Nevada Docs Medical Risk Retention Group, Inc.

608 S. Jones Blvd. | Las Vegas, NV 89107
Phone 702-215-4894 | Fax 702-947-4488

Physicians & Surgeons Professional Liability Insurance Application

YOU MUST ATTACH

- ☐ Copy of current most relevant Medical License and DEA Certificate
- ☐ Copy of letterhead or sample billing statement and all stationary
- ☐ Supplemental claim form for each claim, regardless of outcome
- ☐ Financial Statements / P&L balance sheets
- ☐ Copy of all advertisements within the last 2 years
- ☐ Copy of current Declarations Page
- ☐ Curriculum Vitae
- ☐ Copy of Board Certifications
- ☐ Copy of Medical Degree
- ☐ Copy of Residency Certificates

Please type or legibly print your responses in full. Please supplement this application with copies of the documents requested below and with responses to questions requiring more room than contained in this form.

1. Name (First, Middle, Last): ☐ M.D. ☐ D.O. ☐ Other _____

2. Social Security Number: | 3. Date of Birth: | Birthplace:

4. Narcotics DEA Number: | 5. License Number/Date:

6. Mailing Address:

Street:

City/State/Zip: | County:

Office Telephone: | Fax: | EMail:

Business manager/contact person: | Telephone:

7. Principal office address (if different than mailing address):

Street: | Telephone:

City/State/Zip: | County:

Other Practice Locations:

Residence address (if different than mailing address):

Street: | County:

City/State/Zip: | Residence Telephone:

8. Requested limits of insurance: $1,000,000/$3,000,000 Name of Corporation _____

☐ Shared Limits ☐ Seperate Limits

9. Requested effective date (12:01 a.m.): _____ Requested retroactive date (12:01 a.m.): _____

Retroactive date is the date to which coverage is to be extended for acts prior to the effective date.

10. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage for? ☐ Yes ☐ No

If yes, please list name of employer and insurance company:

11. Medical Specialty: | Subspecialty (if any):

12. Specialty Board Certification(s): | Date of certification(s):

If not board certified, are you board eligible? ☐ Yes ☐ No - Anticipated date of taking exam:

13. All states where you are licensed:

State	License Number	Active/Inactive

14. All hospitals and surgi-centers at which you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each:

Name	City	State	Type of privileges	% of admissions

15. All medical societies, medical associations, or other related professional societies, to which you belong:

16. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation Date
If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates?		☐ Yes	☐ No
If yes, date certified: _____	If no, please explain:		

17. All internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Mo./Yr. Completed
Served internship at:		
Served residency at:		
Served fellowship at:		
Served fellowship at:		

18. All practice locations within the ten years prior to this application, the current or most recent first:

19. Please indicate below your best estimate of the number of the following procedures you expect to perform, or in which you will participate, in the next year, beginning with the date of your requested coverage:

Abortions - first trimester:
_____ Hospital
_____ Clinic
_____ Office
Abortions - after first trimester:
_____ Hospital
_____ Clinic
_____ Office
_____ Acupuncture
_____ Adenoidectomies
_____ "Alternative Medicine" or "complementary medicine" procedures (as viewed by most physicians)
Please describe: _____
Anesthesia - obstetrical:
_____ General
_____ Spinal
_____ Epidural
Anesthesia - non-obstetrical:
_____ General
_____ Spinal
_____ Epidural
_____ Anesthesia (other) - Please describe: _____
_____ Angiographies
_____ Angioplasty
_____ Arteriorgraphies
_____ Assisting in major surgery - own patients
_____ Assisting in major surgery - other than own patients
_____ Breast implants
_____ Breast reductions
Catheterizations:
_____ Cardiac
_____ Arterial
_____ Other - Please describe: _____
_____ Chelation therapy
_____ Chemabrasion
_____ Chemical Peels
_____ Chemotherapy
_____ Colonoscopies
_____ Cosmetic implantation or injection of silicone or other materials - Please describe:
_____
_____ Cryosurgery - Please describe: _____
_____ D & C's
Deliveries:
_____ Vaginal
_____ Cesarean
_____ Vaginal after Cesarean
_____ Discograms
_____ Electromyography
_____ Endoscopy (other than proctoscopy or sigmoidoscopy) - Please describe: _____
_____ Eyeliner pigmentation
_____ Fracture reductions - closed
_____ Fracture reductions - open
_____ Hair transplants, or other hair growing or replacement techniques

_____☐_____ I DO NONE OF THESE PROCEDURES

Hemorrhoidectomies:
_____ Internal
_____ External
_____ Herniorrhaphies
Laparoscopy:
_____ Diagnostic - Please describe: _____
_____ Surgical - Please describe: _____
_____ Laser Surgery - Please indicate type of surgery: _____
_____ Liposuction
_____ Lumbar punctures
_____ Manipulation therapy
_____ Myelography
_____ Needle aspriations
_____ Needle biopsies
_____ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts - Please indicate type of surgery: _____
_____ Pacemaker insertion
_____ Pain management - Please indicate type: _____
_____ Pre-natal care
_____ Radial keratotomies
_____ Radiation - diagnostic
_____ Radiation - therapeutic
_____ Sclerotherapy (choose one) <1mm >1mm
_____ Shock therapy
_____ Spinal Surgery
_____ Tattoo removal
_____ Thoracentesis
_____ Tonsillectomies
_____ Total joint replacements
_____ Tubal ligations
_____ Vasectomies
_____ Venography
_____ Weight control by means other than diet or exercise - Please describe: _____
_____ Any other procedure you reasonably believe will be of interest to a medical professional liability insurer - Please describe: _____
☐ I DO NONE OF THESE PROCEDURES

20. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of major surgery:

_____ Abdominal
_____ Bariatric
_____ Cardiac
_____ Colon/rectal
_____ General
_____ Gynecologic
_____ Hand
_____ Head and Neck
_____ Neurosurgical
_____ Obstetrical
_____ Opthamalogical
_____ Orthopedic - including spinal surgery
_____ Orthopedic - without spinal surgery
_____ Plastic - cosmetic
_____ Plastic - reconstructive
_____ Thoracic
_____ Traumatic
_____ Urologic
_____ Vascular
☐ I DO NONE OF THESE PROCEDURES

21. Please describe, and provide dates for, any major changes in your practice in the last seven years, such as changes of speciality, or significant procedures initiated or no longer performed:

In responding to questions 22 through 38, please explain any "yes" response, or provide any required explanation or details on supplementary pages and attach to this application.

22. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society? ☐ Yes ☐ No

23. A. Has any state ever refused you're a license to practice medicine? ☐ Yes ☐ No
B. Has any state ever restricted, suspended or revoked your license to practice medicine? ☐ Yes ☐ No
C. Have you ever voluntarily surrendered a license to practice medicine? ☐ Yes ☐ No
D. Has any state agency ever placed you on probation or restricted your practice? ☐ Yes ☐ No
E. Have you ever been investigated by any governmental agency? ☐ Yes ☐ No

24. Has any hospital ever denied, restricted, reduced, or suspended your privileges or invoked probation? ☐ Yes ☐ No

25. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? ☐ Yes ☐ No

26. Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or mental illness? ☐ Yes ☐ No

27. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine? ☐ Yes ☐ No

28. Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you? ☐ Yes ☐ No

29. Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense? ☐ Yes ☐ No

30. Have you ever been refused board certification? ☐ Yes ☐ No

31. Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had renewal refused? ☐ Yes ☐ No
To your knowledge is any such action under consideration by any current medical professional liability insurer? ☐ Yes ☐ No

32. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office? ☐ Yes ☐ No

33. Are you an employee of, or do you do contract work for, any government agency? ☐ Yes ☐ No
If so, provide name_____

34. Are you a sports team physician for any college, university or professional team? ☐ Yes ☐ No

35. Do you participate in any pharmaceutical testing programs? ☐ Yes ☐ No
If yes, is it (are they) FDA approved? ☐ Yes ☐ No

36. Please indicate the number of people you employ by the following categories:

_____ Lab or X-ray technicians
_____ Medical Assistants
_____ Nurses
_____ Nurse anesthetists
_____ Nurse midwives
_____ Nurse practitioners
_____ Physicians or surgeons
_____ Physician assistants
_____ Surgical assistants
_____ Other (please specify):

37. Do you treat or review treatment for jail or prison inmates? ☐ Yes ☐ No
(If coverage is to be provided by another carrier, please provide evidence of that other coverage.)

38. Do you admit patients for other physicians? ☐ Yes ☐ No

39. Do you engage in any "moonlighting" activity, apart from your practice? ☐ Yes ☐ No

40. Do you work in an emergency room? ☐ Yes ☐ No

If yes, how many hours on average per week? _____ ☐ Yes ☐ No
For what institution? _____
If coverage is to be provided by another carrier, please provide evidence of other coverage.

41. Do you use a collection agency? ☐ Yes ☐ No
If yes, does the collection agency have authority to file collection suit at its discretion?

42. Do you work with a blood bank? ☐ Yes ☐ No

43. If you are NOT a radiologist:

Do you take and/or interpret your own X-rays or other imaging procedures? ☐ Yes ☐ No
If yes, estimated number per year _____
Does a radiologist over-read your X-rays?
If a non-radiologist is over-reading your X-rays, who? _____
What specialty? _____

44. Do you perform surgery in your office? ☐ Yes ☐ No
If yes, please list the specific procedures: _____
Is general anesthesia administered for these office procedures? ☐ Yes ☐ No
If yes, by whom? _____
With what training? _____

45. Do you perform invasive pain management procedures? ☐ Yes ☐ No
If yes, please list the procedures you perform and indicate if each is done in a hospital or office:
Do you provide fluoroscopic guided procedures ? ☐ Yes ☐ No
Do you use sedation? ☐ Yes ☐ No
Do you place permanent pumps or stimulators? _____

46. Average number of patients per week: # of patients _____

47. Average weekly number of hours practiced per week: hours per week _____
(a) Is your office staff certified in CPR? ☐ Yes ☐ No

48. If you are practicing part time, please provide the date on which you began practicing in that capacity:

49. Do you practice as a Hospitalist: If yes please complete all applicable below ☐ Yes ☐ No

a) Individual (solo practice)? ☐ Yes ☐ No
Please provide the name and Federal ID of the solo professional corporation or service corporation:

b) Employee? ☐ Yes ☐ No
Name of Employer:

c) Independent contractor? ☐ Yes ☐ No
Name of hiring party to contract:

d) Partner/shareholder? ☐ Yes ☐ No
Name of corporation/partnership:
Federal ID of the solo professional corporation or service corporation:

50. If you practice as a partner in a partnership or shareholder in a multi-shareholder professional corporation, is corporation coverage desired? ☐ Yes ☐ No

If coverage is desired, a corporate/organization application may be required. **Note:** This coverage is not available unless all partners, shareholders and employed physicians/surgeons are insured by the company.

51. Beginning with your most recent, or current, insurer please list all professional liability insurers for the past ten years. Please explain any gaps in the continuity of your professional liability coverage.

Name of Insurer	Coverage Type (Occurrence or Claims-made)	Policy Number	Policy Period

52. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer?

☐ Yes ☐ No

(Please provide a copy of the Declarations page of your current coverage and any reporting period extension "tail").

53. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged? ☐ Yes ☐ No

If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to proved coverage? ☐ Yes ☐ No

54. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rending of or failure to render professional services which may give rise to a claim? ☐ Yes ☐ No

If yes, has this incident (these incidents) been reported to a prior insurer? ☐ Yes ☐ No

55. Have you had a request for medical records of a patient which has been reported to your current carrier? ☐ Yes ☐ No

56. Have you served as an expert witness or have you been deposed as an expert in any case of medical malpractice? If so, please supply copies of your deposition or testimony if available. ☐ Yes ☐ No

Please provide complete details for each incident on a separate page and attach to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition or current status must be included.

APPLICANT'S REPRESENTATION AND AUTHORIZATION

A) I understand that no coverage will be bound until after the carrier has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of the carrier intent to provide coverage. If coverage is declined by the carrier, any advance payment will be promptly returned. The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I authorize the release of any underwriting and/or claim information from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals, to the carrier and its subsidiaries or agents. I authorize Nevada Docs Medical Risk Retention Group to release certificates of insurance and claim information to any third party payor, HMO, PPO hospital or Managed Care Organization.

Signature of Applicant Date

B) I have received and reviewed to my satisfaction the Information Circular with all of its attachments dated _____ for the Nevada Docs Medical Risk Retention Group, Inc.

Signature of Applicant Date

C) I understand that to obtain and maintain insurance coverage under this program, I must belong to the Nevada Docs Association and that a copy of this application will serve as my application for membership in that organization. I understand that my dues of $600 in the association must be maintained per the bylaws and that I must maintain my membership in good standing to continue to benefit from the association's programs. The nonrefundable application fee of $50 will be applied to my first year's membership.

Signature of Applicant Date

Nevada Docs Medical Risk Retention Group, Inc.

608 S. Jones Blvd. | Las Vegas, NV 89107
Phone 702-215-4894 | Fax 702-947-4488

RETROACTIVE COVERAGE FORM

(This form must be completed, signed and dated; attach a separate sheet where necessary)

1. Name of Applicant: _____
   First Middle Last
2. I am applying for: Retroactive coverage on my professional liability policy - Effective: _____
   (Retroactive Date)
3. Limits of liability requested: $1,000,000/$3,000,000
4. Did you practice as part of a partnership or corporation during the prior acts period? ☐ Yes ☐ No
   If yes, name(s) of corporation/partnership _____
5. Have you reported any incidents (potential claims) to a prior carrier during the prior acts period? ☐ Yes ☐ No ☐ N/A
   If yes, date of incident: _____ Name of carrier: _____
   If yes, please describe: _____
6. Was the nature of your practice different during any of the prior acts period than it is now? ☐ Yes ☐ No ☐ N/A
   If yes, please describe: _____
7. Did you practice in another state during the prior acts period? ☐ Yes ☐ No ☐ N/A
   Please list states: _____
8. Did you function as a Medical Director for any facility ? ☐ Yes ☐ No
   If yes, name of the facility _____and the length of time you have been there.
   Medical Director from _____ to _____
   Do you admit patients to the above facility ?
9. Are you a hospitalist ? ☐ Yes ☐ No If yes state the name of the facility._____
10. Do you treat or admit patients at a nursing home? ☐ Yes ☐ No If yes how many patients per month ?_____
11. Have you reported all outcomes that have resulted in a death, permanant damage/disability or bad outcome to your current carrier ? ☐ Yes ☐ No ☐ N/A If yes, please list date(s) reported. _____

I understand that, if granted prior acts coverage by the carrier, such coverage will apply only to liability arising out of occurrence which happened prior to the effective date and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

1. **any claim which has been reported to another insurance carrier prior to the effective date,**
2. **any claim known to the insured at the effective date which has not been reported to a prior carrier,**
3. **any claim which may arise out of an incident which has been reported to another insurance carrier prior to the effective date.**
4. **any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer,**

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge, and that I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I further authorize the release of any underwriting or claim information from all prior and current insurers, professional societies or association, or hospitals to the carrier.

FRAUD WARNING

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement or a claim or any false, incomplete or misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Signature of Applicant **Date**

No coverage will be bound until after the Company has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment in advance of review of the application is not an expression of the Company's intent to provide coverage. If coverage is refused by the Company, any advance payment will be returned.

Nevada Docs Medical Risk Retention Group, Inc.

608 S. Jones Blvd. | Las Vegas, NV 89107
Phone 702-215-4894 | Fax 702-947-4488

IMPORTANT: This form must be completed, signed, and dated. If the applicant's claim history is clean, simply mark, "N/A" on form, sign, and date. Thank you

SUPPLEMENTAL CLAIM INFORMATION FORM

Please provide the information below for each additional claim or suit to report.

☐ If you do not have any claims/incidents open or paid, please check the box at left and sign the bottom

1. Physician's name (please print): _____

2. Patient's name: _____ Age: _____ Sex: _____

3. Date of first consultation: _____

4. Physical condition and diagnosis at the above date: _____

5. Nature of treatment given and dates of same: _____

6. Date of incident or occurrence from which claim resulted: _____

7. Date of claim: _____

8. Allegations made against you: _____

9. Was this claim reported to your insurance carrier? ❑Yes ❑No
If yes, list name of carrier and policy number:

10. Present status or disposition of claim including **amount of settlement or judgment**:

11. Subsequent condition or health of patient:

12. Names of other doctors, and hospitals, if any, involoved in the claim or suit:

13. To whom may we refer for further information about the claim?

Signature of Applicant Date