



INDIVIDUAL PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

BY COMPLETING THIS APPLICATION, THE APPLICANT IS APPLYING FOR INSURANCE WITH HOMELAND INSURANCE COMPANY OF NEW YORK

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE AND REPORTED COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR WITHIN (60) DAYS AFTER THE END OF THE "POLICY PERIOD". IF AN EXTENDED REPORTING PERIOD IS APPLICABLE, SUCH COVERAGE WILL APPLY ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER DURING THE EXTENDED REPORTING PERIOD. THE COVERAGE AFFORDED UNDER THIS POLICY DIFFERS IN SOME RESPECTS FROM THAT AFFORDED UNDER OTHER POLICIES. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

A. APPLICANT

1. Name of Applicant: _____ Date of Birth: _____

Social Security #: _____ Federal DEA #: _____

2. Employed / Contract By: _____

3. Date of Hire: _____

4. Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Website: _____ E-mail Address: _____

5. Primary Office Location : _____

City: _____ County: _____ State: _____ Zip Code: _____

Website: _____ E-mail Address: _____

(List all other office locations on a separate sheet.)

6. Office Telephone: _____

7. Current Carrier: _____

8. Current Policy Type: [] Occurrence [] Claims Made Current Retroactive Date: _____

9. Requested Policy Type: [] Occurrence [] Claims Made Current Retroactive Date: _____

(*Note requested coverage is not automatically available; the terms and conditions of the Policy, if issued, will determine actual coverage.):

10. Limits Requested: \$200K/\$600K \$500K/\$1.5MM \$1MM/\$3MM
 \$2MM/\$4MM \$3MM/\$5MM Other: _____
11. Retention Requested: \$5,000 \$10,000 \$15,000
 \$25,000 Other: _____
12. Type of Practice: Employed Physician Partner Owner
 Independent Contractor Other: _____
13. Type of Organization: Professional Corporation Professional Association
 Corporation Sole Proprietor Partnership Other: _____
14. Primary specialty/area of practice: _____
15. Are you currently enrolled in a Patient's Compensation Fund? Yes No
If "yes", which State? _____
16. a. Are you currently participating in a State Excess Fund? Yes No
If "Yes", which State? _____ At what limits of liability? _____
- b. If you receive excess coverage in the state of New York at no additional cost to you, please attach a copy of your certificate of eligibility.

B. EDUCATION

1. a. Medical School: _____
Name of School City State
Year Graduated _____ Degree: M.D. D.O. Other _____
- b. Internship: _____
Name of School City State
From: _____ To: _____
month/year month/year
- c. Residency: _____
Name of Hospital City State
Year Completed: _____ Specialty Type: _____
2. How many continuing medical education credits did you achieve last year? _____ Past 2 years: _____

C. CURRENT PRACTICE

1. Current Medical License#: _____ State: _____
Date Licensed: _____ Expiration Date: _____
% of Practice in this state: _____
Current Medical License #: _____ State: _____
Date Licensed: _____ Expiration Date: _____
% of Practice in this state: _____
- Other medical or professional licenses or certifications, including ECFMG (list states or countries, License number and date):

2. Are you Board Certified? Yes No If "No", are you Board Eligible? Yes No

Date of Certification: _____

Name(s) of approved specialty boards(s): _____

Is re-certification required? Yes No

If "Yes", date of anticipated re-certification: _____

3. What Professional organizations are you a member of? AMA AOA County Medical
 State Medical Other _____

4. Do you have any teaching affiliations? Yes No
If "Yes", please describe (include the number of hours per month), and specify the institution(s): _____

5. Do you participate in research or clinical trials? Yes No
If "Yes," please explain: _____

6. Do you practice (for the organization in A.2)? Full Time Part Time Hours per week: ____
How many patients do you see a week? _____

7. Are you engaged in "moonlighting activities"? Yes No
If "Yes", how many hours per week? _____
If "Yes", please describe where and what services: _____

8. Where have you practiced your profession in the last eight (8) years? (Attach a copy of you CV, include military or any public service and any gaps in practice. Attach a separate sheet if needed.)

_____ Name/ City / State	_____ From: month / year	_____ To: month / year
_____ Name/ City / State	_____ From: month / year	_____ To: month / year
_____ Name/ City / State	_____ From: month / year	_____ To: month / year
_____ Name/ City / State	_____ From: month / year	_____ To: month / year
_____ Name/ City / State	_____ From: month / year	_____ To: month / year

9. List all hospitals where you currently have staff privileges. (Attach a separate sheet if needed):

_____ Hospital	_____ City / State	_____ Hospital	_____ City / State
_____ Hospital	_____ City / State	_____ Hospital	_____ City / State

10. Has your practice changed in the last eight (8) years? Yes No

If "Yes", please explain: _____

D. PRACTICE SPECIALTY

1. Indicate percentage of time devoted to your specialty and sub-specialty:

Specialty: _____ % of time: _____

Sub-specialty: _____ % of time: _____

Check any specialized procedures you normally perform (check all that apply):

- | | |
|---|--|
| <p>2. _____ Abortions
 _____ Acupuncture
 _____ Administer Anesthesia
 General <input type="checkbox"/> Yes <input type="checkbox"/> No
 Spinal <input type="checkbox"/> Yes <input type="checkbox"/> No
 Epidural <input type="checkbox"/> Yes <input type="checkbox"/> No

 _____ Amniocentesis
 _____ Angiography
 Is catheter used? <input type="checkbox"/> Yes <input type="checkbox"/> No

 _____ Arteriography
 Is catheter used? <input type="checkbox"/> Yes <input type="checkbox"/> No

 _____ Breast Biopsies
 _____ Breast Implants
 _____ Breast Reductions
 _____ Bronchoscopy
 _____ Catheterization
 Cardiac <input type="checkbox"/> Yes <input type="checkbox"/> No
 Arterial <input type="checkbox"/> Yes <input type="checkbox"/> No
 Diagnostic <input type="checkbox"/> Yes <input type="checkbox"/> No
 Swan-Ganz <input type="checkbox"/> Yes <input type="checkbox"/> No
 Cord <input type="checkbox"/> Yes <input type="checkbox"/> No

 _____ Colonoscopies
 _____ Cosmetic or Plastic Surgery
 _____ C-Sections
 _____ Discograms
 _____ Endoscopic Retrograde
 _____ Cholangiopancreatography
 _____ Esophageal Dilatation
 _____ Experimental Surgery or Procedures
 _____ Gastroscopy
 _____ Hair Transplants
 _____ Hemodialysis
 _____ In Vitro Fertilization
 _____ IUD Insertion</p> | <p>_____ Laparoscopy
 _____ Laser Surgery
 _____ Lymphangiography
 _____ Myelography
 _____ Needle Biopsy
 Lung <input type="checkbox"/> Yes <input type="checkbox"/> No
 Prostate <input type="checkbox"/> Yes <input type="checkbox"/> No
 Liver/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No
 Bone Marrow <input type="checkbox"/> Yes <input type="checkbox"/> No

 _____ Phlebography
 Is catheter used? <input type="checkbox"/> Yes <input type="checkbox"/> No

 _____ Pneumoencephalography
 _____ Prenatal Care
 _____ Radiation Therapy
 _____ Radiopaque Dye Injections
 _____ Shock Therapy
 _____ Sigmoidoscopies
 _____ Silicone Injections
 _____ Thoracentesis
 _____ Transplants (organ, bone marrow, etc.)
 _____ Tubal Ligations
 _____ Vaginal Delivery
 _____ Vasectomies
 _____ VBAC
 _____ Weight Control with drugs
 _____ Weight Control Surgery
 Gastric Bubble <input type="checkbox"/> Yes <input type="checkbox"/> No
 Gastric Stapling <input type="checkbox"/> Yes <input type="checkbox"/> No
 Intestinal By-Pass <input type="checkbox"/> Yes <input type="checkbox"/> No
 Suction Lipectomy <input type="checkbox"/> Yes <input type="checkbox"/> No`

 _____ Other – Please List: _____

 _____</p> |
|---|--|

3. Do you perform (check all that apply)

- Category 1- No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia, or circumcision.
- Category 2 - Assist in surgery on your own patients.
- Category 3 - Closed fractures – other than fingers and toes

- Category 4 - D&C performed under local anesthesia
Vasectomies
Obstetrical procedures and/or prenatal care beyond the first trimester not including
Cesarean sections
- Category 5 - All other types of surgery and operations performed under general anesthesia
- Category 6 - Administration of anesthesia (other than local)

4. Do you practice Telemedicine? Yes No If "Yes", please provide details: _____
5. Are you currently under contract to supervise or administer any departments within a hospital or other facility? Yes No
If "Yes", please describe: _____
6. Are you currently under contract to provide services on behalf of an HMO or PPO? Yes No
If "Yes", indicate below the name of the HMO and/or PPO and the type of services that you have contracted to provide:

E. INSURANCE AND CLAIMS HISTORY

1. List previous medical professional liability policies for the **past eight (8) years (list additional policies on a separate sheet)**:

Company	Policy Number	Retention	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
							Claims made	Occurrence
Company	Policy Number	Retention	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
							Claims made	Occurrence
Company	Policy Number	Retention	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
							Claims made	Occurrence
Company	Policy Number	Retention	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
							Claims made	Occurrence

2. Has any Insurer ever canceled, declined or reduced coverage (i.e., reduced limits, restricted coverage, surcharged rates, or refused renewal for this or any similar coverage)? Yes No

If "Yes", please provide details: _____

3. a. Have you ever submitted to a liability insurer or risk transfer instrument any claim or given notice of any fact, situation, transaction, event, act, error or omission for a malpractice claim, suit or incident, either directly or indirectly?
 Yes No
- b. Other than claims or potential claims that have been reported to a previous liability insurer or risk transfer instrument, are you aware of any fact, circumstance, situation, transaction, event, act, error or omission which you know or reasonably should know may result in a claim that may fall within the scope of the proposed insurance? For the purposes of this question, "reasonably should know" includes any act, error omission or occurrence that alleged sexual, physical or emotional abuse or misconduct; or was the subject of any peer review; professional or specialty association investigation or review; FDA MedWatch report; internal review or investigation; inquiry by any accreditation or licensing entity; local state or federal investigation; JCAHO "near miss" investigation; sentinel event report or root cause analysis; incident report investigation; written notification, inquiry or demand by legal counsel or matter submitted to legal counsel, mandatory

report on professional conduct; or similar investigation or review.

Yes No

If “Yes” to either 3a or 3b, **please describe each claim, suit, or incident** regardless of its outcome, on the Malpractice Claims Information forms(s) at the end of this Application, and attach a carrier claim report from the past ten (10) years including amounts paid and reserved. Any Malpractice Claims Information forms and carrier claim reports are part of this Application.

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, OR RELATED CLAIM, ARISING OUT OF ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION THAT IS OR SHOULD HAVE BEEN DISCLOSED IN RESPONSE TO QUESTION 3a OR 3b IS EXCLUDED FROM THE PROPOSED INSURANCE.

F. PROFESSIONAL HISTORY

1. Have you ever been investigated, disciplined, censured, or reprimanded by a medical society, professional review board, or state licensing entity or board or had a complaint against you submitted to any such entities? Yes No
If “Yes”, please explain: _____

2. Have you ever had your membership in any professional society or association refuse, suspended, revoked, or received any criticism or reprimand from any specialty society? Yes No
If “Yes”, please explain: _____

3. Have your hospital privileges ever been restricted, denied, suspended, revoked, or has any disciplinary action / observation been taken against you? Yes No
If “Yes”, please explain: _____

4. Has your medical or narcotics license ever been restricted, voluntarily surrendered, suspended or revoked? Yes No
If “Yes”, please explain: _____

5. Have you ever been charged with a felony or misdemeanor other than minor traffic offenses? Yes No
If “Yes”, please explain: _____

6. Do you have any personal health problems that might affect your ability to safely practice medicine? Yes No
If “Yes”, please explain: _____

7. Have you ever filed a long-term disability claim where the claimed disability impacted your ability to perform any aspect of your medical practice? Yes No
If “Yes”, please explain: _____

8. Are you currently or have you ever been treated for a psychiatric condition, alcoholism or substance abuse? Yes No
If “Yes”, please explain: _____

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THE RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. (PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IS NECESSARY.)

Notice to Applicant – Please read carefully.

For the purposes of this Application, the undersigned Applicant declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the “Application”) are true and complete. The Underwriter considers the Application, which is on file with the Underwriter, physically attached to any policy issued. The Underwriter will have relied upon this Application in issuing any policy.

The Applicant authorized the Underwriter to make any inquiry in connection with this Application. Further, the Applicant hereby authorized and directs any medical society, medical doctor, hospital, insurance company, underwriter, and/or insurance agent to furnish the Underwriter with any information concerning the Applicant or the Applicant’s medical practice. The Applicant understands that the Underwriter must have access to all possible information concerning the Applicant’s professional life and personal life to the extent that it affects the Applicant’s professional conduct in order to underwrite professional liability coverage.

The Applicant hereby releases any person or organization furnishing information to the Underwriter pursuant to this consent and direction, together with the agents, employees or officers of such person or organization from any liability, in any way, for furnishing such information, even if the information may be wrong.

If the information in this Application materially changes between the date of this Application and the policy effective date, the Applicant will notify the Underwriter which may modify or withdraw any quotation or agreement to bind insurance. Accepting this Application does not bind the Underwriter to complete, or the Applicant to purchase, the insurance.

The Applicant understands that:

- (i) such insurance applies only to “Claims” first made or deemed made during the “Policy Period” or any Extended Reporting Period; and
- (ii) the Underwriter will have no duty to defend any “Covered Proceeding”.

Notice to Arkansas, Minnesota and Ohio Applicants: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia, Maine, Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Notice to Florida Applicants: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim or an application containing any false or misleading information is guilty of a felony of the third degree.

Notice of Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Notice to Louisiana and New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to Maryland Applicants: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an applicant for an insurance policy is subject to criminal and civil penalties.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Oklahoma Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IN THE EVENT OF ANY MATERIAL UNTRUTH, MISREPRESENTATION OR OMISSION IN CONNECTION WITH ANY PARTICULARS OR STATEMENTS IN THIS APPLICATION, ANY ISSUED POLICY SHALL BE VOID WITH RESPECT TO ANY INSURED WHO KNEW OF SUCH UNTRUTH, MISREPRESENTATION OR OMISSION OR TO WHOM SUCH KNOWLEDGE IS IMPUTED.

I hereby declare that the above statements and particulars are true and that I have not omitted or misstated any material facts and I agree that this Application shall be the basis for any insurance policy that is issued.

APPLICANT		
<hr/>		
BY (Signature)	TITLE	DATE

REQUIRED INFORMATION

PRODUCED BY (Insurance Agent)		
_____		_____
(Please print name)		(Please sign name)
INSURANCE AGENCY		
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.		AGENT LICENSE NO.
ADDRESS (No., Street, City, State and Zip Code)		
EMAIL ADDRESS		
SUBMITTED BY (Insurance Agency)	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENCY LICENSE NO.
ADDRESS (No., Street, City, State and Zip Code)		

Applicant: _____

MALPRACTICE CLAIMS INFORMATION
(To be completed in response to question E.3. Use a separate form for each claim)

1. Name of patient or claimant: _____ Sex: _____ Age: _____

2. Allegation and date of incident: _____

3. Location: _____

4. Your relationship to the patient (attending physician, assistant surgeon, etc): _____

5. Insurance carrier and policy number: _____

_____ Open – Reserve Amount	\$ _____	
_____ Closed – Loss Amount	\$ _____	Date Closed: _____
_____ Settlement – Total Amount	\$ _____	Your Portion: \$ _____
_____ Judgment – Total Amount	\$ _____	Your Portion: \$ _____

6. Other defendants: _____

7. Condition and diagnosis at the time of the incident: _____

8. Description of medical treatment rendered: _____

9. Condition of patient subsequent to treatment: _____

10. To whom may we refer to obtain further information regarding this claim or lawsuit? _____
