



LOUISIANA MISCELLANEOUS HEALTHCARE PROVIDER

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 MISCELLANEOUS HEALTHCARE PROVIDER 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.

Please complete this application ONLY for the practice for which you are applying.

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: ____ / ____ / ____ **Professional Liability Limits Desired (please complete limits addendum)**
MM DD YYYY

1. 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: _____
2. What is your existing form of insurance? Claims-Made Occurrence Self-Insured None Carried
 - a. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement ("tail" coverage)? Yes No
 - b. 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.

3. 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.
4. 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.
5. 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. Professional Designation: please place an "X" next to the appropriate specialty below

- | | |
|---|---|
| <input type="checkbox"/> Aesthetician (specify type): _____ | <input type="checkbox"/> Certified Reg. Nurse Anesthetist (CRNA) |
| <input type="checkbox"/> EEG/EKG Ultrasound Technician | <input type="checkbox"/> Physician Assistant (PA) |
| <input type="checkbox"/> Lab Technician (specify type): _____ | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Registered Nurse (RN) |
| <input type="checkbox"/> Nurse Practitioner (NP area of specialty): _____ | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Optician | <input type="checkbox"/> Surgical Technician |
| <input type="checkbox"/> Optometrist | <input type="checkbox"/> Surgical Assistant (specify type): _____ |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> X-ray Technician |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other: _____ |

2. Briefly explain the type of practice for which you are applying: _____
3. Name of employer for this work: _____
4. Is your employer insured with LAMMICO for this work? Yes No
5. If your employer is not insured with LAMMICO, please list name of insurer for this work: _____
6. Name of medical group for this work (if applicable): _____
7. Do you have a signed protocol agreement in place for this practice? N/A Yes No
If no, please explain: _____
8. For Nurse Practitioners/Midwives:
Do you have a signed Collaborative Practice Agreement with your supervising physician which is in compliance with all applicable state licensing board(s) rules/requirements? Yes No
If no, please explain: _____
9. Name of supervising physician (if required) for this work: _____ N/A
10. Does your supervising physician practice at the same location? N/A Yes No

D. Underwriting and Rating Information

1. Does your practice involve pain management? If yes, please describe in "Remarks". Yes No
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 participate in experimental procedures, devices, drugs, therapy or clinical trials / research in treatment or surgery? If yes, please describe in "Remarks." Yes No
6. Does your practice include cosmetic/aesthetic procedures? If yes, please describe in "Remarks." Yes No
7. Do you provide laser/pulsed light procedures for cosmetic purpose? If yes, please describe in "Remarks." Yes No
8. Do you provide home visits or mobile healthcare services? Yes No
If yes, please explain: _____

9. Do you administer Ketamine for the treatment of mental disorders or chronic pain? Yes No
If yes, please explain: _____
10. Do you provide elective infusion therapy services (e.g. vitamin, drip spas, etc.) Yes No
If yes, please explain: _____
11. 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."
12. 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
13. Do you market or advertise **outside** of your primary state? Yes No
If yes, list state(s) and explain: _____
14. Do you practice medicine **outside** of your primary state? Yes No
If yes, list state(s) and explain: _____
-
15. Do you utilize social media to market/advertise your practice or promote products? Yes No
If yes, please describe: _____
16. 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? ____%
17. 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: _____
18. 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? If no, please explain in "Remarks." Yes No

E. Licensing Information

1. Professional License Information - please list below:

State	License number	License Expiration Date	License Status

2. Has your professional license 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. Do you have prescriptive authority? Yes No Date of Prescriptive License: _____
4. 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
5. 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

Name of School, Location	Field of Study	Degree	Year Graduated

1. Date you began practicing: _____
2. How many continuing medical education credits did you achieve last year? _____
3. 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	<u>NOT</u> 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.



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)**

Please Print Your 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



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