Medical PL EZApp™

PHYSICIAN EDITION
(MD's & DO's)

The Medical PL EZ App™ is designed to be completed in 3 EZ steps:

***Step 1** – user must first have this pdf attachment saved to their own computer file folder.*

***Step 2** - from their computer the user must then open the saved EZ App pdf file with Adobe Reader 9 which will be needed in order to utilize Adobe's "extender save data" format.*

***Step 3** - user can now begin to enter data into the application fields right from their computer keyboard. By utilizing Adobe Reader 9 the input data is permanently saved providing an application data file you can reuse year after year as needed - once fully completed the user will need to sign and date page 6, close and save the attachment and then email it as an attachment directly back to their broker or agent for fast processing.*

(ADOBE offers a free download for Reader 9 on their web site and we have created a link below which may take a few seconds to connect you with the Adobe web link)

Adobe® Reader® 9 FREE DOWNLOAD LINK

REQUIRES ADOBE READER 9.0 or ABOVE to utilize "EXTENDER" feature enabling "SAVE DATA" and "FUTURE REVISION" CAPABILITY

1. PERSONAL INFORMATION

Full Name of Applicant: _____ _____ _____ _____
FIRST MIDDLE LAST SUFFIX

PROFESSIONAL DESIGNATION: ☐ MD ☐ DO **Date of Birth:** _____ **Gender:** ☐ MALE ☐ FEMALE
MONTH DAY YEAR

Place of Birth: _____ **Social Security Number:** _____

2. OFFICE INFORMATION

Principal Office Address: _____

_____ _____ _____ _____
CITY COUNTY STATE ZIP

Office Phone Number: _____ **Office Fax Number:** _____

Email Address: _____ **Office Manager:** _____

Secondary Office Locations (if any): _____

_____ _____ _____ _____
CITY COUNTY STATE ZIP

3. COVERAGE REQUEST

Requested Effective Date: _____ **Retroactive Date:** _____
MONTH / DAY / YEAR MONTH / DAY / YEAR

Please indicate your desired level of coverage in the appropriate box.

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $500,000/$1,500,000 ☐ **$1,000,000/$3,000,000**

☐ $1,300,000/$3,900,000 (New York Only) ☐ $2,000,000/$6,000,000 (Virginia Only) ☐ $2,300,000/$6,900,000 (New York Only)

4. CLASSIFICATION, LICENSING AND BOARD CERTIFICATION INFORMATION

A. What is your present specialty? _____

B. What is your present sub-specialty? _____

C. What percentage of your practice is devoted to your specialty? _____ Sub-specialty? _____

D. Indicate the average number of: Patients seen per week: _____ Hours practiced per week: _____

E. Licensing (List all states in which you are currently licensed.)

STATE	MEDICAL LICENSE NUMBER	% OF PRACTICE	FEDERAL DEA LICENSE NUMBER & STATUS	MEMBER OF STATE MEDICAL ASSOCIATION?
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

F. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates? YES ☐ NO ☐ N/A ☐

G. Are you American Board Certified? ..... YES ☐ NO ☐

i. If "yes," list Specialty Board(s): _____ (Indicate allopathic or osteopathic)

ii. If "yes," list date of initial Board Certification: _____

H. Please indicate the number of Continuing Medical Education (CME) credit hours you have attained over the past 12 months: _____

5. MEDICAL PROCEDURES INFORMATION

- ☐ Abortion, elective
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Caudal
  - ☐ Local
  - ☐ Spinal
  - ☐ Other _____
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On own patients
  - ☐ On patients of others
- ☐ Bariatric Surgical procedures
  - ☐ Gastric banding
  - ☐ Gastric bubble
  - ☐ Gastric bypass
  - ☐ Gastric stapling
- ☐ Blepharoplasty
  - ☐ Cosmetic
  - ☐ Reconstructive
- ☐ Breast Biopsy
- ☐ Breast Implants
- ☐ Breast Reduction
- ☐ Cardiac surgery
- ☐ Cataract surgery
- ☐ Chelation therapy
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Circumcision
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Cryosurgery, other than external lesions
- ☐ Dermatological procedures
  - ☐ Botox injection
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen injection
  - ☐ Dermabrasion
  - ☐ Fat transfer
  - ☐ Hair transplant
  - ☐ Laser hair removal
  - ☐ Laser skin resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone injection
  - ☐ Other _____
- ☐ D & C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Endoscopic laser therapy
- ☐ Endoscopy
  - ☐ Cystoscopy
  - ☐ Bronchoscopy
  - ☐ EGD
  - ☐ Gastroscopy
  - ☐ Hysteroscopy
  - ☐ Proctoscopy
  - ☐ Sigmoidoscopy
  - ☐ Other _____
- ☐ ERCP/ERC
- ☐ Exchange transfusion
- ☐ Facial plastic surgery
  - ☐ Elective cosmetic
  - ☐ Reconstructive
- ☐ Fluoroscopy
- ☐ Fracture Reduction
  - ☐ Closed
  - ☐ Open
- ☐ Hand surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailing
- ☐ Hyperbaric medicine
- ☐ Hysterectomy
- ☐ Intensive care for newborns
- ☐ Intensive care medicine for adults
- ☐ Infertility treatment
  - ☐ Medical
  - ☐ In vitro fertilization
  - ☐ Other surgical
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ LASIK
- ☐ Left heart catheterization
- ☐ Liposuction
  - ☐ Tumescent
  - ☐ Other _____
- ☐ Lithotripsy
- ☐ Mammography
- ☐ Mesotherapy
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Organ transplantation
- ☐ Orthopedic surgery
  - ☐ Including spinal surgery
  - ☐ Without spinal surgery
- ☐ Osteopathic manipulative medicine
- ☐ Pain management
  - ☐ Cordotomy
  - ☐ Dorsal root gangliotomy
  - ☐ Facet blocks
  - ☐ Medication only
  - ☐ Nerve root blocks
  - ☐ Pump implantation and removal
  - ☐ Rhizotomy
  - ☐ Sphenopalatine lesioning
  - ☐ Spinal injections
  - ☐ Thoracic sympathectomy
  - ☐ Trigeminal lesioning
  - ☐ Other _____
- ☐ Percutaneous vertebroplasty
- ☐ Pacemaker placement
- ☐ Polypectomy
- ☐ Prenatal care – 1st Trimester
- ☐ Prenatal care – 2nd Trimester
- ☐ Prenatal care – 3rd Trimester
- ☐ Prolotherapy
- ☐ Provertin retinal therapy
- ☐ Radiation therapy
- ☐ Radiopaque dye injection
- ☐ Roux-en-Y
- ☐ Sclerotherapy
- ☐ Spinal fusion
- ☐ Spinal surgery, other
- ☐ Thoracic surgery _____%
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery/hormonal gender conversion
- ☐ Tubal ligation
- ☐ Vascular surgery _____%
- ☐ Vasectomy

☐ **None of the above apply to my practice (Initial)_____**

☐ **Other procedures not listed above (Please list)**

_____

_____

_____

A. If applying for Obstetrical coverage, indicate:

i. **Average number of deliveries per year _____ Percentage of high-risk deliveries _____**

ii. **Average number of VBAC deliveries per year _____ What induction agents do you use on VBAC patients? _____**

iii. **Do you have privileges to perform C-sections at each hospital you staff? ..... YES ☐ NO ☐**

iv. **If you employ a Nurse Midwife, how many deliveries does that individual perform annually? _____ N/A ☐**

B. Do you or will you staff an emergency room? ..... YES ☐ NO ☐

i. **If "yes," how many hours per week? _____**

ii. **If "yes," in what facilities or for what staffing company? _____**

iii. **Is this emergency room practice required solely to maintain hospital staff privileges? ..... YES ☐ NO ☐**

6. ADDITIONAL PROFESSIONAL INFORMATION - If you answer "yes" to any of these questions please provide details.

A. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ..... YES ☐ NO ☐

B. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? ..... YES ☐ NO ☐

C. Have you ever been refused hospital privileges? ..... YES ☐ NO ☐

D. Have you ever failed any licensing or Board Certification examinations? ..... YES ☐ NO ☐

If yes, how many times? _____

E. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ..... YES ☐ NO ☐

F. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ..... YES ☐ NO ☐

G. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? ..... YES ☐ NO ☐

H. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue?
YES ☐ NO ☐

I. Have you ever been accused of sexual misconduct of any kind? ..... YES ☐ NO ☐

J. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? ..... YES ☐ NO ☐

K. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years?
YES ☐ NO ☐ If YES, please provide details _____

L. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year? .....
YES ☐ NO ☐ If YES, please provide details _____

M. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? ..... YES ☐ NO ☐

N. Do you provide medical services within the confines of any state, local or federal correctional facility, jail or prison? ..... YES ☐ NO ☐

O. Do you treat patients in a nursing home or similar facility? ..... YES ☐ NO ☐

If YES, how many patients do you treat there per month, on average? _____

Are you contracted with facility or are these your own private practice patients? _____

P. Do you serve as a medical director of a hospital, nursing home, or other facility? ..... YES ☐ NO ☐

If YES, please provide details: _____

Q. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (i.e. teleradiology, telemedicine or internet medicine)? .....
YES ☐ NO ☐ If YES, please provide details: _____

7. EDUCATIONAL INFORMATION

MEDICAL SCHOOLS			
NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING					
INSTITUTION	LOCATION	SPECIALTY OR DEPARTMENT	DATES (MONTH/YEAR) START	END	WAS THE TRAINING FULLY COMPLETED?
					YES ☐ NO ☐
					YES ☐ NO ☐
					YES ☐ NO ☐

8. PRACTICE LOCATIONS HISTORY

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY		
LOCATIONS	DATES (MONTH/YEAR)* START	END

9. PRACTICE ORGANIZATION

☐ **If a Solo Practice: Name of your Corporate entity and/or DBA name:** _____

☐ **If a Member of a partnership or multi-shareholder corporation / Partnership/Group Name:** _____

_____

☐ **Work as an Employee or Independent Contractor for Other - please explain and provide name of Entity/Practice you are working for:**

_____

10. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any Ancillary or Allied Health Care Professionals associated with your practice:

Please indicate if coverage is desired for these individuals. A separate application will be required for each individual for whom coverage is requested. N/A ☐ Coverage is not required as there are no Ancillary or Allied Health Care providers in the practice.

NAME	SPECIALTY	EMPLOYMENT STATUS	TO BE CONSIDERED FOR SHARED LIMITS COVERAGE?
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No
		☐ Employee ☐ Contractor	☐ Yes ☐ No

B. Do any of your employees practice at a location geographically separate from yours?..... N/A ☐ YES ☐ NO ☐

If "yes," please explain. _____

11. HOSPITAL AFFILIATIONS AND PRIVILEGES

HOSPITALS WHERE YOU HAVE, OR HAD, ACTIVE PRIVILEGES OR WHERE YOU HAVE APPLIED					
HOSPITAL DATA		DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE?
NAME	MAILING ADDRESS	START	END		
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

12. PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

Insurance Company Name	# of Closed Claims	# of Pending Open Claims	Policy Dates From	To	Retroactive Date	Tail Coverage Purchased?
Current						
Previous						
Previous						
Previous						
Previous						
Previous						

A. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? ..... YES ☐ NO ☐

B. In the past 10 years, have you ever been involved in a malpractice claim or suit, either directly or indirectly? (THIS INCLUDES ANY WHICH HAVE BEEN CLOSED or DISMISSED) ..... YES ☐ NO ☐

If "yes," how many? _____

C. Other than the claims/suits indicated in 12B, are you aware of any 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? If you respond to questions C i. through C v. with a YES response you must provide additional specific details on a separate page.

i. A request for records from a patient and/or attorney related to an adverse outcome?..... YES ☐ NO ☐

ii. A letter from an attorney regarding your medical treatment of a patient?..... YES ☐ NO ☐

iii. Intra-operative or post-operative complications or any other type complications resulting in death, paralysis, other significant disability or the need for follow-up surgery?..... YES ☐ NO ☐

iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? ..... YES ☐ NO ☐

v. Any other incidents or circumstances that might reasonably lead to a claim or suit? ..... YES ☐ NO ☐

D. HAVE ALL INCIDENTS & CIRCUMSTANCES THAT MIGHT REASONABLY LEAD TO A CLAIM OR SUIT (even if you believe the possible claim or suit would be without merit) BEEN REPORTED TO YOUR CURRENT OR PREVIOUS PROFESSIONAL LIABILITY INSURANCE CARRIER? ..... N/A ☐ YES ☐ NO ☐

IMPORTANT!!!!! Please note that a NO answer to question D indicates that you are aware of a potential CLAIM OR SUIT but have not yet reported it to your current insurance company. Using a separate page, please provide the name of the patient you are referring to along with a detailed narrative as to what transpired and the date that the incident in question took place.

I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT MY ANSWERS AND STATEMENTS WILL BE THE BASIS FOR DETERMINING MY INSURABILITY AND PREMIUM FOR THE PROFESSIONAL LIABILITY INSURANCE BEING APPLIED FOR. I FURTHER UNDERSTAND THAT THE COMPLETION AND SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

ANY PERSON WHO KNOWINGLY OR WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

ACKNOWLEDGED AND AGREED:

Applicant Name (Printed)	Applicant Signature (Required)	Date Signed

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING – THANKS!

- ☐ **APPLICATION MUST BE SIGNED AND DATED AT TIME FIRST COMPLETED AND SENT BACK TO US.**
- ☐ **Please provide your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.**
- ☐ **Please provide copies of any applicable current policy endorsements that affect basis of coverage so that we are able to try and obtain coverage aspects equal to or better than what you currently have in place.**
- ☐ **Please provide a copy of an Up-to-date CV (curriculum vitae - also known as a resume).**
- ☐ **Please provide current *(i.e. obtained within 60 days of requested effective date)* Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years – WE WILL BE GLAD TO TRY AND HELP YOU OBTAIN THESE IF NECESSARY.**

If you have the need to provide additional info or to elaborate on previous YES responses please do so in the space provided below:

REQUIRES ADOBE READER 9.0 or ABOVE to utilize "EXTENDER" feature enabling "SAVE DATA" and "FUTURE REVISION" CAPABILITY

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each. Attach additional sheets if needed for adequate explanation. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____
2. Date reported to insurance company: _____
3. Name of Insurance Company: _____
4. Date of incident and your treatment: _____
5. Allegations: _____

_____

_____

6. What is the present condition of the patient? _____

_____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... YES ☐ NO ☐

8. Status of claim (check applicable answer):

☐Suit threatened, no action taken ☐Suit filed but dropped by claimant ☐Summary judgment in your favor ☐Suit settled out of court a. Date claim paid: _____ b. Amount paid: _____ c. Did you want to settle this claim? ☐YES ☐NO	Court outcome in your favor: ☐Jury verdict ☐Directed verdict Court outcome in favor of plaintiff: ☐Jury verdict ☐Directed verdict Amt. of loss payment: _____	Unresolved/Open Claim: ☐Awaiting mediation ☐Awaiting court action Reserve Amount: _____

9. Name and address of the attorney assigned to your case: _____

_____

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ..... YES ☐ NO ☐

    If "yes", amount was _____

11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

_____

_____

_____

Signature: _____ **Date:** _____

Name (Printed): _____