Physicians Insurance Program Reciprocal Exchange

Malpractice Insurance Program

OCCURRENCE AND CLAIMS-MADE COVERAGE AVAILABLE.

FOUNDED FOR THE PROTECTION OF PENNSYLVANIA PHYSICIANS.

PHYSICIAN OWNED COMPANY, OWNED BY POLICYHOLDERS.

PRIOR ACTS COVERAGE AVAILABLE.

REINSURANCE FROM A FINANCIALLY STABLE, GLOBAL REINSURER.

AGGRESSIVE CLAIMS DEFENSE.

CORPORATE COVERAGE AVAILABLE.

CREDITS SUCH AS NEWLY PRACTICING AND CLAIMS-FREE DISCOUNTS AVAILABLE.

LICENSED AND ADMITTED BY THE PENNSYLVANIA INSURANCE DEPARTMENT.

WILL NOT SETTLE A CLAIM WITHOUT THE PHYSICIAN'S CONSENT!!

APPLICATION COVER SHEET INFO TO BE COMPLETED BY APPLICANT

Name:_____

Address:_____
City state zip

Specialty:_____

Phone:_____Fax:_____E-Mail:_____

County:_____ Contact Person:_____

Present Insurer:_____ Renewal Date:_____

Current Type of Policy: ☐ Occurrence ☐ Claims-Made

COVERAGE REQUESTED (please check)

☐ Occurrence ☐ Claims-Made with Retroactive Date as Follows:_____/_____/_____

Corporate Coverage Requested: ☐ YES ☐ NO

EFFECTIVE DATE REQUESTED: _____/_____/_____

PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION
PROFESSIONAL LIABILITY

Physicians Insurance Consultants, Inc., 1540 Bethlehem Pike, Flourtown PA 19031
Phone: 215-233-4410 Fax: 215-233-4409

PRINT OR TYPE ALL INFORMATION

REQUESTED EFFECTIVE DATE_____12:01AM

_____ _____ _____
1. Name of Applicant 2. Telephone 3.Fax

_____
4. Office Street address County City State Zip code

_____
5. Other Office Address County City State Zip Code
**Please attach a list of offices if there are more than 2 locations.

6. Specialty: _____ Sub-specialty (if any):_____

_____ _____ _____
7. Date of Birth 8. Social Security Number 9. Dates of present policy

_____ _____
10. Previous Carrier If claims made, retro-active date

11. Do you want an Occurrence or Claims Made Policy? _____

12. Retro-active date requested, if choosing a Claims Made Policy: _____

13. Do you practice Full Time Part Time TOTAL Number of hours worked PER week _____

14. Type of Practice:_____ Individual_____ Member of Professional Corporation _____Partnership

_____Partnership Association Other _____

15. If employee, Name of employer: _____

16. Name of Corporation, Professional Association or Partnership:_____

17. Is the entity names in #15 to be added as a named insured?** YES NO **if yes, include Articles of Inc.

18. List all names of partners or members of the corporation or association:
_____

_____

_____

19. Professional employees (if insured, please provide professional liability policy number for each):

NAME JOB DESCRIPTION POLICY NUMBER
_____ _____ _____

_____ _____ _____

PROFESSIONAL LIABILITY

PRINT OR TYPE ALL INFORMATION

20.Have you participated in any continuing education programs in the last five years? YES NO

If yes, provide details_____

_____

21. _____
Hospital Name where you practice County City

UNDERWRITING INFORMATION:

1. List all colleges and professional schools attended:

NAME YEARS ATTENDED DATE OF GRADUATION DEGREE

_____

_____

2. Postgraduate education:

(a) Internship: YES NO Hospital _____

Address (City & County) _____Dates _____

(b) Residency/ Fellowship/ Preceptorship: YES NO Hospital _____

Address (City & County) _____Dates _____

3. Board Certification: YES NO If yes, name of board _____Year Certified_____

4. Current Licenses:

STATE LICENSE NUMBER DATE EXAM REQUIRED DTS TAKEN

_____

_____

_____

5. Have you ever had a license revoked or suspended, or have you been put on probation? YES NO

If yes, please explain: _____

6. Have you ever had a narcotic license revoked or suspended, or have you been on probation? YES NO

If yes, please explain_____

7. Have you ever had your privileges denied, suspended, restricted, revoked or not renewed? YES NO

If yes, please explain _____

_____

PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION
PROFESSIONAL LIABILITY

PRINT OR TYPE ALL INFORMATION

8. List ALL malpractice carriers for the past 10 years

DATES NAME COVERAGE (occurrence/ claims made)

_____to_____ _____ _____

_____to_____ _____ _____

_____to_____ _____ _____

_____to_____ _____ _____

9. List ALL facilities where you do surgery or consultations:

NAME ADDRESS YEARS AT FACILITY ADMINISTRATOR

_____

_____

_____

10. Please attach delineation of privileges at each facility. Do you ever perform surgery that is not your delineation? YES NO If yes, please explain: _____

_____

11. Have you ever used any intoxicant, or other psychoactive or depressant drug to the extent that it has interfered with your ability to perform professional duties? YES NO

12. Have you ever had any professional liability insurance declined, cancelled or renewal refused, for reasons other than the company's withdrawal from your professional liability market? YES NO

13. Have you ever had professional liability insurance issued on a restrictive basis (i.e. reduced limits, assigned a deductible, restrictive coverage, surcharge rates)? YES NO

14. Have you ever been the subject of disciplinary proceedings of been reprimanded by an administrative agency, hospital or professional association? YES NO

15. Have you ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? YES NO

16. Have you ever been treated for alcoholism or drug addiction? YES NO If yes, please explain:
_____

17.Have you ever been disabled or had an interruption of your practice because of a disability? Yes NO

18. Do you work for or in a prison? YES NO

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES PLEASE EXPLAIN:_____

_____

PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION
PROFESSIONAL LIABILITY

PRINT OR TYPE ALL INFORMATION

19.Do you administer any sedatives, analgesics or anesthesia (besides Xylocaine) in you office?

YES NO If yes please explain:_____

_____

20. Do you participate in any of the following?

Sports medicine? NO YES Minimal incision surgery? YES NO Emergency room work? YES NO

Laser Surgery:

(a) Do you use a laser in your treatment of patients? YES NO
If yes, with what type of treatment? Explain:_____

_____
(b) How many times a week do you use the laser?_____
(c) What type of training did you receive in the use of the laser? (check all that apply)
_____Seminar _____Course _____ Preceptorship _____ Hands-on_____ other

Please specify names of programs _____

21. Who obtains your informed consent? _____

22. How many patient contacts do you have PER week? _____

23. Have you attended a malpractice loss prevention program in the last 12 months? YES NO If yes, when, where and please describe: _____

24. Are you now or in the LAST 10 years been involved directly or indirectly in a claim, potential claim or suit arising out of the rendering of failing to render professional services? YES NO

If yes, how many? _____ Have these been reported to your insurer? YES NO

25. Do you have knowledge of any incident or unexpected adverse outcome resulting in injury or death, claim, potential claim or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may result in a claim? YES NO If yes, how many? _____ Have these been reported to your professional liability carrier? ** YES NO

**If yes, please provide a copy of the reports and any information relative to any incidents to that which you are aware of but have not yet filed.

I hereby declare and represent that the above statements and particulars are true and complete. I have not withheld or misstated any information requested by the insurance company. I understand and agree that the information contained in this application is material; that it is being relied upon by the Exchange in considering my application for professional liability insurance; and, that it is the basis of any policy of insurance which may be issued to me. I also understand that this application shall be annexed to, and deemed a part of any policy of liability insurance issued to me by the insurance Exchange.

Any person who, knowingly and with the intent to defraud any insurance Exchange or other person, files an application for insurance containing any false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

IT IS FURTHER UNDERSTOOD AND AGREED TO BY ME THAT THERE SHALL BE NO COVERAGE FOR CLAIMS MADE OR CLAIMS ARISING FROM INCIDENTS OCCURRING DURING THE POLICY PERIOD WHICH IS ISSUED UPON THIS APPLICATION, IF ANY OF THE FOLLOWING CONDITIONS APPLY:

(1) The claim arises out of the performance of any procedure or surgery not indicated by me in this application.
(2) The claim arises from the rendering of the professional services outside the scope of the specialty or the sub-specialty stated by me in this application.
(3) Knowledge of or notification of the claim or an incident has occurred prior to the date below of this application.
(4) The claim arises from professional services rendered outside the classification applied for in this application as defined in the classification and rate sheet.

_____ _____ _____

Date Print Name Signature

AUTHORIZATION FOR RELEASE OF INFORMAITON

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information privileged or not, in their dominion, custody, or control regarding insurance application by me, professional liability insurance issued to me, claims made or suits brought against me, applications by me for hospital privileges, decisions, and notes of any credentials or disciplinary committees involving me, any employment of personal records involving me, any records involving me as well as any information obtained by any attorneys who are now representing, of have in the past represented me. I hereby authorize you to make copies of this application as you deem necessary and those copies shall be as valid as originals.

_____ _____ _____

Date Name (Print or Type) Signature

REMINDER: EVERY QUESTION "MUST" BE ANSWERED!

STATE STATUTORY REQUIREMENT

Note: All applicants must read and initial the following:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Initial here:_____

PLEASE READ AND SIGN:

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree to notify the Company if there is any material change in any answer to this application, including, without limitation, any change in my professional specialty, affiliation, or working arrangement with any physician, or dentist, firm or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER AMY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RECIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to be applicable and pertinent to this application and if issued, the contract of insurance issued, the contact of insurance issued hereunder.

_____ _____ _____

Date Signed Print or Type Name Signature

PRACTICE AND PROCEDURES: GENERAL QUESTIONS

Please check the category that most closely describes your practice.

- ❒ **Major Surgery:** Performing any operative procedure done under general, spinal or caudal anesthesia or assisting in "Major Surgery" on other than your own patients.
- ❒ **Minor Surgery:** Performing any operative procedure other than as included in "Major Surgery" or assisting in "Major Surgery" on your own patients.
- ❒ **No Surgery*:** NOT performing any operative procedure including "Major Surgery" or "Minor Surgery".
  *Note: Incising of boils and superficial fascia, suturing of minor lacerations and removal of superficial skin lesions are not considered operative procedures for the purpose of this application.

Indicate percentage of time devoted to the following activities commonly associated with the following surgical specialties.

Percentage	Specialty	Percentage	Specialty	Percentage	Specialty
_____%	Abdominal	_____%	Hand	_____%	Plastic
_____%	Cardiac	_____%	Head & Neck	_____%	Thoracic
_____%	Cardiovascular	_____%	Laryngology	_____%	Traumatic
_____%	Colon & Rectal	_____%	Neoplastic	_____%	Urological
_____%	Gastroenterology	_____%	Otology	_____%	Vascular
_____%	Gynecology	_____%	Otorhinolaryngology	_____%	Other_____

Check any of the following applicable to your practice for which coverage is required.

- ❒ Abortions: Trimester:_____
  Where Performed:_____
- ❒ Administration of General, Spinal or Caudal Anesthesia
- ❒ Acupuncture (*please submit copy of certification)*
- ❒ Amniocentesis
- ❒ Angiograms
- ❒ Angioplasty ❒ Coronary ❒ Other_____
- ❒ Aspiration of Cyst of Breast
- ❒ Assisting in Major Surgery
  ListProcedures:_____
  _____
- ❒ Blepharoplasy
- ❒ Breast Biopsy
- ❒ Bronchoscopy
- ❒ Cardiac Catheterization
  - ❒ Left Heart
  - ❒ Swan Ganz
- ❒ Cataract Surgery
- ❒ Cervical Cautery
- ❒ Chelation Therapy (other than for treatment of heavy metal poisoning)
- ❒ Chemabrasion/Dermabrasion
- ❒ Chemical Peel: Type:_____
- ❒ Chemotherapy
- ❒ Choruinic Villi Sampling
- ❒ Circumcision of Newborn/ Adult
- ❒ Closed Reduction of Fractures
- ❒ Colonoscopy
- ❒ Cosmetic Surgery of Breast
- ❒ Cryosurgery: Compound_____
- ❒ Culdocentisis
- ❒ D & C
- ❒ Deep Radiation/ X-Ray Therapy
- ❒ Duodenoscopy
- ❒ Endometrial Biopsy
- ❒ Endoscopic Retrograde Cholangiopancreatography
- ❒ Ecophagoscopy
- ❒ Excisional Punch Biopsy
- ❒ Foreign body removal from Eye
- ❒ Gastric Bubble
- ❒ Gastroscopy
- ❒ Hair Transplants: Type_____
- ❒ Hemorrhoiectomy
- ❒ Hydrocelectomy
- ❒ Injection of Radiopaque Dye
- ❒ Interventional Radiology Procedures
  _____
- ❒ Insertion of IUD
- ❒ Intestinal Surgery for Obesity
- ❒ Liposuction
- ❒ Laser Surgery:_____
- ❒ Nasal Polypectomy
- ❒ Needle Biopsy: Type_____
- ❒ Peripheral Nerve Block Anesthesia
- ❒ Peritoneal Dialysis
- ❒ Permanent Pacemakers
- ❒ Polypectomy by Endoscopy
- ❒ Prenatal Care
- ❒ Proctoscopy
- ❒ Radial Keratotomy
- ❒ Sigmoidoscopy
- ❒ Stress Testing
- ❒ Telemadicine
- ❒ Temporary Pacemaker
- ❒ Vein Stripping
- ❒ Other:_____

PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION
PROFESSIONAL LIABILITY

PRINT OR TYPE ALL INFORMATION

CLAIMS HISTORY SHEET

FILL OUT A SEPARATE SHEET FOR EACH CLAIM FOR THE LAST "10" YEARS.
MAKE ADDITIONAL COPIES OF THIS FORM, IF NECESSARY

Claimant: _____

Defendant(s):_____

Date suit filed:_____

City, County, State & Name of Court in which Suit was filed:_____

_____

Name & Address of defense attorney:

_____

Settlement amount (if any): $_____ Verdict amount (if any): $_____

Date case was closed:_____

Current status of claim:_____

_____

Name of involved insurance company:_____

Policy number:_____

Brief description of claim:_____

_____

_____

_____

Brief description of defense:_____

_____

_____

_____ _____

Date Signature of Applicant

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

APPLICANT'S INSTRUCTIONS:

1. If you have a Curriculum Vitae (resume) please attach it to the application and check here_____.
2. Answer all questions; if a question is not applicable, state “NOT APPLICABLE”
3. If Space is insufficient to answer any questions fully, attach a separate sheet.
4. The Application must be signed and dated by the applicant.
5. It the answer to any question is none, state “NONE”.

(PLEASE TYPE OR PRINT IN INK)

1. GENERAL SURGERY:
   a. How many Laparoscopic Cholecystectomy procedures performed per month? _____
   b. How many Hernia procedures preformed per month? _____
   c. How many Mastectomy / Lumpectomy procedures do you perform per month? _____

2. ORTHOPEDIC SURGERY:
   a. How many spine procedures do you perform per month? _____
   b. How many knee procedures do you perform per month? _____
   c. How many hip replacements do you perform per month? _____
   d. How many Arthroscopic surgical procedures do you perform per month? _____

3. CARDIO-THORACIC/THORACIC:
   a. How many by-pass procedures do you perform per month? _____
   b. How many Pulmonary Re-section (lobe-wedg) do you perform per month? _____
   c. How many Thoracoscopy procedures do you perform per month? _____
   d. How many Mediastinoscopy procedures do you perform per month? _____

4. VASCULAR SURGERY:
   a. How many Carotid Endorectomy procedures do you perform per month? _____
   b. How many Peripheral Artery By-pass procedures do you perform per month? _____
   c. How many Endo Vascular procedures (Abdominal Aorta, Peripheral Artery) do you perform per month? _____
   d. How many Open Abdominal Aortic Aneurysms do you perform per month? _____

5. NEUROSURGERY:
   a. How many Craniotomy procedures do you perform per month? _____
   b. How many Disc Fusions do you perform per month? _____

DATE: _____ SIGNATURE: _____

PRINT SIGNATURE: _____

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR OBSTETRICIANS AND GYNECOLOCISTS

APPLICANT'S INSTRUCTIONS:

1. If you have a Curriculum Vitae (resume) please attach it to the application and check here_____ .
2. Answer all questions; if a question is not applicable, state "NOT APPLICABLE"
3. If Space is insufficient to answer any questions fully, attach a separate sheet.
4. The Application must be signed and dated by the applicant.
5. It the answer to any question is none, state "NONE".
6. Please do not complete the application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. Name of Applicant: _____

2. How many deliveries have you performed in the last two (2) years? _____

3. Do you have knowledge or information of any potential or actual claim or suit that may be brought against you or of any incidents? _____ If yes, attach a full and complete explanation.

4. Have you received a request from a patient or from his or her representative requesting a copy of your records or those of the hospitals? _____

5. Attach a copy of your Declaration Page [it gives you the dates of coverage and limits] from the most recent policy issued to you.

6. Do you perform sex change operations? _____ If yes, describe:
_____

- Do you perform therapeutic abortions in the first trimester? _____
- Do you perform therapeutic abortions after 12 weeks? _____
- Total number of abortions performed monthly on your patients. _____
- Total number of abortions performed monthly on other patients. _____
- List hospitals, clinics, or other facilities where you perform abortions.

_____

8. Do you perform surgery or surgical research? _____ If yes, describe: _____

_____

9. Do you employ, contract with, or cover midwives? _____

10. Do you perform Suction Lipectomy? _____ If yes, attach confirmation of your training.

11. Do you perform home or non~hospital deliveries? _____ If yes, explain: _____

_____

I declare that I Know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s). I understand that "Carrier" also means "Insurer".

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT IF COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID.

DATE: _____ SIGNATURE: _____

PRINT SIGNATURE: _____

PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION
PROFESSIONAL LIABILITY

SUBSCRIBER'S AGREEMENT

The undersigned subscriber to Physicians' Insurance Program Reciprocal Exchange (the Exchange), a Pennsylvania Reciprocal Insurance Exchange, agrees together with all other Subscriber's to the Exchange, and with Physicians' Insurance Program Management Company (the Company), a Pennsylvania corporation, as the Attorney-in –fact for the Exchange, as follows:

1. **The undersigned agrees to pay its policy premiums and to exchange with the other Subscriber's to exchange, policies at the offices of the Company in Lansdale, Pennsylvania.**

2. **The undersigned appoints the Company as Attorney-in-fact with the power to (a) exchange insurance policies with other Subscribers to the exchange, (b) take any action necessary for the exchange of such insurance policies, (c) issue, change, nonrenew or cancel insurance policies, (d) obtain reinsurance (e) collect premiums, (f) invest and reinvest funds, (g) receive notices and proofs of loss, (h) appear for compromise, prosecute, defend, adjust service of process on behalf of the exchange as insurer and (j) conduct business and affairs of the exchange as set forth herein, in the Declaration or Organization of the Exchange power of attorney is limited to the purposes described in this Subscriber's agreement.**

3. **The undersigned agrees that as compensation to the Company for the Company (a) becoming and serving as Attorney-in –fact for the Subscribers to the Exchange, (b) managing the business and affairs of the Exchange as provided herein and (c) paying the general administrative expenses of serving as Attorney-in-fact for the Exchange, including sales commissions, salaries and employee benefits, rent, supplies and data processing, the Company shall retain up to 20% of the Exchange's gross direct written premium, less return premium. The remainder of all premiums written or assumed by the Exchange shall be used for losses, loss adjustment expenses, investment expenses, damage legal expenses, court costs, taxes, assessments, license fees, any other government fees and for other purposes the Company decides are to the advantage or the Subscriber's to exchange.**

4. **The undersigned agrees to contribute to the Exchange as capital an amount equal or up to 20% of the gross direct written premium, less return premium, charges to the undersigned for the first year, and up to 30% for each year thereafter.**

5. **The undersigned agrees that this Subscriber's Agreement, including the power of attorney set forth herein, shall apply to all insurance policies for which undersigned's coverages.**

6. **The undersigned agrees to sign and deliver to the company all papers required to carry out the Subscriber's Agreement.**

7. **The Subscriber's Agreement including the power of attorney set forth herein, shall not be affected by the undersigned subsequent disability or incapacity.**

8. **This Subscriber's Agreement and the Declaration of Organization of the Exchange are and shall be binding upon the Company and the undersigned and all of their respective executors, administrators, personal representatives, successors and assigns.**

IN WITNESS WHEREOF, the undersigned subscriber hereto sets his hand and seal:

_____ _____

Date **Signature**

_____

Print Name