Application for Coverage – Physicians/Surgeons

This application is for claims made coverage. Please read the policy carefully.

I. Personal Information

Full Name

_____ ☐ MD ☐ DO

First Middle Last

Date of Birth: _____ NPI Number: _____

Specialt(y/ies) for which you are requesting coverage: _____

II. Address

Office Address

_____ _____

Street City County State Zip Code

Office Phone: _____ Office Fax: _____ Office E-mail:_____

Website(s): _____

Home Address

_____

Street City County State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Which is best way to contact you? ☐ Home ☐ Office ☐ Cell Phone

III. Corporation Information

_____

Name of Corporation (if applicable) FEIN Number

Type of Corporation: ☐ Individual/Solo Corporation ☐ Partner/Shareholder/Employee

Is there any other name under which you practice (i.e. DBA)? _____

Is your corporation requesting coverage? ☐ Y ☐ N If yes, Shared or Separate Limits _____

Do you or your corporation have a website(s): _____

IV. Limits of Liability

Texas Only:	☐ $200,000/$600,000	☐ $500,000/$1,000,000	☐ $1,000,000/$3,000,000
Florida Only:	☐ $250,000/$750,000	☐ $500,000/$1,500,000	
Pennsylvania Only	☐ $500,000/$1,500,000		
Remainder of States:	☐ $1,000,000/$3,000,000		

Requested **Effective Date**: _____ Requested **Retroactive Date**: _____

Are you purchasing tail coverage from your current carrier? ☐Y ☐N If yes, please provide a copy.

V. Medical Licensure

State: _____ State: _____ State: _____
License #: _____ License #: _____ License #: _____
Expiration Date: _____ Expiration Date: _____ Expiration Date: _____

DEA License Number: _____

Have you ever had any of your licenses revoked, limited, refused, suspended or denied? ☐ Y ☐ N
If yes, give details _____
_____
_____
_____

VI. Certification

Are you American Board Certified? ☐ Y ☐ N ☐ Eligible – until when? _____

Name of Specialty Board(s): _____ Year _____ Recertified _____

Have you ever failed to pass a Board Examination? ☐ Y ☐ N
If yes, give details:_____

Are you certified in

☐ ACLS Year _____ Recertified _____
☐ ATLS Year _____ Recertified _____
☐ PALS Year _____ Recertified _____

VII. Education/Training

Please complete section or attach copy of most current CV.

Medical School

Medical School: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Degree: _____

Are you a Foreign Medical School Graduate? ☐ Yes ☐ No If yes, please provide a copy of your USMLE.

Internship

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Residency

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

VII. Education/Training (cont'd)

Fellowship

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Please explain any gap in training. _____

Are you entering private practice for the first time following your residency, training, military services or an academic position?
☐ Yes ☐ No

VIII. Current Practice and Practice History

Current Practice
Primary Specialty: _____ Percentage of Practice: _____
Secondary Specialty: _____ Percentage of Practice: _____

Average number of hours worked per week? _____
Average number of patients seen per week? _____

Percentage of practice outside of an office location; please provide details: _____
_____
_____

Have there been significant changes in your practice in the past five-years (i.e. changes in specialty, addition or deletion of procedures)? ☐ Y ☐ N If yes, please explain: _____
_____
_____

Practice Locations—Please provide ten (10) years of practice history from most recent, attach additional page if necessary:

Current Practice Locations:

Location 1: _____ From:_____ To:_____
Location 2: _____ From:_____ To:_____
Location 3: _____ From:_____ To:_____
Location 4: _____ From:_____ To:_____
Location 5: _____ From:_____ To:_____

Historic Practice Locations:

Location 1: _____ From:_____ To:_____
Location 2: _____ From:_____ To:_____
Location 3: _____ From:_____ To:_____
Location 4: _____ From:_____ To:_____
Location 5: _____ From:_____ To:_____

VIII. Current Practice and Practice History (cont'd)

Have you ever had medical professional liability insurance declined, canceled, surcharged, nonrenewed, or issued with a deductible or other reduction in coverage? *(Not Applicable for Missouri Applicants.)* ☐ Y ☐ N

If yes, please describe. _____

_____

Do you treat celebrities or professional athletes? ☐ Y ☐ N

If yes, please describe. _____

_____

Does your practice include care at a prison, correctional facility or for inmates? ☐ Y ☐ N

If yes, please note total percentage of your practice and addresses of the facilities? _____

_____

Do you see patients in a Nursing Home? ☐ Y ☐ N

If yes, please not total percentage of your practice and addresses of the facilities? _____

_____

Do you practice as a Hospitalist? ☐ Y ☐ N

If yes, please note total percentage, and addresses of the facilities? _____

_____

Do you have another practice for which you carry separate coverage or coverage is provided for you? ☐ Y ☐ N

If yes, please attach a copy of a declarations page or certificate of insurance.

_____

Did you practice with other physicians in an employer-employee relationship, implied or formal partnership, professional association or Medical Corporation during the period for which you are requesting prior acts coverage? ☐ Y ☐ N

If yes, please list the full name of the entity(ies)/physician(s) with whom you practiced and the period of each such association.

Name of Entity Name of Physician Dates: From - To

_____

_____

_____

IX. Medical Staff

Do you employ/contract/supervise any of the following personnel? Indicate the number of the following non-physician healthcare providers utilized by you or your group? ☐ Employ ☐ Contract ☐ Supervise ☐ N/A

Please indicate the number of staff below.

		CRNA		CNM		Laboratory Technician	
Other Physicians		Nurse Practitioner		Occupational Therapist		Optician	
Interns		Optometrist		Orthodontist		Pharmacist	
Residents		Physical Therapist		Physician's Assistant		Podiatrist	
Fellows		Psychologist		Respiratory Therapist		Speech Therapist	
		Social Worker		Audiologist/Udiologist		X-Ray Technician	
Other (please explain)							

Are you requesting the above to be covered by ALTOR National? ☐ Y ☐ N

If yes, should the ancillary be covered on a shared or separate limit of liability? _____

Are any of the above ancillary staff independent contractors? ☐ Y ☐ N

If yes, please provide declarations page or certificate of insurance.

Do any of the ancillary staff have his/her own coverage? ☐ Y ☐ N

If yes, please provide declarations page or certificate of insurance.

X. Additional Professional Information

Please provide a complete explanation for each question answered "Yes".

A. Has membership in any Professional Association or Society ever been refused, revoked or limited in any way? ☐ Y ☐ N

B. Have you ever had a complaint filed or any action taken against your license by a State Licensing Board? ☐ Y ☐ N

C. Have you ever been treated for alcoholism, narcotic addiction or mental impairment? ☐ Y ☐ N
If yes, please provide details of rehabilitation program including dates of treatment.

D. Have you ever been indicted, charged or convicted of a felony other than a minor traffic violation? ☐ Y ☐ N

E. Do you work as an emergency room physician, other than for maintaining hospital privileges? ☐ Y ☐ N
If yes, do you have separate coverage for this exposure? ☐ Y ☐ N

F. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director or attending physician at any of the following?

☐ Hospital ☐ Sanitarium ☐ Nursing Home ☐ Surgi-Center
☐ Clinic ☐ Laboratory ☐ Blood Bank ☐ Prepaid Health Plan
☐ HMO ☐ Other Medical Facility

If you checked any of the above, please list the names of the facility and your affiliation with them.

Name	Affiliation	Who Provides Coverage for this	Limits

Do you practice medicine at the above institutions? ☐ Y ☐ N
If yes, are you looking for coverage for this exposure? ☐ Y ☐ N

G. Do you ever enter into arbitration or similar agreements with your patients? ☐ Y ☐ N If yes, please attach a copy of the agreement(s).

EXPLANATION OF QUESTION(S) ANSWERED 'YES'

_____
_____
_____
_____

XI. Hospital Privileges Currently Held

Hospital Name	Location	Privileges

Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily? ☐ Y ☐ N
If yes, please give details _____
_____
_____

Have your hospital privileges been expanded in the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or Specialty Board? ☐ Y ☐ N
If yes, please explain. _____
_____
_____

XII. Medical Procedures

Please check the appropriate box, indicating the extent of surgery you perform:

- ☐ No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing or minor lacerations
- ☐ Minor Surgery includes most procedures performed under local anesthesia
- ☐ Assisting in Major Surgery on your own patients # Annually _____
- ☐ Assisting in Major Surgery on patients other than your own # Annually _____
- ☐ Major Surgery includes all procedures done under general, spinal or caudal anesthesia, and specifically includes tonsillectomy, appendectomy, D&C cesarean section, abortion and open reduction of fractures

Please check the procedures which you preform for which you are requesting coverage. Please check any procedure you have performed in the last three years.

- ☐ Abortion (indicate trimesters) ☐1st ☐2nd ☐3rd
- ☐ Acupuncture or Acupressure
- ☐ Adenoidectomy / Tonsillectomy
- ☐ Aesthetic Procedures please list
- ☐ Anesthesia level ☐3 ☐4 ☐5
- ☐ Angiography, Angioplasty, Arteriography
- ☐ Appendectomy
- ☐ Banding Hemorrhoids
- ☐ Bronchoscopy
- ☐ Cardiac Catheterization ☐Left Heart ☐ Right Heart
- ☐ Cesarean Section _____# per yr
- ☐ Chelation Therapy
- ☐ Chemabrasion/Dermabrasion
- ☐ Clinical Trails
- ☐ Cosmetic Plastic Surgery or Procedures (elective) please list

  _____
  _____
  _____

- ☐ Cryosurgery
- ☐ D&C
- ☐ Endoscopic Procedures - please list

  _____
  _____
  _____

- ☐ ERCP
- ☐ Experimental Surgery – please list

  _____
  _____
  _____

- ☐ Fertility/Infertility Treatment – please list

  _____
  _____
  _____

- ☐ Bariatrics – Please list

  _____
  _____
  _____

- ☐ Hemorrhoidectomy
- ☐ Hernias
- ☐ Hysterectomy
- ☐ Insertion of IUD
- ☐ Laparoscopy – please list

  _____
  _____
  _____

- ☐ Laser used in Therapy or Surgery - please list

  _____
  _____
  _____

- ☐ Liposuction, SAL
- ☐ Nerve Block
- ☐ Obstetrical Deliveries at other than licensed Acute Care Hospital
- ☐ Pre-Natal Care (indicate trimesters) ☐1st ☐2nd ☐3rd
- ☐ Pain Management (other than oral analgesics)
- ☐ Laser Eye Surgery
- ☐ Radiation Therapy
- ☐ Reconstructive Plastic Surgery
- ☐ Robotics Surgery
- ☐ Shock Therapy (ECT)
- ☐ Spinal and epidural anesthesia
- ☐ Surgical Hair Replacement
- ☐ Telemedicine
- ☐ Thoracic Surgery
- ☐ Trauma Surgery
- ☐ Trauma Surgery
- ☐ Tubal Ligation
- ☐ Vascular Surgery
- ☐ VBACS____# per year
- ☐ Use of Blood or Blood By-Products that have not been tested for HIV
- ☐ Sex reassignment or transgender surgery
- ☐ X-Ray

XIII. Previous Insurance – Please provide ten (10) years of previous insurance information

Current Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____
Prior Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____
Prior Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____
Prior Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____

XIV. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐Y ☐N
If yes, please complete a claim supplemental for each claim and provide prior carriers loss history.

Total Number of Claims: _____ Open/Reserved: _____ Closed: _____

Any change in your practice as a result of claims? _____
_____
_____

*Warranty**

These warranties* are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by ALTOR National as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

* Some state laws permit the statements on the application to be only representations. If the policy will be issued in one of these states, your statements will be representations and not warranties.

Acknowledged and Agreed:

_____
Applicant Signature Date

Signing this application does not bind the Company to complete the insurance. All information in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

Fraud Warnings:

Notice to Alabama Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Notice to Alaska Applicants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to California Applicants: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Applicants: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Fraud Warnings continued:

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: 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.

Notice to Oregon Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In addition, if an insured or applicant misstates, misrepresents, omits or conceals information, and we rely on such misstatement, misrepresentation, omission or concealment and it is proven to be material to the policy or fraudulent, we may take action, including denying coverage for a claim or other covered event or rescinding, cancelling, or nonrenewing the policy or coverage.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Tennessee Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Washington Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Notice to West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

_____

Signature **Date**

_____

Printed Name **Title**

This application is not valid without your complete signature, date, printed name, and title above.

Altor National
SUPPLEMENT TO APPLICATION
CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ ☐ Male ☐ Female

2. Date of Incident _____ Location of Incident _____
Insurance Carrier _____ Date Reported to Insurer _____

☐ Suit ☐ Demand for Money ☐ Incident Only
☐ Notice of Intent to Sue ☐ Request for Records ☐ Other _____

3. Summary of condition/diagnosis at time of incident

_____
_____
_____
_____
_____

4. Description of treatment rendered, including dates.

_____
_____
_____
_____
_____

5. Allegation

_____
_____
_____
_____
_____

6. Other physicians or entities involved

_____
_____

7. Status/Disposition of Claim:
- ☐ Closed without indemnity payment
- ☐ Settled
- ☐ Judgment/Verdict
  - ☐ For the defense
  - ☐ For the plaintiff

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendant(s)	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

☐ Open—please provide current status and defense strategy: _____

8. Has there been a change in practice as a result of this claim(s)? ☐ Yes ☐ No
If yes, what has been the change? _____
_____
_____

I understand this information is part of my Application.

Please print your name _____

Signature _____ Date _____