

Physicians & Surgeons

Application for Professional Liability Insurance

Claims - Made

Seattle Office

1730 Minor Avenue, Suite 1800
Seattle, WA 98101
(206) 343-7300
(800) 962-1399
Fax (206) 343-7100
E-mail: info@phyins.com

Eastern Regional Office

421 West Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868
(800) 962-1398
Fax (509) 456-0821

10. Home address:

Street address	City	State	Zip
<hr/>			
Area code ()	Telephone	Fax ()	E-mail address

11. Office practice location(s): *For which you are applying for coverage*

Clinic name:

Street address	City	State	Zip
<hr/>			
Area code ()	Telephone	Fax ()	E-mail address

Average weekly practice time at this location: _____ hours per week

Do you perform surgical procedures at this location? Yes No

If "Yes," list all procedures in the "REMARKS" section.

b. Street address

City	State	Zip	
<hr/>			
Area code ()	Telephone	Fax ()	E-mail address

Average weekly practice time at this location: _____ hours per week

Do you perform surgical procedures at this location? Yes No

If "Yes," list all procedures in the "REMARKS" section.

NOTE: If you have more than two office practice locations, please use the "REMARKS" section.

12. Where have you practiced medicine in the past 5 years? Include military and any public service organizations.

If you have not practiced medicine continuously, or if you have more than two prior practices, **please explain/ document in the "REMARKS" section.** A CV or other application is not an acceptable substitute.

a. Facility name

Street address	City	State	Zip	Dates
<hr/>				

Professional liability insurance carrier

Policy number

Claims-made

Occurrence

b. Facility name

Street address

City

State

Zip

Dates

Professional liability insurance carrier

Policy number

Claims-made

Occurrence

13. Have you practiced without insurance at any time? Yes No *If "Yes," please explain:*

14. Are you a member of the Washington State Medical Association? Yes No If membership is pending, check here:

Are you a member of any other professional societies or associations? Yes No *If "Yes," please list:*

15. Medical school:

Name of school

City

State/Country

Yr graduated

Degree

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates?

Yes No

Have you passed the USMLE (United States Medical Licensing Examination) Steps I and II? Yes No

Have you passed CSA (Clinical Skills Assessment)? Yes No *If "No," please explain:*

16. Residency:

Name of hospital

Street

City

State/Country

Zip

Type of residency:

Dates attended:

_____ to _____

Was residency completed? Yes No *If "No," please explain:*

17. Additional training: Internship Fellowship Second residency *(Please check appropriate box)*

Name of facility (hospital):

Street address

City

State

Zip

Type of specialty

Dates attended:

_____ to _____

Was training completed? Yes No *If "No," please explain:*

18. Board certification:

Name of board

Date certified

Recertified

19. If you are not board certified, have you taken and failed board exams? Yes No

Are you in the certification process? Yes No If "Yes," when will this be completed?

If not board certified and/or board eligible, please explain in the "REMARKS" section.

SECTION II - CURRENT PRACTICE AND RATING INFORMATION –
For which you are requesting Physicians Insurance to provide coverage

20. Principal medical specialty or subspecialty in which you practice and for which you are seeking professional liability insurance:

_____ principal specialty _____% of practice

21. Secondary medical specialty (if applicable):

_____ secondary specialty _____% of practice

22. Hospital privileges:

Primary hospital:

Secondary hospital:

Hospital name:

Hospital name:

City:

City:

Dept. of:

Dept. of:

Category of privileges:

Category of privileges:

Dates privileges held:

Dates privileges held:

Do you staff the E.R. at this hospital other than to maintain hospital privileges?
 Yes No If "Yes,"
Number of hours per week: _____

Do you staff the E.R. at this hospital other than to maintain hospital privileges?
 Yes No If "Yes,"
Number of hours per week: _____

23. Please list any other hospitals at which you hold/held privileges:

Hospital name: _____	Hospital name: _____
City: _____	City: _____
Dept. of: _____	Dept. of: _____
Category of privileges: _____	Category of privileges: _____
Dates privileges held: _____	Dates privileges held: _____

24. If you will not have hospital privileges, please explain why:

25. Your practice is (check all that apply):

- Fellowship program coverage at: _____
- Individual (solo unincorporated)
- Sole shareholder of a medical corporation
Name of corporation: _____
- Employee of*: _____
- Partner of a partnership*
Name of partnership: _____
- Shareholder of a multi-shareholder corporation*
Name of multi-shareholder corporation: _____

*** Provide names of all physicians or attach a copy of letterhead of the organization:**

_____	_____
_____	_____
_____	_____

- Independent contractor for: _____

If you are an independent contractor, please complete the following statement:

My association with _____ (group/physician name) is that of an independent contractor, and the relationship conforms to the guidelines of the Internal Revenue Service.

Signature _____ Date _____

Group/Physician name _____ Carrier _____

A current Declarations Page or Certificate of Insurance for the above group/physician must be attached.

26. Are you a member of a PHO, IPA, MSO, PHCO, IPO, or similar physician organization? Yes No

Name of physician organization: _____

27. If you are a solo practitioner, do you employ other physicians? Yes No

If "Yes," have they applied to Physicians Insurance? Yes No

List names:

28. If you are a solo practitioner, indicate the extent of your professional relationship with any physician(s) with whom you are associated: (Please check all that apply)

- Not applicable
- Share office space only
- Common billing and/or letterhead
- Share professional employees
- See each other's patients (other than on-call)
- Maintain combined patient records

Names of physicians with whom you are associated:

29. How many of the following paramedical employees do you employ, contract, supervise, or sponsor:

(If you are a member of a partnership/corporation, this does not apply to you unless the paramedical employee is employed by you directly.)

_____ RN/LPN	_____ Nurse Practitioner*	_____ Licensed Surgical Assistant*
_____ Lab/X-ray Technician	_____ CRNA*	_____ Certified Nurse Midwife*
_____ Paramedic	_____ Physician Assistant*	_____ Licensed Midwife*
_____ Alternative Health Care Provider (please describe) _____		

**If you employ, contract, supervise, or sponsor any of the above, please contact us for an application for each individual.*

30. Do you have a practice activity or position for which you do NOT require Physicians Insurance coverage? Yes No

If "Yes," please provide details and evidence of insurance: _____

31. Do you hold a Medical Director position? Yes No

Name and location of organization: _____

Do you have a financial interest in this organization? Yes No

32. Do you perform surgery in any non-hospital owned facilities? Yes No

If "Yes," please contact us for a separate Underwriting Information Form for Ambulatory Surgical Facilities, which is also applicable for an office surgical suite or freestanding surgical center.

33. Are you associated (except by medical staff appointment) with the following:

- | | | | | |
|---|------------------------------|-----------------------------|-------|----------------|
| Skilled nursing facility/ Assisted living facility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |
| Jail/Penitentiary | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |
| Health care foundation, blood bank, or freestanding laboratory? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |
| Medical service facility maintained by an industrial firm? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |
| State, federal, or local public entity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |
| Urgent care facility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |
| In an administrative capacity for/with PPOs, HMOs, IPAs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | hours per week |

If the answer to any of the above is "Yes," please provide the full legal name and location of the facility(ies) and the department in which you serve:

Is insurance coverage provided by the entity or organization for the activities listed above? Yes No

Name of insurance company: _____

34. Do you participate in clinical research (including drug studies)? Yes No

If "Yes," please include your IRB (Institutional Review Board) statement.

35. Do you have a Web site? Yes No www. _____

Do you do online consultations? Yes No

How do you advertise? Newspaper Radio Yellow Pages Direct mail

Other _____

SECTION III- EXTENDED REPORTING ENDORSEMENT HISTORY (TAIL)

36. Have you included a copy of your tail endorsement or evidence of occurrence coverage from each prior carrier within the last five years?

Yes No

If "No," please explain: _____

37. Will you be purchasing a tail from your current carrier?

Yes No

If "Yes," please provide a copy of the tail endorsement.

SECTION IV- REQUEST FOR PRIOR ACTS (to be completed by all applicants requesting Prior Acts Coverage)

NOTE: Include current copy of the declarations page from your current or previous insurer.

Retroactive date: __ / __ / ____ (MM/DD/YYYY)

38. Have you been continuously covered by an individual Claims-Made policy for your primary practice from the retroactive date stated on page 1 to the requested effective date of your coverage with Physicians Insurance?

Yes No

If "No," please explain in the "REMARKS" section.

39. Indicate all practice locations during the period for which you are requesting Prior Acts Coverage:

City: _____ State: _____ Dates: _____
City: _____ State: _____ Dates: _____

40. During the period for which you are requesting Prior Acts Coverage, did you practice with other physicians:

- In an employer-employee relationship? Yes No
Locum tenens relationship? Yes No
Formal partnership or informal association? Yes No
Corporation? Yes No

If "Yes," list the full names of all physicians with whom you have been associated during this period:

41. Indicate below the health care providers you employed, contracted, or supervised during the period for which you are requesting Prior Acts Coverage and please describe the nature of your relationship. If none, please indicate.

- Physician Assistant Yes No Dates _____
Nurse Practitioner Yes No Dates _____
Nurse Midwife Yes No Dates _____
Nurse Anesthetist Yes No Dates _____
Licensed Surgical Assistant Yes No Dates _____

42. During the period for which you are requesting Prior Acts Coverage, was your practice different from your practice as described in Section II of this application? For example, did your practice formerly include obstetrical care or emergency medicine services that you are no longer providing?

- Yes No If "Yes," describe below the changes in your practice, including all applicable dates. Attach additional pages as needed.

43. Are you aware of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?

- a. Patient or attorney request for records related to an adverse outcome? Yes No
b. A letter from an attorney regarding your medical treatment of a patient? Yes No
c. Intra-operative or postoperative complications or other complications resulting in death, paralysis, or other significant disabilities?
 Yes No
d. Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? Yes No
e. A patient who is suing another physician or hospital for the same treatment at issue? Yes No
f. Any other circumstance that might reasonably lead to a claim or suit? Yes No

Explain any "Yes" answers on the attached Claim Information Supplement.

44. Have you reported to your current insurance company all the above circumstances of which you are aware that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit)?

- Yes Please attach documentation of all such reports.
- No *Please explain in the "REMARKS" section.*
- None to report

SECTION V - PROFESSIONAL BACKGROUND

**NOTE: If any answer to questions 1 through 13 is "YES," use the "REMARKS" section to provide details.
Providing adequate detail and documentation will assist us in expediting our underwriting review.**

1. Has your license to practice medicine or dispense narcotics in any jurisdiction ever been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you?

- Yes No Medical license
- Yes No DEA license

2. Have any complaints ever been filed against you with a governmental agency, medical or professional society, or other medical entity?

- Yes No

3. Have you ever been subject to disciplinary proceedings or investigations by a governmental agency, medical or professional society, or other medical entity, or have you ever been notified of an intent to pursue such action?

- Yes No

If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification of your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society?

- Yes No

4. Have you ever been convicted for an act committed in violation of any law or ordinance?

- Yes No

NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.

5. Have you ever been charged with or convicted of a crime?

- Yes No

6. Have your hospital privileges ever been reviewed or restricted, suspended, revoked, nonrenewed, or denied, or has any hospital notified you of its intent to pursue such action?

- Yes No

7. Has the threat or avoidance of disciplinary action ever caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration?

- Yes No

8. Has any professional liability insurance carrier ever declined to quote or issue coverage, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature?

Yes No

9. Have you ever been diagnosed with or been treated for alcoholism or chemical dependency, or are you currently being treated for alcoholism or chemical dependency?

Yes No

If yes, please provide proof that you are in compliance with your treatment program.

10. Have you ever incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, hearing or vision impairment, Hepatitis B or C, HIV)?

Yes No

If "Yes," in the "REMARKS" section, state illness or disability with date(s), and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession.

11. Has any incident alleging malpractice been reported, or has any claim or suit alleging malpractice ever been brought, against you or your professional corporation?

Yes No

If "Yes," give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.

12. Have you ever been accused of sexual misconduct?

Yes No

13. Have you ever had contact of a sexual nature with a patient or former patient?

Yes No

SECTION VI - SPECIALTY QUESTIONS

Please answer the following questions AND all questions applicable to your specialty.

1. List any procedures you perform that are NOT considered usual or customary to your specialty or subspecialty.

2. If you are NOT a radiologist or pathologist, do you read your own films or specimens? Yes No

If "yes," do you have them overread by a radiologist or pathologist? Yes No

3. Do you own or work at a medi spa? Yes No

If "yes," are you (check all that may apply): Employed? Contracted? Medical Director? Owner?

Name of medi spa: _____

Location of medi spa: _____

4. Are you performing any non-FDA approved procedures? If yes, please list procedure:

A. ANESTHESIOLOGY

1. Do you practice in other than a hospital setting (office surgical suite, surgery center, etc.)? Yes No

a. If "Yes," please provide name and location of facility:

Name:

Location:

b. If "Yes," is the suite/center certified by the American Association for Accreditation of Ambulatory Surgery Facilities? Yes No

c. If "No," is it certified by any other state and/or federal organization?

Please list:

2. Please indicate type of anesthesia used outside of hospital setting:

3. Do you practice in the field of pain management? Yes No

a. If "Yes," are you board certified in Pain Management by the American Board of Anesthesia? Yes No

Percent of practice _____ %

b. Please list all procedures you use for pain management, including surgical or other minimally invasive procedures:

c. What types of narcotics do you prescribe for relief of pain?

d. Do you use a dictated record for pain patients? Yes No

4. Do you perform acupuncture? Yes No

5. What portion of your practice consists of the following:

Pediatrics _____ % OB _____ % Cardiac _____ %

Pain Management _____ % Bariatrics _____ % All other _____ %

6. Please indicate the type of monitoring you utilize during the administration of IV sedation, spinal, caudal, epidural and major nerve blocks:

Continuous EKG display

Non-invasive blood pressure monitoring

Pulse Oximeter

End tidal CO₂ monitor

Other: _____

7. Do you supervise CRNAs? Yes No

Maximum number of CRNAs you will supervise *at any one time*: _____

Are the CRNAs you supervise: Hospital employees? Your own employees? Other: _____

8. If you provide anesthesia care for Obstetrics, are you on call within the hospital or from home?

Hospital Home Not applicable

a. What is the response time requirement for routine C-sections? _____ minutes

b. What is the response time requirement for emergent C-sections? _____ minutes

B. GENERAL, CARDIAC, NEUROLOGICAL, THORACIC, UROLOGICAL & VASCULAR SURGERY

1. Do you perform organ transplants? Yes No

If yes, what types?

2. Do you perform bariatric surgery? Yes No

If "Yes," please contact Physicians Insurance for a bariatric questionnaire.

Percent of practice _____ %

3. Please indicate the percentage of your practice that the following surgeries constitute:

Bariatric surgery _____ % Cardiac surgery _____ % Colon surgery _____ %

Cosmetic plastic surgery _____ % General surgery _____ % Neurological surgery _____ %

Neuro-otological surgery _____ % Orthopedic surgery _____ % Reconstructive plastic surgery _____ %

Rectal surgery _____ % Thoracic surgery _____ % Traumatic surgery _____ %

Urological surgery _____ % Vascular surgery _____ %

4. Do you subspecialize? Yes No

If "Yes," subspecialty: _____

Percent of practice _____ %

5. Do you perform any surgery that is not categorized as part of your specialty? Yes No

If "Yes," please list procedures performed: _____

C. GENERAL/FAMILY PRACTICE, DERMATOLOGY, GYNECOLOGY, EMERGENCY MEDICINE, PEDIATRICS & OTHER NONSURGICAL SPECIALTIES

1. Do you perform induced, non-spontaneous abortions? Yes No

First trimester, through 12 weeks _____ (number/month)

Second trimester, 13-18 weeks _____ (number/month)

Second trimester, 19-27 weeks _____ (number/month)

Third trimester, 28 weeks or over _____ (number/month)

List hospitals, clinics, or other facilities where performed:

2. Do you provide obstetrical care? Yes No

Uncomplicated prenatal care, labor, and delivery?

_____ Number of deliveries performed per year

High-risk pregnancies, including but not limited to cesarean section, VBAC, or identifiable prospects of multiple births, preeclampsia, insulin-dependent diabetes, cardiac disease, renal disease, morbid obesity, or other life-threatening conditions?

_____ Number of deliveries performed per year

Are deliveries undertaken in other than a licensed hospital (except in an emergency)? Yes No

3. Do you ever administer any spinal, caudal, epidural, or general anesthesia? Yes No

4. Do you perform in-office anesthesia? Yes No

If "Yes," please indicate level:

Local anesthesia Analgesia Conscious sedation Deep sedation General anesthesia

If "Yes," please contact us for guidelines.

5. If you do not perform any of the procedures below, please check here:

Check all that apply	<input type="checkbox"/> Assisting at surgery more than 50% of your practice
<input type="checkbox"/> Assisting at surgery on other than own patients (incidental)	<input type="checkbox"/> Catheterization: heart, left side
<input type="checkbox"/> Biopsies: breast and cone	<input type="checkbox"/> Chemical peels: Baker's/Phenol
<input type="checkbox"/> Capsulotomies performed with the Nd:YAG laser	<input type="checkbox"/> Dermabrasion
<input type="checkbox"/> Cardiac catheterization: right side	<input type="checkbox"/> Endometrial ablation
<input type="checkbox"/> Closed reduction of displaced fractures	<input type="checkbox"/> Hair transplants
<input type="checkbox"/> Dilatation & curettage (D&C)	<input type="checkbox"/> Herniorrhaphies
<input type="checkbox"/> Myringotomy	<input type="checkbox"/> Open reduction of fractures
<input type="checkbox"/> Percutaneous insertion of Hickman catheter	<input type="checkbox"/> T&A
<input type="checkbox"/> Post-partum/mini-lap tubal ligation	<input type="checkbox"/> Transluminal angioplasty
<input type="checkbox"/> Umbilical hernia repair (outpatient only)	<input type="checkbox"/> Tubal ligations (other than post-partum and mini-lap)
<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Urgent care _____% of practice <input type="checkbox"/> Percent of return patients____%
	<input type="checkbox"/> Other procedures performed under general, spinal, or caudal anesthesia Please list: _____

<input type="checkbox"/> Alternative or complementary medicine including acupuncture. Please list procedures: _____
<input type="checkbox"/> Chelation therapy (for other than heavy metal toxicity)
<input type="checkbox"/> Shock therapy
<input type="checkbox"/> Weight reduction drugs Name of medication _____ Percentage of patients _____%
<input type="checkbox"/> Virtual medicine
<input type="checkbox"/> Telemedicine

6. Do you or your staff perform aesthetic or cosmetic procedures, including Botox and fillers? Yes No If "Yes," please list below and include proof of training:

Procedure:	% of practice:	Performed by any other staff:
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Does your practice include videoscopic surgeries (endoscopic, laparoscopic, arthroscopic, etc.)? Yes No

8. Are you a: Hospitalist Intensivist Not applicable

D. OBSTETRICS & GYNECOLOGY

1. Do you limit your practice to Gynecology only? Yes No

If "Yes," are you:

a. obligated to cover for a colleague doing OB? Yes No

b. required to be available for OB consultations and deliveries as a part of your hospital staff privileges? Yes No

2. Do you provide obstetrical services? Yes No If "Yes," please provide:

_____ Number of vaginal deliveries per year

_____ Number of cesarean sections per year

3. Do you perform induced, non-spontaneous abortions? Yes No

_____ First trimester, through 12 weeks (number/year)

_____ Second trimester, 13 through 18 weeks (number/year)

_____ Second trimester, 19 through 27 weeks (number/year)

_____ Third trimester, 28 weeks or over (number/year)

4. **Do you perform deliveries or abortions in a nonhospital facility?** Yes No If "Yes," please list facility name(s):

5. **Does your practice include infertility patients?** Yes No If "Yes," please elaborate on this activity and procedures performed:

6. **Do you follow ACOG guidelines for genetic screening?** Yes No If "No," please explain:

7. **Do you co-manage high-risk* prenatal care/deliveries with your own nurse midwives or ARNPs?** Yes No
8. **Do you co-manage high-risk* prenatal care/deliveries with any non-employed midwives or ARNPs?** Yes No
**High-risk pregnancies, see section C question 3, page 13.*

E. OPHTHALMOLOGY

1. **Do you perform the following procedures?**
Laser procedures Yes No _____ (number/month)
Refractive Surgeries* Yes No _____ (number/month)
2. **Do you perform CLE (Clear Lens Extraction)?** Yes No
If "Yes," for what purpose?

3. **Do you perform any ophthalmologic plastic surgery procedures?** Yes No
If "Yes," please specify type(s) of procedures performed:

**If you perform Refractive Surgery as part of your practice, please contact Physicians Insurance for a Refractive Surgery Questionnaire*

F. ORTHOPEDIC SURGERY

1. **Do you perform any of the following?**
Laminectomies: Yes No Vertebroplasty: Yes No Kyphoplasty: Yes No
2. **Do you subspecialize within your orthopedic practice?** Yes No
Subspecialty: _____ Percent of practice _____ %
3. **Do you perform any spinal surgery?** Yes No

G. OTORHINOLARYNGOLOGY

1. Please check the surgical procedures and medical techniques you perform:

- Traumatic/pathologic plastic surgery Cosmetic plastic surgery Neuro-otological surgery
 Liposuction _____ cc of fat removed

H. PATHOLOGY AND RADIOLOGY

1. Do you perform telemedicine or professional services for outside facilities, practitioners, or labs? Yes No

If "No," you may move on to question 10.

2. If you perform telemedicine or professional services for outside facilities, practitioners, or labs, is there a contractual relationship?

- Yes No *If "yes," please provide a copy of the contract and proof of their insurance*

3. Do any of your professional services involve reads that originate outside the state of which your practice is located?

- Yes No

State _____ License number _____ Percentage of practice: _____%

State _____ License number _____ Percentage of practice: _____%

State _____ License number _____ Percentage of practice: _____%

4. What types of specimens/images are received, and how are they sent?

5. What is the expected turnaround time?

6. Is the original read permanently retained on file in your facility? Yes No

7. What is the average number of reads processed per day?

8. Are there protocols in place to prevent communication failures involving technology, sending/receipt of specimens or films, communication of results, etc.? Yes No *If "Yes," please provide a copy of the protocols.*

9. If you are a *Radiologist*, please check all procedures or medical techniques that you perform or intend to perform:

If you do not perform any of the procedures below, please check here:

<input type="checkbox"/> Abdominal aortic aneurysm stent graft	<input type="checkbox"/> Left heart catheterization
<input type="checkbox"/> Aneurysm embolization	<input type="checkbox"/> Nerve root block: <input type="checkbox"/> cervical <input type="checkbox"/> thoracic <input type="checkbox"/> lumbar
<input type="checkbox"/> Angiography	<input type="checkbox"/> Percutaneous gastrostomy
<input type="checkbox"/> Arteriography	<input type="checkbox"/> Percutaneous nephrotomy or other drainage procedures
<input type="checkbox"/> Automated percutaneous discectomy	<input type="checkbox"/> Pseudoaneurysm thrombosis
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Brain/spine AVM embolization	<input type="checkbox"/> Radiofrequency ablation (RFA)
<input type="checkbox"/> Chemoembolization	<input type="checkbox"/> Radium implants
<input type="checkbox"/> Cryotherapy	<input type="checkbox"/> Right heart catheterization (other than Swan Ganz)
<input type="checkbox"/> Cyst. lymphatic sclerosis	<input type="checkbox"/> Sedation
<input type="checkbox"/> Deep radiation/X-ray therapy	<input type="checkbox"/> Stenting
<input type="checkbox"/> Diagnostic embolization	<input type="checkbox"/> Stroke therapy
<input type="checkbox"/> Discography	<input type="checkbox"/> Swan Ganz catheterization
<input type="checkbox"/> Embolization	<input type="checkbox"/> Thrombolysis
<input type="checkbox"/> Fibroid embolization	<input type="checkbox"/> Tips
<input type="checkbox"/> Gastric band fills	<input type="checkbox"/> Transluminal angioplasty
<input type="checkbox"/> Injection of radiopaque dye	<input type="checkbox"/> Vertebroplasty
<input type="checkbox"/> IVC filter	<input type="checkbox"/> Yttrium-90 Microsphere Radioembolization
<input type="checkbox"/> Kyphoplasty	

I. PEDIATRICS (also complete Section C for other nonsurgical specialties)

1. Do you provide care in a Level II neonatal intensive care nursery? Yes No
2. Do you provide care in a Level III neonatal intensive care nursery? Yes No
3. If your practice includes neonatology, please indicate percentage: _____ %
4. Do you perform surgical procedures? _____ % of practice?
5. Do you assist at C-section? Yes No

Claim Information (Please make additional copies if necessary)

No claims: *A signature is required regardless of claim history*

1. **Name:** (Last, First, Middle) _____ **2. Date of Birth:** (MM/DD/YYYY) _____ / _____ / _____ **3. Gender:** M F

4. **Allegation:** _____

5. **Date of incident:** _____ **6. Date reported:** _____

7. **Insurance carrier:** _____
Was a lawsuit filed? Yes No Are/were you the primary defendant? Yes No
If "No," please describe your involvement in patient care: _____

8. **Additional defendants:** _____

9. **Location of occurrence:** _____

10. **Claim status:**
 Open Closed Date closed: _____
If open, indicate reserve amount: \$ _____
If closed, indicate:
a. Method of closing: Dismissed Settled Judgment
b. Amount of settlement or judgment: \$ _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

11. **Condition and diagnosis at time of incident:** _____

12. **Dates and description of treatment rendered:** _____

13. **Condition of patient subsequent to treatment:** _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Signature _____
(Signature Required) Date

APPLICANT'S AUTHORIZATION AND RELEASE OF CLAIMS INFORMATION (PLEASE READ CAREFULLY)

I authorize and consent to the release of claims information by Physicians Insurance and its authorized representatives to my employer or to any group of which I am an employee, partner, member, or shareholder. I hereby release Physicians Insurance and its authorized representatives from any liability for the release of said claims information, provided that such release is done in a good faith belief that the receiving party is my employer or a group of which I am an employee, partner, member, or shareholder.

This release shall remain in effect until revoked by me in writing.

APPLICANT'S REPRESENTATION (PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree that this shall be the basis of the policy of insurance requested and that I will notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (PLEASE READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any of my attending or treating physicians, the Washington Physicians Health Program, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives.

I understand all health care providers with whom I practice, including physicians and health care extenders, must be insured by Physicians Insurance. Should any health care providers with whom I practice change their insurance coverage from Physicians Insurance to another carrier, while still practicing with me, I understand that my insurance may be canceled. Any exceptions are to be approved by Physicians Insurance.

I agree to notify Physicians Insurance immediately, in writing, if there are any changes from which I have described in this application, including changes in my practice, in my partners or associates, medical license, professional office premises, practice locations, medical procedures or administrative responsibilities and hospital privileges.

I understand that Physicians Insurance does not cover any liability of another person or organization with whom I assume an oral or written contract or agreement.

Signature

(Signature Required)

A photocopy of this Authorization shall be considered as effective and valid as the original

Date

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THIS INSURANCE.

For Washington, state law requires us to inform you of the following: 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.

Revised October 2007