LOUISIANA PHYSICIANS AND SURGEONS FTE/PVP RATED

Application for Full Time Equivalent "Slot" or Per Visit Rated for Claims-Made Professional Liability Insurance

In order to allow adequate time for our underwriting review process, we ask that you please submit your application at least 30 days in advance of your requested effective date. Incomplete submissions or lack of required information will delay the underwriting process. After your application has completed the underwriting process, you will be promptly notified.

Please read the following instructions in order to expedite the review of your application:

1. Answer all questions or mark "N/A" where appropriate
2. Complete the attached Claim Addendum if a claim or suit has been filed against you
3. Submit a loss summary report from your previous carrier(s) – 10 years if applicable
4. Provide a copy of your Curriculum Vitae
5. Sign and date your application

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (2) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

If you have questions, please call the Underwriting Department at 504.831.3756 or 800.452.2120.

Thank you for your interest in LAMMICO. We look forward to serving your medical professional liability insurance needs.

When completed, please remit this application to:

LAMMICO
One Galleria Blvd., Suite 700
Metairie, LA 70001
FAX: 504.841.5205 or 504.841.5300

Louisiana Physicians and Surgeons FTE/PVP Rated Application for Claims-Made Professional Liability Insurance

Under the "claims-made" policy, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force. Please type or print, answer all questions completely.

Personal Information

Application # (LAMMICO use only) ☐☐☐☐☐☐☐

Full Name (Last, First, Middle Initial)			Suffix ☐Jr. ☐Sr. ☐III ☐IV	Gender ☐Male ☐Female	NPI#
Name of the entity you are working for:				Name of Hospital/ER Facility	
Office Address (include city, state, zip)				Other Locations (if any)	
Home Address (include city, state, zip)				Parish Medical Society	
Medical Group Name (if any)	Social Security No.	Date of Birth	Website Address	Email Address	
Office Phone	Fax Number	Home Phone		Cell Phone	
Desired Effective Date					

(LAMMICO Use Only)

Retroactive Date ________________

Parish Code ________ Tax Code _______

Specialty/Class ________________

Discount Code ______ Discount ______ %

Limit/Option ______ Group Code ______

Start of Practice Date ________________

Underwriting and Rating Information

1. Are you a member of the Louisiana State Medical Society (LSMS)? ☐ Yes ☐ No

2.a. Do you have a current license to practice medicine in LA? ☐ Yes ☐ No LA License No.: _______________

2.b. State and Federal Narcotics License Number: _______________________

2.c. Do you have any restrictions? (if *yes*, explain) ☐ Yes ☐ No

3. List other states where licensed and license numbers: ____

____

4.

Undergraduate School, Location	Degree	Year Graduated
Medical School, Location	Degree	Year Graduated
Served Internship at (PG I)	Specialty	Year(s)
Served Residency at (PG II - ?)	Specialty	Year(s)
Fellowship or Postgraduate Training, Location	Specialty	Year(s)

5. Date you began practicing: ____________________________________
6.a. If a foreign medical school graduate, have you obtained an ECFMG Certificate or a Fifth Pathway Certificate? ☐ Yes ☐ No
6.b. Indicate which certification was obtained and year certified: ☐ ECFMG ☐ Fifth Pathway Year Certified: ____________
7.a. Are you certified by an approved specialty board? (If *yes*, which?) ______________________________________ ☐ Yes ☐ No
7.b. Has there been a change in status? (If *yes*, explain) ____ ☐ Yes ☐ No
8. How many continuing medical education credits did you achieve last year? ____
9. If you are coming to Louisiana from another state or country, why? ____
10. What is your medical specialty? ____

Indicate percentage of time devoted to the following medical and/or surgical activities: (total should equal 100%)

%		%		%		%	
____	Addictionology	____	General Practice - Surgery	____	Neuro-radiology	____	Pediatrics
____	Administrative Medicine	____	General Preventive Medicine	____	Neurosurgery	____	Pharmacology-Clinical
____	Aesthetic Medicine	____	General Surgery	____	Nuclear Medicine	____	Physiatry - Phys. Med
____	Allergy	____	Geriatrics	____	Nutrition	____	Psychiatry
____	Anesthesiology	____	Geriatrics/Institutional	____	Obstetrics	____	Psychoanalysis
____	Bariatric Medicine	____	Gynecology	____	Obstetrics/Gynecology	____	Plastic Surgery
____	Bariatric Surgery	____	Gynecology - Surgery	____	Occupational Medicine	____	Pulmonary Diseases
____	Cardiac Surgery	____	Hand Surgery	____	Oncology-Medical	____	Radiology-Diagnostic
____	Cardiovascular Diseases	____	Hematology	____	Oncology-Surgery	____	Radiology-Therapeutic
____	Cardiovascular Surgery	____	Hospitalist	____	Ophthalmology	____	Rheumatology
____	Colon & Rectal Surgery	____	Infectious Diseases	____	Ophthalmology-Surgery	____	Sleep Medicine
____	Dermatology	____	Intensive Care Medicine	____	Orthopedic – Office Only	____	Thoracic Surgery
____	Emergency Medicine	____	Internal Medicine	____	Orthopedic Surgery	____	Trauma Surgery
____	Endocrinology	____	Laborist	____	Otorhinolaryngology	____	Urgent Care Medicine
____	Family Practice	____	Neonatology	____	Otorhinolaryngology/Plastic	____	Urological Surgery
____	Family Practice-Incl. OB	____	Nephrology	____	Otorhinolaryngology/Surgery	____	Urology/Gynecology
____	Family Practice-Surgery	____	Nephrology Interventional	____	Pain Management	____	Vascular Surgery
____	Forensic Medicine	____	Neurology	____	Pathology	____	Wound Care
____	Gastroenterology						
____	General Practice						

Additional Specialties ____
List any non-standard procedures you perform within or outside of your specialty ________________________________

11. Medical or Surgical Procedures (Please indicate whether you perform any of the following):

☐ **Anesthesia** ☐ General ☐ Spinal ☐ Epidural

☐ **Assisting in major surgical procedures**

☐ **Minor Surgery & Procedures**—Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes but is not limited to the following list. Check all applicable:

- ☐ **No procedures—only consulting or diagnostic**
- ☐ Incisions of boils and superficial abscesses
- ☐ Suturing of skin and superficial fascia
- ☐ Acupuncture—other than acupuncture anesthesia
- ☐ Angiography
- ☐ Angioplasty
  - ☐ Coronary
  - ☐ Peripheral
- ☐ Bone fractures: closed treatment
- ☐ Cancer chemotherapy
- ☐ Catheterization
  - ☐ Cardiac
  - ☐ Transarterial
  - ☐ Occasional insertion of pulmonary wedge, recording catheters, or temporary pacemakers
  - ☐ Transvenous
  - ☐ Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency or for transport)
- ☐ Cervical conization—specify type: ______________________
- ☐ Circumcision
- ☐ Colonoscopy
- ☐ Cosmetic injections—specify type: ______________________
- ☐ Cosmetic/reconstructive skin flaps and skin grafts
  - ☐ with arterial blood supply other than cancer therapy
- ☐ Cryosurgery
- ☐ On benign dermatological lesions
  - ☐ Other: ____
- ☐ Dermabrasion
- ☐ Diagnostic sonography
- ☐ Discograms
- ☐ Electroshock therapy (psychiatric)
- ☐ Fiberoptic bronchoscopy
- ☐ Hair transplant
- ☐ Interventional endoscopy—specify type: _______________
- ☐ Laser therapy—specify type:
- ☐ Myelography
- ☐ Needle biopsy
  - ☐ Lung, liver, kidney, or prostate
  - ☐ Other—specify type: ___________________________
- ☐ Nerve blocks, therapeutic—specify type in "Remarks"
- ☐ Pain management—specify type in "Remarks"
- ☐ Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- ☐ Radiopaque contrast material injections into veins, blood vessels, lymphatic, sinus tracts, and fistulae
- ☐ Radiopaque contrast material injections into arteries
- ☐ Radiation therapy
- ☐ Vasectomy
- ☐ Other: ____

☐ **Major Surgery**—Includes operation procedures in or upon any body cavity including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct hazard to life. It also includes but is not limited to the following list. Check all applicable:

- ☐ Amputations
- ☐ Bariatric/Obesity surgery—specify type: ____
- ☐ Bone fractures ☐ Operative treatment ☐ Closed manipulation-general or regional anesthesia
- ☐ Fertility or reproductive surgery
- ☐ Gynecological procedures ☐ Dilation and currettements other than emergency
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy ☐ Diagnostic ☐ Sterilization ☐ Therapeutic
- ☐ Liposuction—specify type, and if performed under general or local anesthesia:
- ☐ Minimal invasive endoscopic surgery—specify type: ____
- ☐ Obstetrical procedures
  - ☐ Abortions
    - ☐ Elective
    - ☐ Therapeutic
  - ☐ Cesarean sections
  - ☐ Forceps delivery other than outlet forceps
  - ☐ Home delivery
  - ☐ Vaginal delivery
  - ☐ Other: ________________________________

- ☐ Penile implants
- ☐ Percutaneous disc surgery
- ☐ Plastic surgery
  - ☐ Cosmetic—specify type: ____________________________ ☐ Breast augmentation/reduction
  - ☐ Reconstructive—specify type: ____
  - ☐ Facial—specify type: ____
- ☐ Radial keratotomy
- ☐ Spine surgery
  - ☐ **Primary**
    - ☐ Cervical
    - ☐ Thoracic
    - ☐ Lumbar
    - ☐ Spinal instrumentation
  - ☐ **Reoperative**
    - ☐ Cervical
    - ☐ Thoracic
    - ☐ Lumbar
    - ☐ Spinal instrumentation
- ☐ Tonsillectomies and/or adenoidectomies
- ☐ Other—specify type: ____

12. Do you dispense drugs (other than free samples) in your office? ☐ Yes ☐ No

    If yes, please list your Louisiana State Dispensing number ___________________and outline your training.

NOTE: If you answer yes to any of the following questions, please give detailed information in the remarks section of this application. (Attach additional sheets if necessary.)

13. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? ☐ Yes ☐ No
14. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? ☐ Yes ☐ No
15. Has your license to practice medicine or narcotics license ever been revoked, voluntarily suspended, or subjected to probation/restrictions or are you aware of any circumstances that might lead to such? ☐ Yes ☐ No
16. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? ☐ Yes ☐ No
17. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No
18. Have you volunteered to or been asked to participate in a physician's health (impaired) program? ☐ Yes ☐ No
19. Have Preceptor(s) or assisting physicians ever been assigned to your practice by a state licensing committee? ☐ Yes ☐ No
20. Have you now or have you ever had a chronic illness or physical limitation that impairs or could tend to impair your ability to practice medicine? ☐ Yes ☐ No
21. Have you been charged with or convicted of a crime (other than a minor traffic violation)? ☐ Yes ☐ No
22. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? ☐ Yes ☐ No
23. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy? ☐ Yes ☐ No
24. Has any insurance carrier ever declined to offer professional liability insurance to you? ☐ Yes ☐ No
25. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No

    If *yes*, has this been reported to your present or prior insurer(s)?
26. Are you aware of any circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No

    If *yes*, has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No

NOTE: If you answered yes to question 25 or 26, please provide the following information to complete and expedite our underwriting review:

1. **For each claim, complete the attached CLAIM ADDENDUM**
2. **A copy of the petition filed against you, if available**
3. **If you think it will help in the evaluation of the claim, include a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim**

We may ask for additional information as needed. Please be as thorough as possible in order to expedite the review of your application.

IMPORTANT NOTICE: Individuals covered by FTE/PVP rating and coverage are not eligible to purchase an individual Reporting Endorsement ("tail"). The waived Reporting Endorsement ("tail") provisions are not available due to the special rating and coverage. The Reporting Endorsement ("tail") is only available for purchase at the request of the Named Insured when the Named Insured or LAMMICO terminates the FTE/PVP coverage or its special coverage provisions. I understand that under the FTE/PVP coverage for which I am applying, the Reporting Endorsement ("tail") is not available to me individually.

Please initial here __________

Question No.	Remarks (Attach additional sheets, if necessary)

Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I understand that the statements and answers will be relied upon by LAMMICO and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize release of my name, business address, policy and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

____ ______________________

Applicant Signature **Date**

LAMMICO is required by LA Revised Statute 40:1424, to include the following on this application:

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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

CLAIM/SUIT/COMPLAINT INFORMATION ADDENDUM

If additional space is required, please photocopy this form as needed. Please type or print in black ink.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

Name of applicant: ____

Patient's Initials: ___________ Age: ___________ Sex: ___________ Date of incident: _____________
(DD/MM/YYYY)

Insurance company defending your claim : ______________ Policy No. ___________

Location of Incident: ________________________________ City: _______________ State: ___________
(Hospital, Office, Etc.)

Procedures Performed: ____
____

Allegations and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.). If you already have a written narrative, please attach it to this form. Please attach a second sheet of paper if additional space is required.

____
____
____
____
____
____
____

Co-defendants: ____

Present Status

Medical review panel date: ___________ Panel Opinion: ☐ Favorable ☐ Unfavorable ☐ Issue of Fact

Suit Filed: ☐ Yes ☐ No If *yes*: Month ______________________ Year ___________

Court Trial: ☐ Yes ☐ No Verdict: ☐ Defense Verdict ☐ Plaintiff Verdict Amount: $___________

☐ Claim settled without indemnity payment on your behalf ☐ Claim is pending ☐ Claim dismissed or withdrawn

Amount in reserve by insurance company $___________
Total amount paid to claimant on your behalf $___________
Total amount paid to claimant for all defendants $___________

The Applicant understands that the information submitted herein becomes part of the Professional Liability Application for insurance and declares that no material facts have been suppressed or misstated.

____ ______________________
Applicant Signature in Full Date