	_____ Oncology	_____ Geriatrics
_____ Emergency Medicine	_____ Ophthalmology	_____ Gynecology
_____ Endocrinology	_____ Orthopedics	_____ Hand
_____ Family Practice or General Practice	_____ Otology	_____ Head & Neck
	_____ Otorhinolaryngology	_____ Neonatal
_____ Forensic Medicine	_____ Pathology	_____ Neurology
_____ Gastroenterology	_____ Pain Management	_____ Obstetrics
_____ General Preventative Medicine	_____ Pediatrics	_____ OB/GYN
_____ Genetic Counseling	_____ Pharmacology-Clinical	_____ Ophthalmology
_____ Geriatrics	_____ Physiatry	_____ Orthopedic
_____ Gynecology	_____ Physical Medicine & Rehabilitation	_____ Otorhinolaryngology
_____ Hematology		_____ Pain Management
_____ Hypnosis	_____ Psychiatry	_____ Pediatric
_____ Infectious Diseases	_____ Psychoanalysis	_____ Plastic
_____ Intensive Care Medicine	_____ Psychosomatic Medicine	_____ Plastic-ENT
_____ Internal Medicine	_____ Public Health	_____ Thoracic
_____ Laryngology	_____ Pulmonary Diseases	_____ Traumatic
_____ Legal Medicine	_____ Radiology	_____ Urological
_____ Neonatology	_____ Rheumatology	_____ Vascular
_____ Neoplastic Diseases	_____ Rhinology	_____ Other _____

Do you perform: *(Please check all boxes that apply.)*

- ☐ **Category 1 --** No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia or circumcision.
- ☐ **Category 2 --** Perform minor surgery or assist in surgery on your own patients.
- ☐ **Category 3 --** All other types of surgery and procedures performed under general anesthesia and assisting in surgery on other than your own patients
- ☐ **Category 4 --** Obstetrics including normal deliveries and c-sections

Please check the following medical techniques or procedures you perform:

☐ Acupuncture – other than acupuncture anesthesia	☐ Elective abortions
☐ Administration of general anesthesia (other than local)	☐ ERCP (Endoscopic retrograde cholangiopancreatography)
☐ Arteriography/Arteriography	☐ Exchange transfusions in newborns
☐ Breast implants	☐ Holistic/Alternative medicine
☐ Breast biopsy	☐ Laser Surgery
☐ Catheterization – arterial, cardiac, or diagnostic, **other than:** Occasional emergency insertion of pulmonary wedge, Pressure recording catheters, or temporary pacemakers.- Urethral catheterization – Umbilical cord catheterization for Diagnostic purposes or for monitoring blood gases in Newborns receiving oxygen	☐ Myelography ☐ Needle biopsy – including lung and prostate but **not including** liver, kidney or bone marrow biopsy ☐ Phlebography ☐ Pneumatic or mechanical esophageal dilatation (not with bougie or olive)
☐ Chelation therapy	☐ Pneumoencephalography
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☐ Cryosurgery – other than external lesions	☐ Radiation Therapy
☐ Endoscopy other than proctoscopy, sigmoidoscopy, colposcopy and cystoscopy	☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts, and fistulae
☐ Dilatation and curettage	☐ Shock therapy
☐ Discograms	☐ Spine surgery
☐ Dermatological surgery ☐ Chemical peels ☐ Chemobrasion ☐ Dermabrasion ☐ Fat transfer ☐ Hair transplants ☐ Silicone injections ☐ Tumescent liposuction	☐ Pain management (medicine only) ☐ Spinal Cord Stimulators ☐ Implantation of drug infused pumps ☐ Sphenopalatine lesioning ☐ Dorsal Root gangliotomies ☐ Thoracic sympathectomies ☐ Trigeminal lesioning ☐ Cordotomies
☐ Elective plastic surgery	☐ Vasectomies
Please indicate below if you do not perform any of the above procedures ☐ NONE OF THE ABOVE	☐ Weight control (medicine only) ☐ Gastric bubble ☐ Gastric stapling

How many scheduled patients do you see per week? _____ How many walk-in patients do you see per week? _____	How many hours do you work per week? _____	
Has there been any change in your practice or specialty in the past five years? ☐Yes ☐No	Change of specialty	When did this change occur?
Change of status – full time to part time ☐ part time to full time ☐	Other	When did this change occur?
Are you subject to the Federal Tort Claims Act: ☐Yes ☐No.		

Name and location of all hospitals where you hold staff or courtesy privileges:

Name	Location (City/State)	Nature of Privileges

1. a. Do you normally staff an emergency room? ☐Yes ☐No
   If yes, is coverage being requested for this work? ☐Yes ☐No
   b. Do you practice in or staff an urgi-center or similar minor emergency clinic? ☐Yes ☐No
   c. Are you employed full time by the Federal Government or are you in the military service? ☐Yes ☐No
   d. Are you engaged in any "moonlighting " activities? ☐Yes ☐No
   Numbers of hours per month spent moonlighting _____
   e. Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? ☐Yes ☐No
   f. Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? ☐Yes ☐No
   g. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked? ☐Yes ☐No
   h. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation ever been invoked? ☐Yes ☐No
   i. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental health? ☐Yes ☐No
   j. Have you ever been asked to participate in or have you volunteered to participate in an impaired physician program? (If yes, please attach a copy of your recovery plan) ☐Yes ☐No
   If yes, was your participation: ☐Mandatory ☐ Voluntary
   k. Have you ever been denied a medical license or been denied certification by a specialty board? ☐Yes ☐No

l. Do you do outside peer reviews or medical exams, or have a contract with an insurance company to do reviews? *if yes, % of practice*_____ ☐Yes ☐No

m. Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program? ☐Yes ☐No

n. Do you provide any diagnostic, consulting or other professional services to patients in states other than those in which you are currently licensed? ☐Yes ☐No

o. Have you ever had any claims of sexual misconduct made against you? ☐Yes ☐No

p. Have you ever had your request for coverage denied, your policy canceled or non-renewed or had a policy issued to you that contained restrictions or special exclusions? ☐Yes ☐No

q. Has a patient or his representative ever filed a complaint or grievance against you with a hospital committee, state licensing or regulatory agency or other medical review committee? ☐Yes ☐No

r. Other than a minor traffic offense, have you ever been convicted of or pled guilty to or entered into a plea agreement for a violation of any law or ordinance? ☐Yes ☐No

s. Have you performed and/or do you currently perform silicone breast implants? (If yes, describe the types and time frames in which they were performed. Confirm compliance with FDA recommendations regarding silicone breast implants.) ☐Yes ☐No

t. In the past twelve months, have you had any injury, illness, or other event occur that may impair, lessen or diminish your physical or mental ability to practice medicine? ☐Yes ☐No

u. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? ☐Yes ☐No

2. Have any claims or suits ever been made or brought against you? ☐Yes ☐No
Indicate number of previous claims or suits (include closed, dismissed, and/or dropped cases) _____
Indicate number of pending claims or suits _____

The attached Supplementary Claims Information Form must be completed for each case indicated above

3. Do you have any knowledge of any claims which might be made against you (other than those indicated above) or activities that might reasonably give rise to a claim or suit being brought against you even if you believe the claim or suit would be without merit? (include any requests for medical records.) ☐Yes ☐No

Explain any "yes" answers to questions 1,2 and 3 immediately above. [use additional sheets as necessary]

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS COMPLETE, ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MISREPRESENTATIONS IN THIS APPLICATION MAY RESULT IN CANCELLATION OR RESCISSION OF COVERAGE. I UNDERSTAND AND AGREE THAT MY POLICY MAY BE ASSIGNED, INDIVIDUALLY OR COLLECTIVELY, PURSUANT TO STATUTE, TO A THIRD PARTY IF THE THIRD PARTY COVERAGE IS COMPARABLE, AS DETERMINED BY THE WEST VIRGINIA BOARD OF RISK AND INSURANCE MANAGEMENT. I FURTHER AGREE TO REMIT PREMIUMS FOR COVERAGE IN A TIMELY MANNER IF COVERAGE IS PROVIDED THROUGH THE WEST VIRGINIA BOARD OF RISK AND INSURANCE MANAGEMENT AND UNDERSTAND THAT FAILURE TO PAY SUCH PREMIUM IN A TIMELY AGREED MANNER MAY RESULT IN CANCELLATION OF COVERAGE.

_____ _____

Applicant Signature Date

⇒ New Business Applicants - Please attached the following to your application: 1) Copy of most current declarations page, 2) Curriculum Vital, 3) Five-year Company Loss History ⇐

For Agent's Use Only

Name of Agency: _____ Name of Agent: _____

Address: _____ Phone Number: _____

Signature: _____ Date: _____

Supplementary Claims Information Form

Please complete a Supplementary Claims Information Form for each case indicated in questions #2 and #3. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

1. Patient's name:_____
2. Date reported to insurance company:_____
3. Name of Insurance Company:_____
4. Date of incident and your treatment:_____
5. Allegations:_____

_____

_____

6. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? € YES NO

7. Status of claim (check applicable answer):

Suit threatened, no action taken

Suit filed but dropped by claimant

Summary judgment in your favor

Court outcome in your favor: € Jury verdict € Directed verdict

Court outcome in favor of plaintiff: € Jury Verdict € Directed verdict $_____ Verdict Amount

Suit settled out of court

a. Date claim paid: _____
b. Amount paid on your behalf: $_____
c. Did you want to settle this claim? YES NO

Awaiting mediation

Awaiting court action $_____ Reserve Amount

Signature:_____ Date: _____

Name (printed): _____