



PART I - PRODUCER INFORMATION

Producer Name, Address, Telephone, Producer License Number, State, Federal Tax ID, Most Recent ProMutual Group Policy Number

PART II - APPLICANT INFORMATION

Name of Applicant, E-Mail Address, Mailing Address, Business Address, Billing Address, if different, Residence Telephone, Office Telephone

PART III - COVERAGE INFORMATION

Type of Coverage, Moonlighting Only (occurrence), Location of primary practice, Insurer of primary practice

PART IV - LIMITS OF LIABILITY (Indicate Limits Desired)

Professional Liability, Each Claim \$, Annual Aggregate \$

PART V - CURRENT PRACTICE

Type of Practice: Individual, Partnership, Postgraduate year one (intern), Professional Association, Resident, Fellow, Professional Corporation

Residents and Fellows (complete this section)
Indicate specialty this year
Date Program ends

Partnership, Association or Corporation (complete this section)
Name of Partnership, Association or Corporation
Name of partner(s) or other members

Name of Employer, if applicable

Are you employed full time by the Federal Government or are you in military service?
Do you practice less than 21 hours per week in direct patient care services?
Do you hold a full time teaching appointment with regular clinical supervision responsibilities?
Do you use Locum Tenens Physicians?
If Yes, indicate number of days per year: days

PART VI - PRACTICE LOCATION(S)

License Number/State(s) in which you practice, % of Activities in each State, Do you own, operate or use surgi-center facilities?
Do you normally staff an emergency room?
If yes, are you board certified in emergency medicine?
Give number of hours in emergency medicine per month: hrs.

Name and location of all healthcare facilities where you have medical staff or courtesy privileges: JCAHO Approved? Yes No

PART VIII - PRACTICE ACTIVITIES

General Surgeons, please provide breakdown of surgical activities:

Please state your medical specialty: _____

Indicate below the percentage of time devoted to the following medical activities.

% (Surgery)

- ___ Abdominal
- ___ Cardiac
- ___ Colon/Rectal
- ___ General
- ___ Gynecology
- ___ Hand
- ___ Head/Neck
- ___ Laparoscopic Surgery ★
- ___ OB/GYN
- ___ Laser Surgery
- ___ Orthopedic (including spinal surgery)
- ___ Orthopedic (no spinal surgery)
- ___ Otorhinolaryngology
- ___ Plastic
- ___ Plastic Otorhinolaryngology
- ___ Thoracic
- ___ Traumatic
- ___ Urological
- ___ Vascular

- | | | |
|--|--|--|
| ___ Administrative | ___ Hematology/Oncology | ___ Otology/Neurotology |
| ___ Aerospace | ___ Hospitalist | ___ Otorhinolaryngology |
| ___ Allergy | ___ Hyponosis | ___ Pain Management |
| ___ Anesthesiology | ___ Infectious Disease | ___ Pathology |
| ___ Broncho-esophagology | ___ Intensive Care
(your patients only) | ___ Pediatrics |
| ___ Cardiovascular | ___ Intensive Care
(Including patients of others) | ___ Pharmacology-clinical |
| ___ Dermatology | ___ Internal Medicine | ___ Physiatry |
| ___ Diabetes | ___ Laryngology | ___ Physical Medicine & Rehabilitation |
| ___ Emergency Medicine | ___ Neoplastic Disease | ___ Podiatry |
| ___ Endocrinology | ___ Nephrology | ___ Psychiatry |
| ___ Family Practice
(exclude all OB) | ___ Neurology | ___ Psychoanalysis |
| ___ Family Practice
(includes prenatal care only) | ___ Nuclear Medicine | ___ Psychosomatic Medicine |
| ___ Forensic | ___ Nutrition | ___ Public Health |
| ___ Gastroenterology | ___ Obstetrics | ___ Pulmonary Diseases |
| ___ General Practice | ___ OB-GYN | ___ Radiology |
| ___ General Preventive | ___ Occupational Medicine | ___ Radiation Oncologist |
| ___ Geriatrics | ___ Ophthalmology | ___ Rheumatology |
| ___ Gynecology | ___ Orthopedics
(office practice only) | ___ Rhinology |
| | | ___ Urgent Care/Intensivist |
| | | ___ Urology (office practice only) |
| | ___ Other, Specify: _____ | |

★ Please list type of Laparoscopic procedures performed:

Select one of the following as applicable:

- No Surgery - Includes incision of boils and superficial abscess, or suturing of skin or superficial facia.
- Minor Surgery - Includes obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered *major surgery*. If assisting on own patients, indicate average time per month: _____
- Major Surgery - Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life. It also includes: Removal of tumors, open bone fractures, the removal of any gland or organ, plastic surgery, and any operation done using general anesthesia.
- Assisting in Major Surgery - On the patients of others. If assisting, indicate the percentage of total practice spent assisting: _____%. (Do not include if you occasionally assist on an emergency basis.)

Obstetricians, Family & General Practitioners

Give the number of the following you perform per year

- Deliveries: _____
- Babies delivered by normal vaginal delivery only: _____
- Babies delivered by C-Section: _____
- C-Section Assists: _____
- Are you assisting on your own patients or patients of others?

Otorhinolaryngologists - Do you:

- Perform plastic surgery? Yes No
- Perform cosmetic plastic surgery? Yes No

If Yes, do you do reconstructive or any other plastic surgery procedure in an area of the anatomy other than the ear, nose, throat area? Yes No

If Yes, please specify _____

PART VII - PRACTICE ACTIVITIES (continued)

All Specialities: Identify the medical techniques/procedures that you perform by indicating the number per month.

- | | |
|---|--|
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Laparoscopy (diagnostic) |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Lasers – used in therapy |
| <input type="checkbox"/> Catherization: cardiac OR | <input type="checkbox"/> Lymphangiography |
| <input type="checkbox"/> Insertion of permanent pacemakers | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Catherization: arterial, diagnostic, swan ganz, or umbilical OR | <input type="checkbox"/> Needle Biopsy – other than liver, breast, kidney, or bone marrow biopsy. Indicate type: _____ |
| <input type="checkbox"/> Insertion of temporary pacemakers | <input type="checkbox"/> Phlebography |
| <input type="checkbox"/> Circumcisions | <input type="checkbox"/> Pneumatic or mechanical esophageal dialation (not with bougie or olive) |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Cryosurgery – other than use on benign or pre-malignant dermatological lesions | <input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae |
| <input type="checkbox"/> ERCP(Endoscopic retrograde cholangiopancreatography) | <input type="checkbox"/> Suction Lipectomy |
| <input type="checkbox"/> Hair Transplants | <input type="checkbox"/> None of the Above |

PART VIII - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the Policy Services Department.

Separate Limit of Liability for Partnership, Corporation, or Professional Association Yes No
 Not available on solo corporations. Current practice must be partnership, corporation, or association.

Employees as Additional Insureds Yes No

Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. Employees you name below will have separate limits under your professional liability coverage for a premium charge. This coverage cannot be purchased for employed physicians. No application required; complete section below.

List the names and job categories of employed healthcare professionals for whom you desire to purchase separate limits and name as additional insureds:

_____	_____
_____	_____
_____	_____

Professional Contractual Liability Yes No

Protects you against hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance.* There is a charge based on a percentage of professional liability premium. No application required; complete section below.

Please list the Health Maintenance Organizations or Managed Care Organizations with which you have signed provider agreements.

_____	_____
_____	_____
_____	_____

NO FACT, CIRCUMSTANCE OR SITUATION INDICATING THE PROBABILITY OF A "CLAIM" OR ACTION AGAINST WHICH INDEMNIFICATION WOULD BE AFFORDED BY THE PROPOSED INSURANCE IS NOW KNOWN BY ANY PERSON OR ENTITY APPLYING FOR THIS INSURANCE OTHER THAN THAT WHICH IS DISCLOSED IN THIS APPLICATION. IT IS AGREED BY ALL CONCERNED, WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, THAT IF ANY PERSON OR ENTITY APPLYING FOR THIS INSURANCE HAS ANY KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY "CLAIM" SUBSEQUENTLY EMANATING THEREFROM SHALL BE EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE AS TO ALL INSURED PERSONS.

BY SIGNING THIS APPLICATION, THE APPLICANT CERTIFIES THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF THE APPLICANT'S KNOWLEDGE AND BELIEFS, AND ACKNOWLEDGES THAT PROVIDING TRUTHFUL AND ACCURATE INFORMATION IS A CONDITION PRECEDENT TO OBTAINING THE INSURANCE REQUESTED IN THIS APPLICATION. THE APPLICANT FURTHER ACKNOWLEDGES THAT ANY INSURANCE WHICH MAY BE ISSUED UPON RECEIPT OF THIS APPLICATION WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED, AND IF SUCH INFORMATION IS MISLEADING OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.

SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS APPLICATION WILL BE PART OF SUCH POLICY, IF ISSUED AND ATTACHED THERETO. THE UNDERWRITER IS HEREBY AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT MAY DEEM NECESSARY.

IT IS AGREED THAT IN THE EVENT THERE IS ANY MATERIAL CHANGE IN THE ANSWERS TO THE QUESTIONS CONTAINED HEREIN PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE UNDERWRITER AND, AT THE SOLE DISCRETION OF THE UNDERWRITER, ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN.

Date

Signature of Applicant