Professional Liability/Medical Malpractice
Preferred • Standard • Non-Standard

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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a 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.

APPLICATION FOR PHYSICIANS & SURGEONS PROFESSIONAL LIABILITY INSURANCE

Notice: The policy for which application is made applies only to "Claims" first made during the "Policy Period." Unless amended by endorsement, the limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: ______________________
   (ii) Professional Degree: ______________________
   (b) Principal practice address: ______________________
   (Street) (County)
   ____
   (City) (State) (Zip)
   (c) Additional practice locations: ______________________
   ____
   ____
   (d) (i) Phone: ______________ (ii) Fax: ______________
   (iii) E-Mail Address: ______________ (iv) Website Address: ______________
   (e) (i) Date of Birth (MM/DD/YYYY): ______________ (ii) Place of Birth: ______________
2. Are you a U.S. citizen?..........[ ] Yes [ ] No
   If No, what is your status in the U.S. and current citizenship? ______________________
3. Are you currently in active military service? ....[ ] Yes [ ] No
4. Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)
   [ ] professional corporation [ ] professional association
   [ ] limited liability company [ ] partnership
   [ ] other ______________________
5. (a) Answer the following. If None, check here [ ]
   Full name of entity: ______________________
   Address: ______________________
   (Street) (County)
   ____
   (City) (State) (Zip)
   (b) Do you want coverage for the entity named Item 5(a) above?..........[ ] Yes [ ] No
   (c) Attach a copy of your letterhead.
   (d) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, list the names of all physicians practicing under the entity named in Item 5(a) above.
   ____
   ____

6. Does your practice:
   (a) Have a Blog? .... [ ] Yes [ ] No
   (b) Utilize an Electronic Health Records (EHR) system? .... [ ] Yes [ ] No
7. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .... [ ] Yes [ ] No

   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .... [ ] Yes [ ] No
   (b) Provide the name and title of the Applicant's Privacy Officer. ____________________

   Our Business Associate Agreement is available by calling (502) 244-1056 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

II. LICENSE INFORMATION

1. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

2. Federal DEA License No. and status: ____________________

III. EDUCATION AND TRAINING

1. (a) Provide your medical or surgical specialty: ____________________
   (b) Do you limit your practice to the specialty stated in 1.(a) above? .... [ ] Yes [ ] No
   (c) Do you have a subspecialty? .... [ ] Yes [ ] No
   If Yes, describe. ____________________

2. Are you American Board certified? .... [ ] Yes [ ] No
   (a) If Yes, provide the following:
      (i) Medical specialty in which you are certified: ____________________
      (ii) Date of certification: ____________ Any recertification date(s): ____________
   (b) If No, do you plan on taking the Board examination? .... [ ] Yes [ ] No

3. Provide the following information:

	Name of Institution	City	State	Date Completed
Medical School				
PGY-1/Internship				
Residency – Specialty: ______				
Fellowship – Specialty: ______				
Other: ______				

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? .... [ ] Yes [ ] No
   If Yes, provide the following: year of certification: ______ describe your medical degree: ____________

5. Attached a CV or provide a detailed summary of where you have practiced your profession since completing your training:

Name of Practice	City/State	From (MM/YYYY)	To (MM/YYYY)

6. Are you a member of any professional societies? .... [ ] Yes [ ] No
   If Yes, provide information regarding your membership(s). ____________________

7. How many hours of continuing medical education have you take within each of the last two (2) years? ____________