



# Voluntary Attending Physicians (VAP) Application for Professional Liability Insurance

Please return the original application, along with a copy of your New York State professional license, and the declaration page from your current insurance policy (if applicable), in the enclosed pre-addressed envelope. All questions must be answered. If a question is not applicable, write "NONE." Please attach additional pages and date and initial each attachment.

Check appropriate hospital

- Checkboxes for hospital selection: Beth Israel Medical Center, Mount Sinai Medical Center, Maimonides Medical Center, New York Eye & Ear Infirmary, Montefiore Medical Center.

You must have current privileges in place at one of the above hospitals to qualify for enrollment.

If your application is approved, coverage can be provided no earlier than the day following the postmark on the envelope containing the completed and signed application.

## General Information

1. The desired effective date of coverage is \_\_\_\_\_

2. This is an individual professional liability insurance application for a (check one)  Physician (MD, DO)  Dentist (DDS, DMD)

3. Applicant information

Name \_\_\_\_\_ LAST DESIGNATION (MD, DO, ETC.) FIRST MI

Residence phone number \_\_\_\_\_

Residence fax number \_\_\_\_\_

E-mail address \_\_\_\_\_

Date of birth \_\_\_\_\_ Sex  Male  Female

New York State professional license number \_\_\_\_\_

Federal DEA number \_\_\_\_\_ Social Security number \_\_\_\_\_

Do you have a license to practice outside of New York State (NYS)?  Yes  No

If yes, which state(s)? \_\_\_\_\_

Non-NYS professional license number(s) \_\_\_\_\_

Status \_\_\_\_\_

What percentage (%) of your practice is located outside of NYS? \_\_\_\_\_

4. Mailing address

Address fields: NUMBER, STREET, APT., CITY, STATE, ZIP CODE

Billing address (if different from mailing address)

Billing address fields: NUMBER, STREET, APT., CITY, STATE, ZIP CODE

5. Professional office locations (please list your primary office location first)

a. \_\_\_\_\_  
STREET CITY STATE ZIP

\_\_\_\_\_ OFFICE PHONE OFFICE FAX OFFICE E-MAIL

b. \_\_\_\_\_  
STREET CITY STATE ZIP

\_\_\_\_\_ OFFICE PHONE OFFICE FAX OFFICE E-MAIL

An **Occurrence Policy covers** claims brought against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice during the policy period, regardless of when the claim is made. As long as you provided (or failed to provide) those professional services during the policy period, a related claim is covered no matter when it is brought against you.

A **Claims Made Policy covers** claims made against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice as long as the claim is first made against you and reported during the policy period or within 60 days after expiration of the policy or any renewal thereof. You must have provided (or failed to provide) these professional services on or after the retroactive date and before the end of the policy period **and** the claim must be first reported to the company during the policy period or within 60 days following any termination of coverage. A claim is not covered under this policy unless **both** conditions are met. (See page 10.) An Optional Extended Reporting Period Endorsement may be purchased, which would provide an unlimited time period to report claims.

6. Coverage type requested  Occurrence  Claims Made (complete page 10)

## Professional Activities

1. Specialty(ies)

a. Coverage (see page 12) requested for Code \_\_\_\_\_ Specialty \_\_\_\_\_

b. Sub-specialty \_\_\_\_\_

c. Board certification(s) \_\_\_\_\_  
SPECIALTY DATE ACQUIRED  
 \_\_\_\_\_  
SPECIALTY DATE ACQUIRED

2. Date practice as licensed professional commenced \_\_\_\_\_  
MM DD YYYY

Medical school \_\_\_\_\_ Degree \_\_\_\_\_ Year \_\_\_\_\_

Internship/Residency \_\_\_\_\_ Specialty \_\_\_\_\_ Year \_\_\_\_\_

Residency \_\_\_\_\_ Specialty \_\_\_\_\_ Year \_\_\_\_\_

Fellowship \_\_\_\_\_ Specialty \_\_\_\_\_ Year \_\_\_\_\_

If you are a new graduate, check here

3. Licensing board/governmental agency disciplinary proceedings

- a. Has your license to practice ever been revoked in any state?  Yes, specify MM/YY \_\_\_\_\_  No
- b. Has your license to practice ever been suspended/restricted in any state?  Yes, specify MM/YY \_\_\_\_\_  No
- c. Has your license to practice ever been voluntarily surrendered?  Yes, specify MM/YY \_\_\_\_\_  No
- d. Have you ever been placed on probation in any state?  Yes, specify MM/YY \_\_\_\_\_  No
- e. Has your permit to prescribe medications ever been denied/revoked?  Yes, specify MM/YY \_\_\_\_\_  No
- f. Has your permit to prescribe medications ever been restricted/voluntarily surrendered?  Yes, specify MM/YY \_\_\_\_\_  No
- g. Are there any investigative or disciplinary actions by any governmental agency currently pending against you in any state?  Yes, specify MM/YY \_\_\_\_\_  No

Please provide details for any 'Yes' answers above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?  Yes, specify MM/YY \_\_\_\_\_  No

Please provide details for a 'Yes' answer above and provide a letter from your treating physician addressing your state of health and whether any condition exists that could adversely affect the practice of your medical specialty.

\_\_\_\_\_

5. Health care facility/professional medical association disciplinary proceedings  
(exclude disciplinary proceedings for lateness in recordkeeping and/or lateness in submitting proof of insurance coverage)

- a. Have your privileges ever been revoked by any hospital/other institution/managed care organization?  Yes, specify MM/YY \_\_\_\_\_  No
- b. Have your privileges ever been restricted or suspended by any hospital/other institution/managed care organization?  Yes, specify MM/YY \_\_\_\_\_  No
- c. Are you aware of any disciplinary proceedings pending against you?  Yes, specify MM/YY \_\_\_\_\_  No
- d. Have you ever voluntarily relinquished privileges at any hospital/other institution/managed care organization?  Yes, specify MM/YY \_\_\_\_\_  No

Please provide details for any 'Yes' answers above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Average number of patients seen per week at your professional office location(s) \_\_\_\_\_

7. As of the effective date of this insurance, will you be practicing as

a. A solo private practitioner?  Yes  No

b. An employee of a partnership, professional corporation, group or physician/surgeon?  Yes  No

c. A full-time or part-time hospital employee?  Yes  No

If yes, provide hospital name and hours worked per week \_\_\_\_\_

d. A full-time or part-time employee of a nursing home, managed care facility or other health care facility?  Yes  No

If yes, provide facility name and hours worked per week \_\_\_\_\_

e. An independent contractor?  Yes  No

If yes, with whom are you under contract? \_\_\_\_\_

8. Indicate each hospital, nursing home, managed care facility and/or other health care facility where you **have had** privileges to treat patients during the past 12 months or to which you are applying for privileges. Provide the number (not percentage) of admissions, consultations and/or procedures performed at each facility.

	FACILITY	POSITION	NUMBER OF ADMISSIONS	NUMBER OF CONSULTS	NUMBER OF SURGERIES/ DELIVERIES/ PROCEDURES	DO YOU TREAT CLINIC OR SERVICE PATIENTS?*	
						YES	NO
<input type="checkbox"/> **							
<input type="checkbox"/> **							
<input type="checkbox"/> **							
<input type="checkbox"/> **							
<input type="checkbox"/> **							
<input type="checkbox"/> **							
<input type="checkbox"/> **							
<input type="checkbox"/> **							

\*A clinic or service patient is one whose care is rendered by a hospital house staff member under your supervision.

\*\*Please indicate in the box provided where you **will have** privileges at the onset of your coverage.

## Prior Insurance and Claims Information

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1. List your insurance history for the past five (5) years (new graduates should include residency).

Insurer \_\_\_\_\_ Policy number \_\_\_\_\_ from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Insurer \_\_\_\_\_ Policy number \_\_\_\_\_ from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Insurer \_\_\_\_\_ Policy number \_\_\_\_\_ from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Insurer \_\_\_\_\_ Policy number \_\_\_\_\_ from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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2. Is your current policy Claims Made?  Yes (If yes, complete pages 10 and 11)  No

3. Has any insurer ever canceled, declined, refused to renew, or restricted professional liability insurance to you, or offered such insurance to you with a deductible or at higher than regular rates?  Yes  No

If yes, explain, and include name of company \_\_\_\_\_  
\_\_\_\_\_

4. Have you ever been surcharged by an insurer?  Yes  No

If yes, explain, and provide date \_\_\_\_\_

Have you received notice that a surcharge will be imposed in a future period?  Yes  No

If yes, explain, and provide name of company \_\_\_\_\_  
\_\_\_\_\_

5. Have you ever practiced without professional liability insurance?  Yes  No

If yes, provide details, including dates \_\_\_\_\_

6. Have you ever had a malpractice claim or suit (closed or pending) asserted against you?

Yes, provide number \_\_\_\_\_  No

If yes, complete the Claim Information section on page 17, 18 or 19 for each case.

7. Are you aware of any event(s) or incident(s) that may or will result in a claim against you?  Yes  No

If yes, provide details of each and specify which have been reported to your current professional liability insurer.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Business Entities

1. Are you a medical director, department head or chief of staff at a hospital, nursing home, HMO, managed care facility or other health care facility?  Yes  No

If yes, please provide the following information for *each* facility

Facility \_\_\_\_\_

Insurance carrier \_\_\_\_\_

2. Do you own or operate a hospital, nursing home, clinic, laboratory, sanitarium, dispensary or other medically related business?

Yes  No

If yes, provide Official corporate name \_\_\_\_\_

Type of operation/services offered \_\_\_\_\_

Your relationship to business \_\_\_\_\_

Insurance carrier \_\_\_\_\_

3. Are you a partner, shareholder, director, officer, employee or member of a medical partnership, professional corporation, association, joint venture or other health care facility?  Yes  No

a. Please specify type  medical partnership  professional corporation  association  joint venture  other

b. What is the name of the entity(ies)?

\_\_\_\_\_  
NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY STATE ZIP CODE

\_\_\_\_\_  
NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY STATE ZIP CODE

c. Date of formation \_\_\_\_\_

d. Professional liability insurance carrier of the entity \_\_\_\_\_

e. What is your relationship to the entity?  shareholder  employee  other \_\_\_\_\_

Your individual Hospitals Insurance Company, Inc. (HIC) policy will provide professional liability coverage for the professional entity only if 50% or more of the entity owners (e.g., shareholders, partners, members, etc.) maintain primary professional liability coverage with HIC. Therefore, you must list the name of each entity owner and his/her respective primary professional liability carrier. Incomplete information or a change in the relevant percentage of entity owner to below 50% after the date of your application may preclude HIC from providing liability coverage to your corporation.

Entity owner (if there are additional entity owners, please list on page 22)

Name \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Name \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Name \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

4. Do you individually, or does your professional entity, employ or contract with other physicians, surgeons or dentists?

Yes  No

If yes, please list. Name \_\_\_\_\_

Medical speciality \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Medical speciality \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Medical speciality \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Relationship \_\_\_\_\_

**[Please note that your HIC policy will not provide you with coverage for your liability arising out of the acts or omissions of employed physicians or surgeons unless they are also insured against professional liability with Hospitals Insurance Company, Inc.]**

5. Do you individually, or does your professional entity, employ or contract with any physician, dentist, nurse-midwife, nurse-anesthetist, nurse-practitioner, podiatrist, chiropractor, radiation therapist, physician's assistant or registered specialist's assistant?  
 Yes  No

If yes, provide name, profession and license number of each such person.

Name \_\_\_\_\_

Profession \_\_\_\_\_ License \_\_\_\_\_

Name \_\_\_\_\_

Profession \_\_\_\_\_ License \_\_\_\_\_

Name \_\_\_\_\_

Profession \_\_\_\_\_ License \_\_\_\_\_

**[Please note that your HIC policy will not provide you with coverage for your liability arising out of the acts or omissions of any employed physicians, dentists, nurse-midwives, nurse-anesthetists, nurse-practitioners, podiatrists, chiropractors, radiation therapists, physician's assistants or registered specialist's assistants unless those persons are also insured against liability by HIC.]**

6. Have you signed, or will you sign, any contract or agreement to assume the liability of others?  Yes  No

**[Please note that your HIC policy will not provide you with coverage for liability of others that you assume by contract or agreement.]**

## Part-time Private Practice Coverage

Hospitals Insurance Company, Inc. (HIC) provides a discounted premium to part-time physicians and surgeons whose total practice covered under a HIC policy does not exceed **20 hours** in any given week. Part-time private practice coverage is not available to the following premium classes: **Cardiothoracic Surgery, Neurosurgery, Obstetrics and Orthopedic Surgery.**

Use the table below to record the number of hours spent weekly in the portion of your practice to be covered by HIC. (Include all professional activity as a physician or surgeon, including patient care, record keeping, consultation, hospital rounds, accreditation and other review functions on behalf of a hospital, long-term care facility, medical group or professional society.)

**Hours By Day of Week**

	IN OFFICE	IN HOSPITAL	OTHER	HOSPITAL NAME(S) (Please Print)	TOTAL HOURS
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
<b>TOTAL</b>					

Number of hours per week that are or will be covered by insurance **other** than HIC \_\_\_\_\_ (if none, write none).

Describe all activities covered by such insurance and name the insurance company(ies) and policy number(s) \_\_\_\_\_

**As a condition for this reduced rate of premium, an endorsement will be attached to your policy excluding coverage for these activities.**

Number of hours per week for which you require coverage under a HIC policy \_\_\_\_\_

Describe all activities to be covered by HIC policy \_\_\_\_\_

This is to certify that my practice (including all locations), other than time devoted to teaching activities, is limited to not more than 20 hours per week. As a further condition for a reduced premium, I herein consent to an audit of my records to substantiate the limited hours of practice to be covered by Hospitals Insurance Company, Inc.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

**NOTE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 WILL INVALIDATE YOUR INSURANCE COVERAGE.**

## Discounts

### No Consent Discount

I hereby authorize Hospitals Insurance Company, Inc., in exchange for a discount to my basic premium, to settle any and all claims brought against me without my consent.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

### Full Payment Discount

To qualify for a full payment discount, I will pay Hospitals Insurance Company, Inc. the full premium in a lump sum.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

## Certifications

### Risk Management Course

I have completed a New York State Insurance Department approved risk management course with my present carrier.

Provider \_\_\_\_\_

Date of completion \_\_\_\_\_

(Submit proof of course completion, including date discount became effective.)

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

## For Claims Made Policies *Only*

If coverage is selected on a Claims Made basis (individual and professional partnership/corporation/association), please note the following:

1. The policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts that took place prior to the retroactive date stated in the policy, unless prior acts coverage is purchased pursuant to number 5 (below).
2. The policy covers only claims against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice. You must have provided (or failed to provide) these professional services on or after the retroactive date and before the end of the policy period **and** the claim must be first reported to the company during the policy period or within 60 days following any termination of coverage. (A claim is not covered under this policy unless **both** conditions are met.)
3. The automatic extended reporting period coverage is not unlimited and potential coverage gaps may arise upon its expiration unless the named insured purchases Optional Extended Reporting Endorsement Coverage. Optional Extended Reporting Endorsement Coverage covers you for claims which are first reported to the company **after** the 60th day following any termination of coverage. **Optional extended reporting endorsement coverage does not extend the period during which you may provide professional services.** Optional Extended Reporting Endorsement Coverage is valid for an unlimited time period, except that it may be cancelled by the company if you fail to pay the premium for this coverage when it is due.
4. During the first several years of the Claims Made relationship, Claims Made rates are comparatively lower than occurrence rates. The named insured can expect substantial annual premium increases, independent of overall rate level increases, until the Claims Made relationship reaches maturity.
5. Prior acts (nose/retroactive) coverage

a. Is this policy to replace an existing Claims Made policy?  Yes  No

b. Do you wish prior acts (nose) coverage beginning on the initial issue date of your expiring Claims Made policy?

Yes  No

The desired effective date of coverage is (see General Information page 1, number 1) \_\_\_\_\_

The desired retroactive date of policy is (see below) \_\_\_\_\_

c. Do you know of any claims or incidents that may lead to potential claims, for medical services you provided that occurred during the period for which prior acts coverage is desired, that have not been reported to the previous carrier of record?

Yes  No

If yes, please explain (attach additional pages if necessary) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

d. If prior acts (nose/retroactive) coverage is desired for a time period covered by another insurer, list the following

CARRIER	POLICY NUMBER	DATES OF POLICY
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CARRIER	POLICY NUMBER	DATES OF POLICY
---------	---------------	-----------------

CARRIER	POLICY NUMBER	DATES OF POLICY
---------	---------------	-----------------

SIGNATURE OF APPLICANT	DATE
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*continues*

e. Indicate if and how any classification (*i.e.* specialty, full-time to part-time) or territory has been modified since you *first* entered into the Claims Made program.

Type of change \_\_\_\_\_

Effective date of change \_\_\_\_\_

Type of change \_\_\_\_\_

Effective date of change \_\_\_\_\_

If you ever made changes to your specialty classification (as noted above) and changes have occurred or if you are requesting a change now, please provide your prior insurance history for all Claims Made policies including name and address of insurance carrier, policy numbers and dates of coverage since you first entered into the Claims Made program.

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

I authorize the Hospitals Insurance Company, Inc. to verify the above information with my prior insurance carriers.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

## Specialty Classifications\*

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### PREMIUM CLASS 1

- 80152 Neurosurgery

### PREMIUM CLASS 2

- 80153 Obstetrics and Gynecology

### PREMIUM CLASS 3

- 80144 General Surgery (*including* bariatric surgery)

### PREMIUM CLASS 4

- 80154 Orthopedic Surgery

### PREMIUM CLASS 5

- 80143 Cardiothoracic Surgery
- 80143 General Surgery (*excluding* bariatric surgery)

### PREMIUM CLASS 6

- 80167 Gynecology Only (*excluding* prenatal care; obstetrical deliveries of any kind except for assistance at Cesarean sections; induced abortions except for those in the first trimester; or treatment of spontaneous abortions except for those in the first trimester)
- 80291 Otolaryngology (*including* cosmetic plastic surgery)
- 80156 Plastic and Reconstructive Surgery
- 80146 Vascular Surgery
- 80155 Colon and Rectal Surgery and/or Proctology
- 80157 Family/General Practice (*including* limited major surgery)
- 80288 Neurology and/or Psychiatry (*including* supervision, direction and/or performance of myelography and/or angiography)
- 80159 Otolaryngology (*excluding* cosmetic plastic surgery)
- 80145 Urology (*including* major surgery)

### PREMIUM CLASS 8

- 80280 Computerized Tomography
- 80280 Diagnostic Radiology Only
- 80280 Diagnostic Radiology and Radiation Oncology

### PREMIUM CLASS 9

- 80102 Emergency Medicine

### PREMIUM CLASS 10

- 80284 Internal Medicine (*including* cardiac catheterization)

### PREMIUM CLASS 11

- 80285 Otolaryngology (*including* minor surgery, *excluding* tonsillectomy and adenoidectomy)
- 80421 Family/General Practice (*including* minor surgery)

### PREMIUM CLASS 12

- 80261 Neurology and/or Psychiatry (*excluding* supervision, direction and/or performance of myelography and/or angiography)

### PREMIUM CLASS 13

- 80151 Anesthesiology

### PREMIUM CLASS 14

- 80282 Dermatology (*including* dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using phenol, Mohs microsurgery and all procedures listed in 80256 dermatology)
- 80257 Internal Medicine (*excluding* cardiac catheterization but *including* cardiology, gastroenterology, rheumatology, pulmonary medicine, endocrinology and medical oncology)

- 80253 Radiation Oncology Only

- 80294 Urology (*including* minor surgery)

### PREMIUM CLASS 15

- 80114 Ophthalmology (*including* major surgery)

### PREMIUM CLASS 16

- 80233 Family/General Practice (*excluding* surgery)
- 80289 Ophthalmology (*including* minor surgery)
- 80293 Pediatrics (*excluding* tonsillectomy and adenoidectomy, other major surgery or general or spinal anesthesia)

### PREMIUM CLASS 17

- 80266 Pathology and/or Hematology

### PREMIUM CLASS 18

- 80254 Allergy (*including* pediatric allergy)
- 80256 Dermatology (*including* use of laser, face peels with agents other than phenol, collagen injections and sclerotherapy, but *excluding* all procedures listed in 80282 dermatology)
- 80263 Ophthalmology (*excluding* surgery)
- 80235 Physical Medicine, Rehabilitation, Preventive Medicine, Public Health
- 80249 Psychiatry (*excluding* supervision, direction and/or performance of myelography and/or angiography)

### PREMIUM CLASS 20

- 80210 Oral Surgery (*including* dentists engaged in oral surgery or operative dentistry on patients rendered unconscious through the administration of any anesthesia or analgesia)

\***NOTE:** For insurance purposes, tonsillectomies, adenoidectomies, Cesarean sections, and abortions (other than the treatment of spontaneous abortions) are considered major surgery.

A physician will not qualify for a Family/General Practice classification if he/she (1) performs open orthopedic procedures or elective intra-abdominal surgery including hysterectomies, cholecystectomies, or gastrectomies or (2) in the opinion of the underwriters, represents a risk similar to that of a specialist.

## Practice and Underwriting Information

Classification code \_\_\_\_\_ Specialty \_\_\_\_\_ (see page 12)

Have your practice procedures or your specialty changed in the past five years? If yes, please explain, including dates of changes.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate any procedures or therapies you perform in your practice. Provide additional information as requested and answer all questions.

	Yes	No
Abortion . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
By suction curettage up to 12 weeks . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Where is it performed (circle one)?   Office   Hospital   Clinic		
Acupuncture (If yes, enclose certificate) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Alternative medicine . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
_____		
Anesthesia . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Administered outside hospital . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify where administered _____		
Distance to nearest hospital _____		
Equipment available in the event of emergency _____		
Written transfer agreement with nearby hospital? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Angiography . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Botox, Restylane . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac catheterization . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Colon and rectal surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Limited to colon, rectum, anus . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal approach . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
_____		
Dermabrasion . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

*continues*

	Yes	No
Dilatation and curettage . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic dilatation and curettage . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Electric shock therapy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Type _____		
If perform endoscopic retrograde cholangiopancreatography, where is it performed (circle one)?	Office	Hospital    Clinic
Facial peels . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Hair transplants . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Laparoscopy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Procedures _____		
_____		
Laser therapy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Eye . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Skin . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Liposuction . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Lithotripsy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Mohs microsurgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Myelography . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical/Gynecological care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Limited to gynecological surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
If yes, provide full details _____		
_____		
Prenatal . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Deliveries . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Home deliveries . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
VBACs . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

*continues*

	Yes	No
Organ transplants (excluding corneal) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker insertion . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pain management . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
_____		
Plastic/cosmetic surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Radiological studies . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Interventional radiology . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
General (specify type and percentage) _____		
Other (specify type and percentage) _____		
In non-hospital setting (specify where, type, percentage, equipment available in the event of emergency, and if there is a written transfer agreement with a nearby hospital) _____		
_____		
Thoracic surgery (cardiac) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic surgery (non-cardiac) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Vascular surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Weight control therapy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Medications prescribed _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight control surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Procedures _____		
_____		
X-ray therapy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Deep and superficial (if yes, provide preceptor training details and number of years of experience)		
_____		
Isotope (if yes, provide preceptor training details and number of years of experience)		
_____		

**Medical and Family/General Practice Specialties *Only*** (This section does not apply to surgical specialties.)

Indicate which of the following procedures you currently perform, or anticipate performing in the next 12 months, and the number you anticipate performing (include office and hospital practice).

	Yes	No	Number
Deliveries .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoidectomies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pilonidal cysts .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Open reduction of fractures .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closed reduction of fractures .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excision of superficial growths .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diagnostic dilatation and curettage .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herniorrhaphies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsillectomy and adenoidectomy .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abortions (suction curettage through 12 weeks) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vasectomies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose vein surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Assistance at major surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prenatal care .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Limited to uncomplicated pregnancies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
(Prenatal care for uncomplicated pregnancies does not include the care of patients with high-risk conditions such as hypertension and diabetes, or pregnancies with known breech presentations or multiple gestations, unless there is antepartum consultation with a qualified obstetrician and a qualified obstetrician is readily available for consultation and treatment of the patient if necessary.)			
Other major/minor procedures .....	<input type="checkbox"/>	<input type="checkbox"/>	
(other than those listed in Practice and Underwriting Information)			
Specify type _____			_____



## Claim/Lawsuit Information

Patient name \_\_\_\_\_  
LAST FIRST MI

Age \_\_\_\_\_ Sex  Male  Female

Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Nature of allegation in the claim or suit \_\_\_\_\_

Date of incident \_\_\_\_\_

Report date \_\_\_\_\_

Insurance carrier \_\_\_\_\_

Name of other doctor(s) and hospital(s), if any, involved in claim or suit \_\_\_\_\_  
\_\_\_\_\_

### Disposition of the claim

- Abandoned (no activity over 3 years)
- Won by defense
- Judgment or verdict vs. co-defendant(s) only
- Settled or  won by claimant If so, how much was paid on your behalf? \_\_\_\_\_
- Open (current status) \_\_\_\_\_

Location of incident \_\_\_\_\_

Narrative description of the medical facts (must include, but not be limited to the type of treatment and/or surgery; your involvement, i.e., consultant, assistant in surgery, ED physician, primary surgeon, resident, other).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above information is complete and true to the best of my knowledge and belief.

\_\_\_\_\_  
SIGNATURE OF APPLICANT



## Request for Certificate of Insurance

---

I authorize the Hospitals Insurance Company, Inc. (HIC) to issue Certificate(s) of Insurance to the following:  
(Print clearly, include full address and make copies of blank form for future use.)

Attention \_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

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Attention \_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

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Attention \_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

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Attention \_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

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Attention \_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

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Attention \_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

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**Please sign, date and return to:** Hospitals Insurance Company, Inc.  
50 Main Street, Suite 1220  
White Plains, NY 10606

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

## Release and Authorization

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I hereby authorize HIC to obtain full information from any insurer or from any person, health care facility, organization or governmental agency with respect to any claim, suit or incident pertaining to professional acts or omissions asserted against me. I recognize that I may be required to furnish, as part of my application, a copy of my National Practitioner Data Bank report. I expressly release and discharge any insurers, persons, organizations or agencies, including but not limited to HIC, from liability for providing or receiving such information. I further authorize that a photocopy of this release may be accepted with the same authority as the original.

I appoint HIC (and/or such attorneys or representatives as it may appoint) to act in my behalf as attorney in fact in exercising any or all of my rights arising under or in relation to the policies of insurance, which are, have been, or will be in force for my benefit, including but not limited to the following: notification of claims; presentation of information and documentation; demand, receipt and remittance of payments and any other monies representing the liabilities of insurers under policies covering me, making of financial arrangements to facilitate the payment of claims and any other actions that HIC may deem necessary or useful. This appointment shall apply in respect of all insurance policies arranged for me by HIC whether they be past, present or future.

I hereby attest that the statements made in this application are true, complete and accurate and may be relied upon by HIC for the purpose of issuing coverage.

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SIGNATURE OF APPLICANT

---

FULL NAME (PLEASE PRINT)

---

DATE OF SIGNATURE

**NOTE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 WILL INVALIDATE YOUR INSURANCE COVERAGE.**





Application for Excess (Section 18) Professional Liability Insurance

Excess (Section 18) professional liability insurance is available to you at no charge, provided you have the following: a) a valid New York State license to practice medicine; b) an individual primary professional liability policy of \$1.3 million/\$3.9 million; c) an affiliation with a New York State general hospital and d) completion of a qualified risk management program.

GENERAL INFORMATION

New York State professional license number Date of birth
Federal DEA number Specialty class code (see page 12)
Phone number E-mail address
Medical/Dental school attended Date graduated

TO APPLY FOR THIS COVERAGE, THE FOLLOWING MUST BE COMPLETED.

1. Name LAST FIRST MI
2. Mailing address STREET CITY STATE ZIP
3. Name of primary hospital affiliation
4. Additional hospital affiliation(s)
5. Primary coverage insurance company Policy number
6. Risk management program completed? Yes No Provider Date completed MM/YY
7. Boards certification(s)
8. Licensing board disciplinary proceedings
(a) License to practice ever revoked/suspended in any state? Yes No If yes, date
(b) Probation ever invoked in any state? Yes No If yes, date
9. Hospital disciplinary proceedings
(a) Privileges ever revoked in any hospital? Yes No If yes, date
(b) Privileges ever restricted or suspended in any hospital? Yes No If yes, date
10. Claim history? None Yes (If yes, attach additional page(s) to list claimant's name, date of incident and settlement, and amounts paid.)
11. Do you own or operate a hospital, medical clinic or laboratory? Yes No
If yes, provide name and address
12. Is your practice limited to 20 hours or less per week (excluding teaching time)? Yes No
13. Do you, as an individual or a professional corporation, employ any other licensed physician, dentist, podiatrist, osteopath, certified nurse midwife, laboratory technician, licensed X-ray therapy technician, nurse, licensed dental hygienist, pharmacist, optician, licensed X-ray therapist, nurse anesthetist or physiotherapist? Yes No

IMPORTANT: THIS APPLICATION AND RELEASE MUST BE SIGNED BY THE APPLICANT.

I authorize the release and exchange of information, involving but not limited to claim matters, between my professional society or association, previous insurance carrier, hospital or clinic and Hospitals Insurance Company, Inc. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT
FULL NAME (PLEASE PRINT)
DATE OF SIGNATURE

THIS COVERAGE WILL NOT BE EFFECTIVE UNTIL YOUR APPLICATION IS ACCEPTED AND YOU RECEIVE WRITTEN NOTIFICATION FROM HOSPITALS INSURANCE COMPANY, INC.

