

LAMMICO

LOUISIANA PHYSICIANS AND SURGEONS

Application for Professional Liability Insurance

Please refer to www.lammico.com for a downloadable version of this application.

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 current professional liability policy or declarations page
5. Provide a copy of your Curriculum Vitae
6. 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 (3) 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 APPLICATION FOR 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. Under an "Occurrence" policy, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is reported.

A. Personal Information

Full Name (Last, First, Middle)		Suffix <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number	Date of Birth (mm/dd/yyyy)	NPI Number	
Primary Practice Address (include city, state, zip)		Office Phone Number	
Practice Name (if any)		Fax Number	
Years at Current Practice Location	Other Practice Locations? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please list in "Remarks" section		
Practice Mailing Address (include city, state, zip)			
Home Address (include city, state, zip)		Home Phone Number	
Email Address	Website Address	Cell Phone Number	

B. Coverage Information

Requested Effective Date: ____ / ____ / ____
MM DD YYYY

Professional Liability Limits Desired (please complete attached limits addendum)

- List names of all professional liability insurance carriers that you have been insured with for the last 10 years, dates of coverage and reasons for change: _____
- What is your existing form of insurance? Claims-Made Occurrence Self-Insured None Carried
 - If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement ("tail" coverage)? Yes No
 - If *no*, are you applying for prior acts coverage from LAMMICO? Yes No

If *no*, I realize that not purchasing the "tail" from my current carrier can result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy I am purchasing from LAMMICO will not provide prior acts coverage. Initial here _____

LAMMICO may give consideration for prior acts. To see if you qualify, please submit a copy of your current policy showing the retroactive date and, if applicable, a current certificate of enrollment from your state patient's compensation fund. Any claims or any circumstances that might reasonably lead to a claim or suit must be reported to your present carrier prior to the requested effective date of this insurance.

- During the period for which you are requesting Prior Acts Coverage, was your practice different in any way from Yes No your current practice? (e.g., different states, procedures, coverages, etc.) If yes, please describe changes/dates in "Remarks".
- Retroactive date used by your existing carrier: _____
NOTE: To prevent possible gaps in your claims-made coverage, either a reporting endorsement ("tail") or prior acts coverage must be purchased.
- Are you applying for insurance to cover only part-time practice or moonlighting activities? Yes No
Type: part-time semi-retired moonlighting another limited activity?
If yes, please describe the activity: _____
Number of **hours per month** the activity involves: _____

When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds.

6. Do you anticipate changes in your practice or specialty in the next 12 months? Yes No
 If yes, please describe: _____
7. Has there been any change in your practice or specialty in the past 10 years? Yes No
 If yes, please describe: _____
- Please explain any gaps in your practice history in "Remarks".**
8. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes?

C. Specialty Information

1. What is your primary medical specialty? _____
2. Secondary Specialty (if applicable): _____

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

%	%	%	%
<input type="checkbox"/> Addictionology	<input type="checkbox"/> General Practice	<input type="checkbox"/> Neurohospitalist	<input type="checkbox"/> Pathology
<input type="checkbox"/> Administrative Medicine	<input type="checkbox"/> General Practice – Surgery	<input type="checkbox"/> Neuro-radiology	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Aesthetic Medicine	<input type="checkbox"/> General Preventive Medicine	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Pharmacology – Clinical
<input type="checkbox"/> Allergy	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Neurosurgery-no intracranial	<input type="checkbox"/> Physiatry – Phys. Med
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Plastic Surgery
<input type="checkbox"/> Bariatric Medicine	<input type="checkbox"/> Geriatrics/Institutional	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Obstetrics	<input type="checkbox"/> Psychoanalysis
<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Gynecology – Surgery	<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Pulmonary Diseases
<input type="checkbox"/> Cardiothoracic Surgery	<input type="checkbox"/> Hand Surgery	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Radiation – Oncologist
<input type="checkbox"/> Cardiovascular Diseases	<input type="checkbox"/> Head & Neck Surgery	<input type="checkbox"/> Oncology – Medical	<input type="checkbox"/> Radiology – Diagnostic
<input type="checkbox"/> Cardiovascular Surgery	<input type="checkbox"/> Hematology	<input type="checkbox"/> Oncology – Surgery	<input type="checkbox"/> Radiology – Therapeutic
<input type="checkbox"/> Colon & Rectal Surgery	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Ophthalmology – No Surgery	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Infectious Diseases	<input type="checkbox"/> Ophthalmology – Ocular Plastic	<input type="checkbox"/> Sleep Medicine
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Intensive Care Medicine	<input type="checkbox"/> Ophthalmology – Surgery	<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Orthopedic – No Surgery	<input type="checkbox"/> Trauma Surgery
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Laborist	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Urgent Care Medicine
<input type="checkbox"/> Family Practice-Incl. OB	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Otorhinolaryngology	<input type="checkbox"/> Urological Surgery
<input type="checkbox"/> Family Practice-Surgery	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Otorhinolaryngology/Plastic	<input type="checkbox"/> Urology/Gynecology
<input type="checkbox"/> Forensic Medicine	<input type="checkbox"/> Nephrology Interventional	<input type="checkbox"/> Otorhinolaryngology/Surgery	<input type="checkbox"/> Vascular Surgery
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Wound Care

List any procedures or practice activities you perform that are not routinely performed by other physicians practicing in your specialty or sub-specialty: _____

4. 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

Cryosurgery

On benign dermatological lesions

Other: _____

- 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/Aesthetic procedures – specify type in “Remarks”
- Cosmetic injections—specify type: _____
- Cosmetic/reconstructive skin flaps and skin grafts
 - with arterial blood supply other than cancer therapy
- Dermabrasion
- Diagnostic sonography
- Discograms
- Electroshock therapy (psychiatric)
- Fiberoptic bronchoscopy
- Hair transplant
- Interventional endoscopy—specify type: _____
- Laser therapy—specify type: _____
- Mohs Surgery
- Myelography
- Needle biopsy
 - Lung, liver, kidney or prostate
 - Breast
 - 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
- Vein procedures – in office only – specify type in “Remarks”
- Other: _____

Major Surgery & Procedures—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 – specify type: _____
- Bariatric/Obesity surgery—specify type: _____
- Bone fractures
 - Operative treatment
 - Closed manipulation-general or regional anesthesia
- Fertility or reproductive surgery
 - Gender reassignment
 - Adult
 - Minor
- 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
 - Cesarean sections
 - Forceps delivery other than outlet forceps
 - Abortions
 - Home Delivery
 - Vaginal Delivery
 - Elective
 - Other: _____
 - Therapeutic
- Ophthalmology Surgery – (e.g. laser, transplant, cataract, etc.) specify type(s): _____
- Penile implants
- Percutaneous disc surgery
- Plastic surgery
 - Cosmetic—specify type: _____
 - Breast augmentation/reduction
 - Reconstructive—specify type: _____
 - Facial—specify type: _____
- Spine surgery
 - Primary**
 - Cervical
 - Thoracic
 - Lumbar
 - Spinal instrumentation
 - Reoperative**
 - Cervical
 - Thoracic
 - Lumbar
 - Spinal instrumentation
- Tonsillectomies and/or adenoidectomies
- Transplant surgery – specify type: _____
- Other: _____

D. Underwriting and Rating Information

1. What percentage of your practice is devoted to treatment of chronic pain with controlled substances/medications only? _____%
2. Do you provide care for local/state/federal prison or other correctional institution inmates? Yes No
If yes, please list institution(s) in "Remarks".
If yes, what percentage of your practice does this involve? _____%
(a) Does the institution(s) cover you for this exposure? Yes No
3. Do you provide care for inpatient nursing home or long-term care facility patients? Yes No
If yes, what percentage of your practice does this involve? _____%
4. Do you provide care for any sports team or other athletic organization? Yes No
If yes, please specify team name(s) / location(s): _____
(a) Does the team(s) cover you for this exposure? Yes No
(b) Do you travel outside of your primary state as part of your duties for the team(s)? Yes No
If yes, please describe: _____
5. Do you practice as a radiologist? Yes No
If yes, do you interpret mammograms? Yes No
6. Do you practice as a pulmonologist? Yes No
If yes, do you also practice as an intensivist? Yes No
If yes, what percentage of your practice does this involve? _____%
(a) Do you accept primary responsibility for ICU patient care for patients other than your own patients? Yes No
If yes, what percentage of your practice does this involve? _____%
7. Do you participate in experimental procedures, devices, drugs, therapy or clinical trials / research in treatment or surgery? If yes, please describe in "Remarks". Yes No
If yes, do you follow FDA-approved protocols? If no, please describe in "Remarks". Yes No
(a) Are you indemnified / held harmless by the clinical trial sponsor? Yes No
If no, please explain: _____
(b) Have you agreed to indemnify / hold harmless the clinical trial sponsor? Yes No
If yes, please explain: _____
(c) Is your role in the clinical trial within the scope of your medical specialty? Yes No
If no, please explain: _____
8. Does your practice include cosmetic/aesthetic procedures? If yes, please describe in "Remarks." Yes No
9. Do you provide laser/pulsed light procedures for cosmetic purpose? If yes, please describe in "Remarks". Yes No
If yes, are these procedures performed under your direct on-site supervision? Yes No
If no, please explain: _____
10. Do you provide home visits or mobile healthcare services? Yes No
If yes, please explain: _____
11. Do you administer Ketamine for the treatment of mental disorders or chronic pain? Yes No
If yes, please explain: _____
12. Do you provide elective infusion therapy services (e.g. vitamin, drip spas, etc.) Yes No
If yes, please explain: _____
13. Are you in the employ of or under contract to any governmental entity? Yes No
If yes, provide a detailed explanation including a description of your responsibilities in "Remarks".
14. Are you under contract to provide professional services to any individual, firm, corporation or athletic organization other than your own? If yes, please explain the details of your responsibilities in "Remarks". Yes No
15. Do you serve as a **Medical Director**? If yes, list in "Remarks" the facility name and your responsibilities. Yes No
16. Do you serve as a **Medical Review Officer (MRO)**? If yes, please explain in "Remarks". Yes No
(Example: Evaluate/review lab results generated by an employer's drug-testing program.)
17. Do you perform **Independent Medical Exams (IME)**? If yes, please explain in "Remarks". Yes No
18. Do you perform any **coroner** duties? If yes, please describe in "Remarks". Yes No
If yes, are you requesting LAMMICO to cover you for your **coroner** duties? Yes No
19. Describe your practice mix, e.g., inpatient vs. outpatient, surgical to non-surgical, city or rural, welfare or private pay, etc.: _____
20. What call arrangements have you made in your practice and what are the qualifications of the person(s) taking your calls?
(a) Do you verify whether the person taking your calls purchases professional liability insurance? N/A Yes No
21. Do you market or advertise **outside** of your primary state? Yes No
If yes, list state(s) and explain: _____

22. Do you practice medicine **outside** of your primary state? Yes No
 If yes, list state(s) and explain: _____
23. Do you utilize social media to market/advertise your practice or promote products? Yes No
 If yes, please describe: _____
24. Do you perform telehealth or internet medicine **outside** of your primary state, including but not limited to the use of communications technology as the medium for rendering medical services, medical opinions, or medical advice? Yes No
 If yes, identify all states in which such patients reside: _____
 If yes, what percentage of your practice is involved in such activities? ____%
25. Does your practice involve services for patients residing in states **other** than your primary practice address? Yes No
 If yes, identify all states in which such patients reside: _____
26. Do you work in an emergency department on a scheduled basis? Yes No
 (a) Indicate number of hours per month devoted to hospital emergency department care: ____ hours per month
 (b) Is this emergency department care: On your own patients only? Yes No
 Required for staff privileges Yes No
 Other—please describe: _____
 (c) Are you requesting LAMMICO to cover you for emergency department work? Yes No
27. Do you perform major surgery in a non-hospital setting (e.g. ASC, office-based surgery center, etc.)? Yes No
 If yes, please describe: _____
28. Do you recommend medical marijuana for therapeutic purposes only? Yes No
 If yes, have you complied with all state regulatory and licensing board requirements to recommend medical marijuana for therapeutic purposes? Yes No
 If no, please explain in “Remarks”.

E. Licensing Information

1. Medical License Information - please list below:

State	License number	License Expiration Date	License Status

2. 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
 If yes, please describe: _____
3. State Narcotics / CDS License #: _____ Federal Narcotics / DEA License #: _____
 (a) Does your narcotics license include Schedule 1 drugs? If yes, please explain in “Remarks”. Yes No
4. Do you dispense drugs (other than free samples) in your office? Yes No
 If yes, please list your State Dispensing number: State ____ Number _____ and outline your training and record keeping under “Remarks” section.

F. Education / Training Information

Undergraduate School, Location	Degree	Year Graduated
Medical School, Location	Degree	Year Graduated
Served Internship at (PG I)	Specialty	Dates Attended (from – to) _____-_____
Served Residency at (PG II - ?)	Specialty	Dates Attended (from – to) _____-_____
Did you successfully complete any residency program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <i>no</i> , please explain in the “Remarks” section	
Fellowship or Postgraduate Training, Location	Specialty	Dates Attended (from – to) _____-_____



1. Date you began practicing: _____
2. Are you a member of a state medical society? Yes No Specify state(s): _____
3. Are you a member of a parish/county medical society? Yes No Parish/County(ies): _____
4. Are you a foreign medical school graduate? Yes No (If you did not obtain a certificate please explain in "Remarks")
 (a) Indicate which certification was obtained and year certified: ECFMG Fifth Pathway Year Certified: _____
5. Are you certified by an approved specialty board? (If yes, which?) _____ Yes No
 (a) Has there been a change in board status? (If yes, explain) _____ Yes No
6. How many continuing medical education credits did you achieve last year? _____
7. If you are coming from another state or country, please explain why: _____

G. Practice / Entity Information

1. Practice / Ownership information:
 - (a) Practice Structure: (please check all that apply) / Practicing as:
 Solo Practitioner Solo Corporation Independent Contractor Limited Liability Partnership Medical Partnership
 Employer of other physicians Using a DBA or trade name - _____
 Member of a group practice – Group Name: _____
 Employed by another individual or corporate entity - Employer Name: _____
 Hospital Employee – Facility Name: _____
 Hospitalist – Facility Name: _____
 Other – describe: _____
 - (b) Are you an owner or partner in a medical partnership, professional medical corporation, hospital or other healthcare facility / business entity related to your practice of medicine? Yes No
 If yes, please list each medical partnership, professional medical corporation, or other business entity.

Name	Description of Interest	% of Practice

- (c) Name each partner/shareholder and indicate if they are insured / **not** insured by LAMMICO.

Name	LAMMICO Insured	NOT LAMMICO Insured

- (d) Is a medical corporation, partnership, or other entity **to be added** as an additional insured on your policy? Yes No
 Question 1(d) does not apply to entities already covered for you by LAMMICO. If the answer is yes, please provide a copy of the Articles of Incorporation or Partnership Agreement for each entity that is to be covered.
- (e) **Do you want separate limits of liability for the entity?** Yes No

2. Do you (or does your partnership/association/corporation/joint venture) employ or contract with any of the following? Yes No

Indicate the number of personnel in each applicable category.

Professional Type:	Employed	**Contract	Professional Type:	Employed	**Contract
*Certified Nurse Midwife (CNM)			Aesthetician		
*Chiropractor			*Orthotist		
*Clinical Nurse Specialist (CNS)			*Perfusionist		
*Nurse Anesthetist (CRNA)			Physical Therapist		
*Nurse Practitioner			*Prosthetist		
*Optometrist			RN First Assistant		
*Pharmacist			Surgical Assistant		
*Physician Assistant			Specify type:		
*Podiatrist			Other:		
*Psychologist					
*Separate LAMMICO application is required for coverage / **For independent contractors, list names and provide certificates of ins.					

NOTE: If you answered "yes" to any part of question 2, please list all names in the "Remarks" section. If you want to apply for insurance for these medical professionals through LAMMICO, please indicate in the "Remarks" section.

- (a) Do you have a signed protocol agreement in place for any of the individuals referenced above? Yes No
 If no, please explain: _____
- (b) For APRNs you supervise, do you have a signed Collaborative Practice Agreement in compliance with all applicable state licensing board(s) rules/requirements? Yes No
 If no, please explain: _____
- (c) Are the providers listed above currently covered by LAMMICO? Yes No
 If covered elsewhere, please provide certificates of insurance.
- (d) Are the providers listed above qualified with a state patient's compensation fund, if applicable? N/A Yes No
- (e) Do you supervise any individuals other than your employees? Yes No
 If yes, please explain: _____

H. Additional Information

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.)

1. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? Yes No
2. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? Yes No
3. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? Yes No
4. Have you been treated for alcoholism, narcotic addiction or mental illness? Yes No
5. Have you volunteered to or been asked to participate in a physician's health (impaired) program? Yes No
6. Have Preceptor(s) or assisting physicians ever been assigned to your practice by a state licensing committee? Yes No
7. 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
8. Have you been charged with or convicted of a crime (other than a minor traffic violation)? Yes No
9. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? Yes No
10. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged? Yes No
11. Has any insurance carrier ever declined to offer professional liability insurance to you? Yes No
12. 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)? Yes No
13. 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 12, 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.

14. Why did you choose LAMMICO? _____



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, 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 (MM/DD/YYYY)**

Print Name _____

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE
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.



LOUISIANA LIMITS ADDENDUM

Professional Liability Limits: (please check the limits desired)

Claims-Made:

- \$ 100,000 each medical incident / \$ 300,000 aggregate
- \$ 500,000 each medical incident / \$ 500,000 aggregate
- \$1,000,000 each medical incident / \$3,000,000 aggregate
- \$2,000,000 each medical incident / \$2,000,000 aggregate
- Higher Limits: Please refer to Company

Occurrence:

- \$100,000 each medical incident / \$300,000 aggregate

CERTIFICATES OF INSURANCE

List hospitals or other healthcare facilities where you hold or are applying for staff privileges. Place an *X* in the box in front of each facility requiring a certificate of insurance. Also list other entities (i.e., credentialing organizations, managed care entities, etc.) requiring certificates of insurance.

Institution Code
(LAMMICO Use Only)

<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		



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: (mm/dd/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: \$ _____
Settlement Out of Court: Yes No If yes: Month _____ Year _____ 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