

# LAMMICO

## OKLAHOMA PHYSICIANS AND SURGEONS

Application for Professional Liability Insurance

Please refer to [www.lammico.com](http://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



## OKLAHOMA 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 no, 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					
<b>*Separate LAMMICO application is required for coverage / **For independent contractors, list names and provide certificates of ins.</b>					

**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.

**Professional Liability Limits: (please check the limits desired)**

**Claims-Made:**

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



## 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"/>		
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## 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