

PREMIER PHYSICIANS INSURANCE COMPANY, INC.
A Risk Retention Group

APPLICATION INSTRUCTIONS

**PHYSICIANS & SURGEONS APPLICATION FOR
PROFESSIONAL LIABILITY INSURANCE**

In order to hasten your request for coverage and avoid any unnecessary delay, please complete all questions. If a question does not apply to your specialty, mark "None" or "N/A" (Not Applicable). Do not leave any question unanswered! Please use separate paper for any additional comments, explanation or clarification if necessary.

Before submitting your application, please review this checklist to ensure the information below has been included. Missing information could delay the approval of your application.

- Sign, initial and date the application where indicated. The company will not issue quotes for unsigned applications.
- Include a copy of your current Curriculum Vitae (CV).
- Include a copy of your most recent professional liability declaration page and claims history with retroactive date.
- Complete the "Remarks" section for any questions requiring additional details.
- If you have completed a residency or fellowship within the past year, provide two references from your training program, including one from your chief of service.

If you need assistance with the application, please call (866) 371-7742 and ask to speak with a medical liability specialist.

Premier Physicians Insurance Company, Inc., is a Risk Retention Group. Your Risk Retention Group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency funds are not available for your Risk Retention Group. Therefore, these funds will not pay your claims or protect your assets if your Risk Retention Group, the insurer, becomes insolvent and is unable to make payments as promised.

Your Risk Retention Group's forms include a provision requiring "binding arbitration".

Your Risk Retention Group's forms require only 30 days notice of non-renewal of coverage. Authorized insurers must give at least 60 days notice, and, in some cases, such as those classes identified as "essential medical specialties", additional notice is required.

III. TRAINING INFORMATION (Continued)

Please Refer to my "CV" _____. (Initial) I understand information submitted in my "CV" becomes part of the PPIC's Named Insured's records.

e. Fellowship _____ FROM _____ / _____ / _____ TO _____ / _____ / _____
Mo/Day/Year Mo/Day/Year

STREET ADDRESS CITY STATE ZIP COUNTRY

f. Other _____ FROM _____ / _____ / _____ TO _____ / _____ / _____
Mo Day Year Mo Day Year

STREET ADDRESS CITY STATE ZIP COUNTRY

IV. PRACTICE HISTORY

Please Refer to my "CV" _____. (Initial) I understand information submitted in my "CV" becomes part of the PPIC's Named Insured's records.

1. Please list all locations where you have practiced since residency, beginning with the most recent location first.
 (Include Military Service)

a. SOLO EMPLOYEE GROUP

PRESENT GROUP / PRACTICE NAME CITY STATE FROM _____ / _____ / _____ TO _____ / _____ / _____
Mo/Day/Year Mo/Day/Year

b. SOLO EMPLOYEE GROUP

GROUP / PRACTICE NAME CITY STATE FROM _____ / _____ / _____ TO _____ / _____ / _____
Mo/Day/Year Mo/Day/Year

c. SOLO EMPLOYEE GROUP

GROUP / PRACTICE NAME CITY STATE FROM _____ / _____ / _____ TO _____ / _____ / _____
Mo/Day/Year Mo/Day/Year

d. SOLO EMPLOYEE GROUP

GROUP / PRACTICE NAME CITY STATE FROM _____ / _____ / _____ TO _____ / _____ / _____
Mo/Day/Year Mo/Day/Year

2. Hospitals where you practice. (Please list principal locations first)

a. _____
HOSPITAL ADDRESS CITY STATE ZIP

b. _____
HOSPITAL ADDRESS CITY STATE ZIP

c. _____
HOSPITAL ADDRESS CITY STATE ZIP

d. _____
HOSPITAL ADDRESS CITY STATE ZIP

IV. PRACTICE HISTORY (Continued)

MUST COMPLETE THIS SECTION:

3. List all previous professional liability carriers for the last 5 years, beginning with your current carrier first.
 If None, state "NONE"

Insurance Carrier	Limits of Liability Ie. \$1M / \$3M	Premium	Policy Period	
			FROM	TO
	/		/ /	/ /
	/		/ /	/ /
	/		/ /	/ /
	/		/ /	/ /
	/		/ /	/ /

4. Please explain all gaps in coverage greater than 60 days. (Use a separate sheet if necessary)

V. PROFESSIONAL HISTORY

MUST COMPLETE THIS SECTION:

- | | | |
|--|-----|----|
| 1. Have you ever had your hospital privileges suspended, denied, restricted, placed in probationary status or revoked? (If Yes, please explain on a separate sheet) | Yes | No |
| 2. Has any governmental agency investigated, suspended, revoked, or taken any other action Against either your narcotics license or your license to practice medicine? (If Yes, please provide copies of complaint and disposition documents) | Yes | No |
| 3. Have you ever been charged with or convicted of a crime other than minor traffic violations? (If Yes, please explain on a separate sheet) | Yes | No |
| 4. Have you ever been diagnosed, treated or voluntarily entered into treatment for alcoholism, drug addiction, chemical dependency or a mental or chronic physical illness? (If Yes, please explain on a separate sheet) | Yes | No |
| 5. Has any professional liability carrier ever terminated, restricted or modified your coverage (e.g. Applied surcharges, co-payments or deductibles) or denied you professional liability coverage? (If Yes, please explain on a separate sheet) | Yes | No |

VI. TYPE OF PRACTICE

MUST COMPLETE THIS SECTION:

1. Please list the names of all physicians with whom you practice in an office setting:

With whom do you share call? _____

2. Indicate your practice type:

- | | |
|-------------|--|
| INDIVIDUAL | SOLO / PROPRIETOR USING A DBA |
| PARTNERSHIP | OFFICE SHARING ARRANGEMENT |
| EMPLOYEE | MEMBER OF A MULTIPERSON CORPORATION OR ASSOCIATION |
| CORPORATION | |

Complete the following if your practice is:

	<u>NAME OF ENTITY</u>	<u>FICTITIOUS NAME (DBA)</u>
<input type="checkbox"/> An Office Sharing Arrangement	_____	_____
<input type="checkbox"/> A Partnership	_____	_____
<input type="checkbox"/> A Corporation	_____	_____
<input type="checkbox"/> Solo Practice / Owner Using a DBA	_____	_____

With whom do you share call? _____

3. List the names of all partners, shareholders, independent contractors or employees, and associates who provide medical care and do not have the Premier Physicians Insurance Company coverage.

4. State formal business/fictitious names of your partnership, association or corporation.

VI. TYPE OF PRACTICE (Continued)

MUST COMPLETE THIS SECTION:

5. Do you require "Entity" coverage for your business, partnership, association or corporation? Yes No
 If "Yes" indicate if you want "Shared" or Separate Limits. Shared Limits Separate Limits

6. Do you employ, contract with or supervise any physicians or surgeons? Yes No
 If Yes, please enter information below and attach current certificate(s) of insurance:

Name	Medical Specialty	Limits of Liability	Insurer

VII. PRACTICE INFORMATION

MUST COMPLETE THIS SECTION:

1. Do you employ, contract with or supervise any allied health care professionals? Yes No
 (ie. Nurse Practitioner, Nurse Midwife, CRNA)

If Yes, please indicate below:

2. Please indicate the total number of hours worked per week: _____

3. Do you provide medical services as a designated sports team physician? Yes No

If Yes, please check all that apply:

High School College Professional Other _____

Name and Location of team(s): _____

4. Do you require coverage as a proprietor, partner, officer, director, administrator or Medical director in any medical enterprise? If "YES" please be advised that PPIC does not provide this coverage unless given prior approval before your effective date.

Yes No

If Yes, describe percentage of your practice and name(s) of medical enterprise:

5. Do you engage in telemedicine activity? Yes No

If Yes, please explain on a separate sheet.

6. Do you prescribe drugs or provide diagnosis via the internet? Yes No

If Yes, please explain on a separate sheet.

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|--|-----|----|
| 7. Does your entity include a surgicenter, laboratory or other freestanding facility. | Yes | No |
| If Yes: | | |
| Does the laboratory provide services solely for your patients? | Yes | No |
| Will Non-Premier Physicians Insurance Co. Insured Physicians use the facility? | Yes | No |
| Do you want Premier Physicians to insure your partnership or corporation? | Yes | No |
| (If Not <i>LIMITED</i> to your patients, please explain on a separate sheet) | | |
| 8. Do you have a full ACLS Resuscitation (crash) cart in your office? | Yes | No |

VIII. APPLICANT CLAIMS HISTORY

MUST COMPLETE THIS SECTION:

DEFINITION: A claim is a demand for money from a patient or on a patient’s behalf, a 90-day notice of intention to sue, a lawsuit, a counterclaim or a demand for arbitration. Please be advised that you will have no coverage from Premier Physicians Insurance Company for any known claims or incidents that may lead to a claim or lawsuit. All claims or incidents that may lead to a claim or lawsuit should be reported to your current malpractice insurer before terminating your existing policy (coverage for any such lawsuits, claims or incidents is subject to the terms of your current carrier’s policy).

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|--|-----|----|
| 1. Have you ever been or are you now involved in any professional liability (malpractice) claims or lawsuits? | Yes | No |
|--|-----|----|

If Yes, Number of Claims: _____

If Yes, the **Claims Information** *MUST* be completed for each claim. *Refer to Section IX.*

- | | | |
|--|-----|----|
| 2. Have all claims been reported to your current or previous professional medical liability insurance carrier(s)? | Yes | No |
|--|-----|----|

- | | | |
|--|-----|----|
| 3. Have you ever attempted or settled a claim on your own behalf that you did not report to a previous medical liability carrier? | Yes | No |
|--|-----|----|

- | | | |
|---|-----|----|
| 4. Has any claim or suit been brought against any of your employees? | Yes | No |
|---|-----|----|

If Yes, the **Claims Information** *MUST* be completed for each claim or suit. *Refer to Section IX*

- | | | |
|--|-----|----|
| If Yes, has this information been reported to your current or prior insurance carrier? | Yes | No |
|--|-----|----|

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

If Yes, please explain and specify dates:

X. MEDICAL PROCEDURES INFORMATION

MUST COMPLETE THIS SECTION:

Premier Physicians Insurance Company uses the following definitions to clarify proper specialty classification. Please review the definitions, then proceed to indicate which procedures you perform if any.

No Surgery - Any practitioner who does not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin superficial fascia) and do not assist in surgery.

Minor Surgery - Any practitioner who assists in major surgery on their own patients, and performs catheterization, endoscopy (other than colonoscopy, proctocolonoscopy, or sigmoidoscopy) vasectomies, hemorrhoidectomies, diagnostic D & C's and vacuum curettage abortions during the first trimester of pregnancy.

Major Surgery - Any surgery other than "Minor Surgery" and assisting at major surgery on other than on their own patients.

Do you perform any of the following procedures?

ANESTHESIA (Pain Management Only)	Yes	No	NON-FDA APPROVED DRUGS, PHARMACEUTICALS OR MEDICAL DEVICES	Yes	No
ARTERIOGRAPHY	Yes	No	PHYSICAL MEDICINE & REHABILITATION (No Procedures)	Yes	No
BARIATRIC SURGERY	Yes	No	PHYSICAL MEDICINE & REHABILITATION (Minor Procedures)	Yes	No
BOTOX	Yes	No	PHYSICAL MEDICINE & REHABILITATION (Major Procedures)	Yes	No
CARDIAC CATHETERIZATION	Yes	No	PLASTIC SURGERY	Yes	No
CONVULSIVE SHOCK THERAPY	Yes	No	SKIN RADIATION TREATMENT	Yes	No
CORONARY ARTERIOGRAPHY	Yes	No	SURGICAL ASSIST (On Own Patients)	Yes	No
CORONARY ANGIOPLASTY	Yes	No	SURGICAL ASSIST (On Other Patients)	Yes	No
COSMETIC PROCEDURES & SURGERY (Please describe below)	Yes	No	TEACHING	Yes	No
DERMABRASION	Yes	No	URGENT CARE	Yes	No
EMERGENCY ROOM DUTIES	Yes	No	NO SURGERY	Yes	No
LAMINECTOMY	Yes	No	MINOR SURGERY	Yes	No
OBSTETRICS	Yes	No	MAJOR SURGERY	Yes	No

Please describe all Cosmetic Procedures & Surgery:

XI. APPLICANT RETROACTIVE COVERAGE

MUST COMPLETE THIS SECTION:

The following questions refer to your application for retroactive coverage (ie. "Prior Acts" or "Nose Coverage") with Premier Physicians Insurance Company (PPIC).

If you are approved for retroactive coverage, you will receive a certificate of coverage with a specified retroactive coverage date. Thereafter and subject to the terms, conditions and exclusions of the PPIC policy, you will be entitled to claims defense and claims payment services described in your policy with PPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences subsequent to the retroactive date indicated in your certificate of insurance with PPIC.

Retroactive coverage is only available from PPIC to those physicians who have maintained continuous and uninterrupted "Claims Made" medical professional liability coverage up to the commencement date of their coverage with PPIC.

Whether or not you believe you were at fault:

1. Are you aware of any incidents resulting in injury or death to a patient where your professional services were utilized. (e.g. Attending Physician, Assistant, Consultative, etc.) Yes No
2. Are you, your employees or associates aware of any threats or complaints that could lead to legal action against you or your medical practice? Yes No

If Yes, please indicate the number of threats or complaints and describe below. (Use separate paper if necessary)

3. Have you ever been the subject of a deposition or subpoena as a result of medical service provided by you on behalf of a patient? (other than as an expert witness, but including consultative services) Yes No

OBLIGATION OF DISCLOSURE

Nevada law requires you to disclose to Premier Physicians Insurance Company (PPIC) any information known to you that would influence PPIC's decision to approve your application for coverage, including the information you provide in this claims section. You also have an obligation to inform PPIC of any information that becomes known to you between the date of your signature below and the effective date of coverage with PPIC that could alter your previous response to the claims information requested herein. You are advised to notify PPIC of any additional information not previously disclosed in your application for coverage.

Yes

I request retroactive coverage from PPIC for any unknown incidents that may lead to a claim or lawsuit arising out of occurrences in Nevada and subsequent to my retroactive coverage date with PPIC.

I represent and warrant that I will maintain my current professional liability coverage up to the commencement date of my membership with PPIC. I make this representation with the understanding that should any future investigation reveal that I did not maintain continuous claims made professional liability coverage, PPIC may deny all claims defense and claims payment services for any claim arising out of professional services that I rendered to patients during the retroactive coverage period.

I also make this representation with the understanding that my failure to meet my obligation of disclosure may result in the termination of my policy with PPIC and the loss of all claims defense and claims payment services.

Requested Retroactive Date: _____ / _____ / _____
Mo/Day/Year

NO, I decline retroactive coverage

This application for Retroactive Coverage is deemed part of your Application for Membership in PPIC and is incorporated by this reference into the PPIC policy.

I declare under penalty of perjury that the foregoing is true and correct. Executed this _____ of _____, 200____
Day Month Year

In _____, _____ by _____
City State Signature

XII. DISCLOSURE & WARRANTY

MUST COMPLETE THIS SECTION:

DISCLOSURES

REPRESENTATIONS AND WARRANTIES: I hereby warrant the truth of all statements and answers contained in this application. I have not withheld any facts about my professional practice which are reasonably calculated to or may influence the judgment of PPIC in considering this application. I understand that if I have withheld an material facts concerning the risk exposure of my professional practice and PPIC is made aware of my lack of disclosure, I will have no coverage for any claims that may arise due to my lack of disclosure and my coverage with PPIC may be declined. I agree to notify PPIC in a timely manner of any change to my practice or to the information regarding an open claim or incident as it becomes available to me. I acknowledge that coverage through PPIC is governed by the terms of my PPIC policy. I agree that upon PPIC's acceptance of my application, my execution of the insurance agreement and the initiation of payments of my insurance premium, I will be deemed to have professional liability coverage by Premier Physicians Insurance Company. I understand that my execution of this application does not bind PPIC to admit me as a member in PPIC, nor does it bind me to become a member of PPIC, if accepted. In addition I understand and agree that I have no right to information regarding the basis of reasons by PPIC concerning my application for coverage. I further understand that my membership and my professional liability coverage does not become effective until my application has been accepted by PPIC and payments for coverage have been received.

ARBITRATION: I agree that any dispute or controversy arising out of or in connection with this application shall be submitted to, determined and resolved by, binding arbitration in Reno, Nevada before three (3) arbitrators. The arbitration shall be conducted pursuant to my underwriting policy.

REFERENCES: I authorize and direct any individual, government agency, medical society, physician, hospital, insurance agent or company representative to furnish information concerning me or my medical practice which PPIC may require. This authority extends to the release of information regarding professional liability coverage and claims. I also agree that any person or organization, together with the officers, directors and agents, will not be liable in any way for furnishing such information even though the information may be incomplete or incorrect.

Should I employ the services of an insurance broker/consultant through PPIC to assist me in securing professional liability coverage, I hereby authorize PPIC to release any and all necessary information to such individuals or agency/organizations.

Requested Effective Date: ____/____/____

Requested Retroactive Date: ____/____/____

IMPORTANT: *The Declarations Page of your current policy must be attached if a retroactive date is requested. The company may not provide requested dates.*

Policy Limits: \$1,000,000 EACH CLAIM / \$3,000,000 POLICY AGGREGATE

Coverage is solely as stated in your PPIC policy, and provided on a "Claims Made" basis for **those claims first reported (i.e. "Tail Coverage") against the insured during the policy period** unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I warrant to PPIC my understanding and acceptance of the notice stated above and that the information contained herein is true and shall be inclusive of the basis of the policy of insurance and deemed incorporated therein, should the insurer evidence its acceptance of this application by issuance of a policy.

I authorize the release of all claims information from any prior insurer to Premier Physicians Insurance Company.

NAME OF APPLICANT

SIGNATURE OF APPLICANT

____/____/____
DATE

Signing this application does not bind the applicant or the insurer or the underwriting manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.