

## ONLINE QUOTE FORM FOR PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

Please answer the questions below by providing as much detail as possible. All information gathered on this form will remain confidential. Before you can submit a Request for Quote, please review our [Privacy Policy](#) and [HIPAA](#) form, then check this box  after you have read, accept and understand them.

Submitted by:  \*

Agency:  \*

Mailing Address:  \*

City:  \*

State:  \*

Zipcode:  \*

Phone Number / Area Code:  \*

Fax:  \*

Email Address:  \*

### Applicant's Instructions:

1. Complete the online form including the claim form if applicable
2. If you have a CV.(resume) please email to pbs@pbsinsurance or fax to 502-254-1056
3. Please DO NOT complete the application earlier than 60 days before the proposed effective date of coverage.

### General Information:

1. Full Name:

2. Professional Designation: Choose  Other:

3. Principal Practice Address:

4. City:  State:  Zip:  County:

5. Phone:  Fax:

6. Email:  Website:

7. Date of Birth (MM/DD/YYYY)  /  /  Soc # (xxx-xx-xxxx)  -  -

A. Place of Birth

8. Federal Tax ID Number  Federal DEA License Number

9. Effective Date of Policy Desired (MM/DD/YYYY)  /  /

10. If claims made date (MM/DD/YYYY)  /  /

11. Retroactive date (MM/DD/YYYY)  /  /

12. Desired Limits: Fully Insured Choose  Other Limits:

Defense Only (Reimbursement) Choose

13. Are you a U.S. Citizen?  yes  no

If NO, what is your status?

14. Type of Practice Choose

Other: or Employee of: or Contractor of:

A. Do you want coverage for the entity named above: (Enter Name of Entity)

15. States in which you Practice

State:  License no.  Active:  yes  no  
State:  License no.  Active:  yes  no  
State:  License no.  Active:  yes  no

16. Please provide the name(s) for all Hospitals and Surgi-Centers where you are currently staffed:

Name:  City:  State:  % of work:   
Name:  City:  State:  % of work:   
Name:  City:  State:  % of work:

17. Avg. # of hrs. per week worked (Includes hospital & office hours for which coverage is sought)

18. Are you currently a hospital chief of staff or head of any hospital department or medical director?  yes  no  
If yes, Explain?:

**Education and Training:**

1. Specialty Choose  Other:

2. Sub-Specialty Choose  Other:

3. Board Certified  yes  no If Yes, Date of Certification:  /  /

A. If yes, which specialty: Choose

B. If no, why not?:

4. Please provide the following:

	Name of Institution:	City	State
Me	dical School: <input type="text"/>	<input type="text"/>	<input type="text"/>
D	ate Completed: <input type="text"/> / <input type="text"/> / <input type="text"/>		
I	nternship: <input type="text"/>	<input type="text"/>	<input type="text"/>
D	ate Completed: <input type="text"/> / <input type="text"/> / <input type="text"/>		
R	esidency (Specialty): <input type="text"/>	<input type="text"/>	<input type="text"/>
D	ate Completed: <input type="text"/> / <input type="text"/> / <input type="text"/>		
F	ellowship (Specialty): <input type="text"/>	<input type="text"/>	<input type="text"/>
D	ate Completed: <input type="text"/> / <input type="text"/> / <input type="text"/>		

5. 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:

B. Describe Medical Degree: (Ex: MD)



## Scope of Practice:

1. If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: Hospital, Office or Surgi-Center.

Procedure	Location	Procedure	Location
<input type="checkbox"/> Abortions - 1st trimester	Choose One	<input type="checkbox"/> Laser Surgery Please Describe:	Choose One
<input type="checkbox"/> Abortions - 2nd/3rd trimester	Choose One	<input type="checkbox"/> Lymphangiography	Choose One
<input type="checkbox"/> Acupuncture	Choose One	<input type="checkbox"/> Minimally Invasive Surgery - Please Describe:	Choose One
<input type="checkbox"/> Adenoidectomy/Tonsillectomy	Choose One	<input type="checkbox"/> Moh's Micrographic Surgery	Choose One
Anesthesia - obstetrical		<input type="checkbox"/> Myelography	Choose One
<input type="checkbox"/> General	Choose One	<input type="checkbox"/> Needle Biopsies Please Describe:	Choose One
<input type="checkbox"/> Spinal	Choose One		
<input type="checkbox"/> Epidural	Choose One	Anesthetics:	
Anesthesia - non-obstetrical		<input type="checkbox"/> Prenatal Care	Choose One
<input type="checkbox"/> General	Choose One	<input type="checkbox"/> Normal Deliveries	Choose One
<input type="checkbox"/> Spinal	Choose One	<input type="checkbox"/> Caesarean Sections	Choose One
<input type="checkbox"/> Epidural	Choose One	<input type="checkbox"/> VBAC Deliveries	Choose One
<input type="checkbox"/> Anesthesia - Other Please Describe:	Choose One	<input type="checkbox"/> Open Reduction of Fractures	Choose One
		<input type="checkbox"/> Pain Management Please Describe:	Choose One
<input type="checkbox"/> Angiography	Choose One		
<input type="checkbox"/> Angioplasty	Choose One	Plastic - Cosmetic Procedures:	
<input type="checkbox"/> Anti-aging Procedures other than use of human growth hormone Please Describe:	Choose One	<input type="checkbox"/> Blepharoplasty	Choose One
		<input type="checkbox"/> Collagen Injections	Choose One
<input type="checkbox"/> Arteriography	Choose One	<input type="checkbox"/> Botox Injections	Choose One
<input type="checkbox"/> Assisting in surgery - on own	Choose One	<input type="checkbox"/> Liposuction Under 3500 cc's Volume	Choose One
<input type="checkbox"/> patients or the Patients of others	Choose One	<input type="checkbox"/> Liposuction 3500 cc's or more Volume	Choose One
<input type="checkbox"/> Breast implants	Choose One	<input type="checkbox"/> Phalloplasty or Penile Implant	Choose One
<input type="checkbox"/> Breast reductions	Choose One	<input type="checkbox"/> Rhinoplasty	Choose One
<input type="checkbox"/> Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel	Choose One	<input type="checkbox"/> Silicone Implants	Choose One
<input type="checkbox"/> Chelation therapy	Choose One	<input type="checkbox"/> Silicone Injections	Choose One
<input type="checkbox"/> Cosmetic implantation or injection of silicone or other material	Choose One	<input type="checkbox"/> Other Plastic - Cosmetic Procedures	Choose One
<input type="checkbox"/> Cryosurgery - other than on benign or pre-malignant dermatological lesions	Choose One		
<input type="checkbox"/> Dermabrasion/Chemical Peels	Choose One		

- Dilation and Curettage Choose One
- Discograms Choose One
- Electroconvulsive Therapy Choose One
- Endoscopic procedures Choose One
- Hair Transplants or Suturing of Hairpieces Choose One
- Hyperbaric Medicine Choose One
- Laser Skin Resurfacing Choose One

Please Describe:

- Pneumoencephalography Choose One
- Prolotherapy/Proliferative Therapy Choose One
- Radiation Therapy Choose One
- Radiopaque Dye Injections into Blood Vessels, Lymphatics, Sinus Tracts or Fistulae Choose One
- Refractive Surgery: LASIK, PRK, AK, PTK, ICR Choose One
- Spinal Surgery (incl Chemonucleolysis or Percutaneous, Lumbar Discectomy) Choose One
- Trans Myocardial Laser Procedures Choose One

2. Do you perform surgery for obesity?  yes  no If YES, complete section below.

If you perform any of the following procedures, check all that apply and provide the number of procedures performed:

Ro

ux-en-Y:

- Laparoscopic:
  - Number performed in past 12 months:
  - Number you expect to perform in next 12 months:
- Open:
  - Number performed in past 12 months:
  - Number you expect to perform in next 12 months:

B

anding:

- Laparoscopic:
  - Number performed in past 12 months:
  - Number you expect to perform in next 12 months:
- Open:
  - Number performed in past 12 months:
  - Number you expect to perform in next 12 months:

Gastric Restriction, Other (describe)

- Number performed in past 12 months:
- Number you expect to perform in next 12 months:

3. Is general anesthesia administered for any of the procedures identified in 1 or 2 above?  yes  no

If YES, is anesthesia administered by:

Y ou?

- yes  no

A n Anesthesiologist?

- yes  no

A Certified Registered Nurse Anesthetist (CRNA)?

- yes  no

If YES, is the CRNA directed by or responsible to an Anesthesiologist?

- yes  no

If NO, explain the type of surgery and percentage of your surgeries or average number of such cases per month.

Are Harvard Standards for the administration of all anesthesia adhered to?

yes  no

4. Do you perform any surgery in your office?

yes  no

If YES, answer the following:

Describe each procedure not already identified in 1 or 2 above:

Is your surgical suite certified?

yes  no

Do you perform any surgery in other non-hospital facilities?

yes  no

If YES, answer the following:

Describe each procedure not already identified above in 1 or 2 above:

Name each facility:

5. Do you perform any hospital emergency room care?

yes  no

If YES, is this solely a requirement for active admitting privileges?

yes  no

If NO, provide a detailed description including the approximate number of hours per month spent in emergency room care.

6. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise?

yes  no

If YES, answer the following:

(a) Percentage of your patients that are weight control patients:

(b) Do you dispense any drugs?

yes  no

If Yes, provide the names of the drugs dispensed.

(c) Do you use injections for weight control?

yes  no

If Yes, provide the names of the drugs injected.

7. Do you use experimental procedures, devices, drugs or therapy in treatment or surgery?

yes  no

If YES, do you follow FDA-Approved protocols?

yes  no

If Yes, Describe.

(a) Are you a principal investigator for any clinical trial?

yes  no

If Yes, Please explain.

8.

Do you read, interpret or diagnose films, slides or specimens taken

from patients residing in states other than your primary practice address?

yes  no

If YES, identify all states in which such patient reside.

9. Do you perform consultations, telemedicine or internet medicine outside the state of your primary office address  yes  no

If YES, provide the following:

Identify all states in which such patients reside:

What percentage of your total practice is involved in such activities?

10. Indicate the number of professional employees in your practice for each of the following:

If none, check here

- Physicians other than yourself     Podiatrists     Chiropractors     Optometrists
- Physician's Assistants     Nurses     Nurse Practitioners     Nurse Anesthetists
- Surgeon's Assistants     Nurse Midwives     Psychologists

Other (Please describe)

11. Average weekly patient load:

12. Average number of hours you practice each week:

13. Are you currently insured?  yes  no

If YES, please supply the following:

Insurance Company:

Limits:

Current Deductible

Current Premium:

Effective Date: (MM/DD/YYYY)  /  /

Retro Date: (MM/DD/YYYY)  /  /

If NO, why not insured?

12. Are you a Medical Director?

yes  no

13. Do you work for any locum tenens company?

yes  no

14. Do you work or provide any services to adult or juvenile inmates?

yes  no

15. Are you engaged in any moonlighting activities?

yes  no

If YES to any of the above, please explain in detail:

## Claims and History

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance?  yes  no  
If YES, how many?  Please explain:
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer?  yes  no  
If YES, how many?  Please explain:
3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?  yes  no  
If YES, how many?  Please explain:
4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges?  yes  no
5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?  yes  no
6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct?  yes  no
7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance?  yes  no
8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders?  yes  no
9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation,, would limit your ability to safely practice in your medical specialty?  yes  no

This application, information submitted with this application and all previous application and material changes thereto of which PBS Insurance Underwriting Corporation and affiliates or the Insurance Company receives notice is on file with PBS Insurance Underwriting Corporation or the Insurance Company who is quoting. PBS Insurance Underwriting Corporation and affiliates or the Insurance Company will have relied upon the information within the online application to render a premium indication. If information on the company application materially changes then the company may modify or withdraw any outstanding indication or agreement to bind coverage.

## Warranty

I warrant to PBS Insurance Underwriting Corporation and affiliates or the Insurance Company, that I understand and accept the notice stated above and that the information contained herein is true. I authorize the release of claim information from any prior insurer to PBS Insurance Underwriting Corporation and affiliates or the Insurance Company.

You must provide your Name, Title and Today's Date in order to submit this quote request.

/  /   
Name of Applicant Title Date

**Note:** Typing your name will be deemed as your electronic signature.

Completion of this form does not bind the applicant or PBS Insurance Underwriting Corporation and affiliates or the Insurance Carrier and/or The Underwriting Manager to complete the Insurance.

## Notice to 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 the person to criminal and civil penalties.

If you should have any additional information to add that would be helpful to better understand your practice and/or situation, please explain below.

**Do not submit more than 60 days before your renewal date of present coverage or before the proposed effective date.**

If we require additional information what would be the best method to contact you.

- Email       Fax  
 Regular Mail       Phone

If by phone which would be the best time to call:

- AM     PM

By typing my name below I certify it as my signature

Type your name here: