MISSOURI 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

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MISSOURI 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 ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV	Gender ☐ M ☐ 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? ☐ Y ☐ 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 your current practice? (e.g., different states, procedures, coverages, etc.) If *yes*, please describe changes/dates in Remarks. ☐ Yes ☐ No
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**

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

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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.

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 an impaired provider 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)

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.

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MISSOURI 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 / $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)
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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