POSITIVE PHYSICIANS INSURANCE EXCHANGE
850 Cassatt Road, 100 Berwyn Park, Suite 220
Berwyn, PA 19312
Phone: 888-335-5335 Fax: 610-644-5265

600 Germantown Pike
Lafayette Hill, PA 19444
215-233-4410 / 800-466-6906
Fax: 215-233-4409
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PHYSICIAN PROFESSIONAL LIABILITY APPLICATION

Please print responses in ink, and answer all questions in full. If a question does not apply to your practice, state "none" or "N/A" (Not Applicable). Please indicate any additional responses on the Remarks Section, Page 6.
The complete application, together with any supplementary information, must be signed in ink and dated by the applicant in all spaces indicated. Failure to provide complete information will delay the processing of the application.

I GENERAL INFORMATION

First Name Middle Name Last Name Title

Date of Birth _____/_____/_____ Social Security Number: _____/_____/_____

Requested effective date of coverage: _____/_____/_____ Retroactive Date: ____/_____/_____

Type of Coverage requested: _____ Occurrence
_____ Claims Made Coverage without Prior Acts Coverage
_____ Claims Made Coverage with Prior Acts Coverage *****
*PPIX Claims Made Prior Acts Supplemental Application is necessary.

Medical Licenses: Specify states where you are or have been licensed.

State	Expiration	License #	Permanent	Temporary	Status
State	Expiration	License #	Permanent	Temporary	Status
State	Expiration	License #	Permanent	Temporary	Status

Primary Office Address and Information:

Please list all office locations where you currently practice. Use the Remarks Section to list additional locations at which you render professional services.

a) Street _____ Building/Suite _____

City _____ State _____ Zip Code _____

County _____ Number of years at this location_____ % of practice _____

Primary Practice Office Phone ( ) Fax ( )

Practice Web Site Address:

E-mail Address:

Secondary Practice Addresses:

b) Street _____ Building/Suite _____

City _____ State _____ Zip Code _____

County _____ Number of years at this location_____ % of practice _____

c) Street _____ Building/Suite _____

City _____ State _____ Zip Code _____

County _____ Number of years at this location_____ % of practice _____

Billing Address Other than Primary Practice

If you require that your premium billing be sent to an address other than your primary practice address, please indicate.

Street _____ Suite/Bldg._____

City _____ State _____ Zip Code_____

List where have you practiced your profession for the past 10 years other than your current practice locations. Please explain any gaps in your practice. Use the Remarks Section to list additional locations. **Do not list training locations.**

Entity Name _____

Address _____

City _____ State _____ From _____/_____ to _____/_____
Mo. Yr. Mo. Yr.

Entity Name _____

Address _____

City _____ State _____ From _____/_____ to _____/_____
Mo. Yr. Mo. Yr.

II MEDICAL TRAINING AND HISTORY *If CV is attached, please skip questions #1 and 2.*

1. Education: Medical School

Name _____

City/State/Country _____

Degree _____ Dates _____

2. Additional Education If you have completed more than one residency, one fellowship, or other training program, provide explanation in the Remarks section.

A) Internship

Hospital _____ City/State _____

Date _____/_____/_____ to _____/_____/_____

B) Residency

Hospital _____ City/State _____

Date _____/_____/_____ to _____/_____/_____

Type _____

C) Fellowship

Hospital _____ City/State _____

Date _____/_____/_____ to _____/_____/_____

Type _____

D) Other Training

Hospital _____ City/State _____

Date _____/_____/_____ to _____/_____/_____

Type _____

3. If you are a graduate of a non-U.S. Medical school, are you certified by the Educational Council For? Foreign Medical School Graduates? Yes _____ No _____

4. Number of hours of CME credits in past year (by category):_____

5. Are you a member of any national (not specialty) medical societies? Yes ☐ No ☐

If yes, list: _____

III PRACTICE INFORMATION

6. Are you Board Certified? Yes ☐ No ☐ If yes, date _____/_____/_____

7. Name of Board _____

8. If not board certified, what is the expiration date of eligibility? _____/_____/_____

9. If expired, why? _____

10. Primary Specialty: _____ % of Practice _____

11. Secondary Specialty: _____ % of Practice _____

Nature of practice to be insured if different from specialty: _____

12. List the 5 most frequent surgical procedures performed: _____

_____

13. List the 5 most frequent non-surgical procedures performed: _____

_____

14. Have your specialties/procedures or practice, etc. changed in the past five years?

Yes ☐ No ☐

If yes, please explain how your practice has changed and give the dates of changes.

_____
_____
_____

15. Are you entering practice for the first time since completing an internship, residency program, fellowship or military service?

Yes ☐ No ☐

16. Indicate your number of practice hours per week (include office hours, administrative activities, direct patient care, surgery, consultation, etc.). *Please indicate only the practice hours to be insured by PPIX.*

_____	_____	_____	_____
Average # of office hours per week	Average Patients per week	Average # of Hospital hours per week	Average # of Hospital admissions per year

17. Indicate number of weeks per year you practice (include office hours, administrative activities, direct patient care, surgery consultation, etc.) _____

18. If less than 26 weeks, are the weeks all consecutive? Yes ☐ No ☐

19. Maximum number of consecutive weeks out of practice: _____

20. Do you have any teaching or medical director responsibilities? Yes ☐ No ☐

If yes, complete the following questions. Use Remarks Section if needed.

A. Name of facility and locations:_____

_____

B. What is your title? _____

C. Describe your responsibilities: _____

_____

D. Does the entity provide coverage for your administrative responsibilities? _____Yes _____ No
Your direct patient care? _____Yes _____No

E. If teaching, what percentage of your weekly time is devoted to clinical teaching _____%

List all facilities, including non-hospitals and ambulatory surgery centers, where you hold staff or courtesy privileges. List principle location first. Use the Remarks Section to list additional facilities and explain any restrictions.

Facility _____ City _____ State _____

_____% of practice Type: ____Full / Active ____Courtesy ____Consulting ____Restricted ____Other

Facility _____City _____ State _____

_____% of practice Type: ____Full / Active ____Courtesy ____Consulting ____Restricted ____Other

Facility _____ City _____ State _____

_____% of practice Type: ____Full / Active ____Courtesy ____Consulting ____Restricted ____Other

Facility _____ City _____ State _____

_____% of practice Type: ____Full / Active ____Courtesy ____Consulting ____Restricted ____Other

Do you practice in any office surgical facility in which IV analgesia or general anesthetics are administered?

Yes ☐ No ☐ If yes, list facilities:_____

If yes, is the office certified by JACHO or AAAHC?

Yes ☐ No ☐

If yes, please submit a copy of current certification.

If you answer yes to any of the following questions, please **give full details in the Remarks Section**. Include dates and copies of related documents.

22. Are you now being, or have you have been, treated for alcoholism, narcotics addiction or mental illness? Yes _____ No _____
(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution).

23. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? Yes _____ No _____
(If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution).

24. Have you ever had professional liability insurance declined, non-renewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you? Yes _____ No _____

25. Have you ever been investigated by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended, or limited in any way? Yes _____ No _____

26. Has any hospital ever restricted or revoked your privileges or involved probation (for any cause other than incomplete charts), not renewed/denied, or notified you of its intent to pursue any of these actions? Yes _____ No _____

27. Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a Hospital or notified of its intent to pursue such action? Yes _____ No _____

28. At the request of the hospital staff, have you ever voluntarily agreed to a modification or termination of your privileges? Yes _____ No _____

29. Have you ever been indicted and/or convicted of a crime or felony other than minor traffic violations? Yes _____ No _____

30. Have you ever been suspended, restricted, or put on probation by any governmental health program? Yes _____ No _____

31. Do you provide treatment to professional athletes? Yes _____ No _____

32. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes _____ No _____

33. Do you treat or review treatment of prison inmates? Yes _____ No _____

34. Has any claim or suit for alleged sexual misconduct ever been brought against you? Yes _____ No _____

35. Have you ever performed weight control surgery or prescribed weight control medication? Yes _____ No _____

36. Do you diagnose and treat patients via Telemedicine? Yes _____ No _____

37. Have you been involved in a malpractice claim/suit/ incident in the **past 10 years**? Yes _____ No _____
If yes, how many _____

*(If you answer yes, provide complete details of all open and closed claims/suits/incidents**, including those closed with no payments/dismissed and /or discontinued**, using the attached Claim Information Form. Copy and complete **a separate form for each**.)*

REMARKS SECTION

If additional space is needed, please use your letterhead. .

QUESTION NUMBER	**ADDITIONAL REMARKS**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV PROCEDURES **Please indicate with an X which you perform:**

NO SURGERY: includes incision of boils, superficial abscesses or suturing of skin and superficial fascia, similar minor procedures of a normal family type practice. Administration of anesthesia by topical or local infiltration. No obstetrical procedures or assisting in surgery.

MINOR SURGERY: includes the above and general practioners and specialists performing normal vaginal deliveries and assisting in major surgery on their own patients only. Invasive procedures that do not open or enter a major body cavity.

MAJOR SURGERY: includes the above, minor surgery not included above, assisting in major surgery on other than their own patients, major surgery. Any operation done using general anesthesia including operations in or upon any body cavity.

_____ Spinal Surgery
Cervical
Lumbar
Thoracic
_____ Laminectomies
_____ Anterior Vertebral Spinal Fusion
_____ Cervical Fusion
_____ Reconstructive Spinal
Deformities & Scoliosis
_____ Right Heart Catheterization

_____ Left Heart Catheterization
_____ Implantable Defibrillators
_____ Angioplasty
_____ Arteriography
_____ Heart Transplant
_____ Permanent Pacemaker Insertion
_____ Valve Implant
_____ Hair Transplant
_____ Scalp Reduction

_____ Botulinum Toxin Injection
_____ Dermabrasion
_____ Chemical Peels
_____ Face Phenol Peels
_____ Silicone Injections
_____ Skin flap/grafts
_____ Removal of Tumor
_____ Plastic/Cosmetic Surgery
other _____

_____ Chemotherapy
_____ Radiation Therapy
_____ Radiopaque Dye (non ionic only)
_____ Lymphangiography
_____ Myelography
_____ Phlebography
_____ Mammograms
_____ Acupuncture

_____ No surgery (defined above)
_____ Minor Surgery (defined above)
_____ Major Surgery (defined above)
_____ Adenoidectomies
_____ Tonsillectomies

_____ Cataract Surgery
_____ LASIK

_____ Refractive Keratotomy
_____ Operative Hysterectomy
_____ Major Gynecological Surgery
_____ Amniocentesis
_____ Prenatal Practice
_____ Deliveries (vaginal or C-section)
_____ Tubal Ligation
_____ Vasectomies
_____ Mastectomies
_____ D&C
_____ Abortions

_____ Bariatric Surgery
_____ Colonoscopy over 60 cm
_____ ERCP
_____ Bronchoscopy
_____ Laparoscopy
_____ General/Spinal/Caudal Anesthesia
Monitoring Devices:

End Tidal CO2 Analyzer ____
BP Monitor by Intra-Adterial ____
Electric Monitor or BP Cuff ____

_____ Laser Surgery,
specify:_____
_____ Laser Therapy,
specify:_____
_____ Transplants,
specify:_____
_____ Locum Tenens, describe practice: _____
_____
_____

V INSURANCE CARRIERS

To assure that there are no gaps in coverage, please list all previous medical professional liability Insurance carried during the **past 10 years**, beginning with your current carrier. Use the Remarks Section, page 6, to list additional carriers.

Current Carrier _____

Policy Period _____/_____/_____ to _____/_____/_____ Limits of Liability _____

Type of Policy _____(occurrence or claims-made)

Retroactive Effective date, if applicable: _____/_____/_____

Attach a copy of the Declarations Page from your most recent policy.

First Prior Carrier _____

Policy Period _____/_____/_____ to _____/_____/_____ Limits of Liability _____

Type of Policy _____ (occurrence or claims-made)

Second Prior Carrier _____

Policy Period _____/_____/_____ to _____/_____/_____ Limits of Liability _____

Type of Policy _____ (occurrence or claims-made)

Third Prior Carrier _____

Policy Period _____/_____/_____ to _____/_____/_____ Limits of Liability _____

Type of Policy _____ (occurrence or claims-made)

Prior Carrier _____

Policy Period _____/_____/_____ to _____/_____/_____ Limits of Liability _____

Type of Policy _____ (occurrence or claims-made)

IF CURRENT COVERAGE IS CLAIMS MADE

If your current policy is claims-made and you cancel this policy without purchasing an extended reporting endorsement (tail coverage) from the current carrier, there will be no coverage for any claim from any act or omission that took place during that period of claims-made coverage.

However, you may apply for coverage with a retroactive date back to the first day of your claims-made policy. A completed PPIX Claims Made Prior Acts Coverage Supplemental Application is necessary.

Retroactive coverage does not cover current claims that have been filed against you and/or reported to the previous insurer prior to the effective date of the policy with PPIX. Any claims and all conduct, circumstances, or incidents that could reasonable be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

VI AUTHORIZATION

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgement of the company in considering this application for professional liability insurance. I hereby acknowledge that I have completed the required reporting of

claims and incidents to my current carrier. Erroneous information and/or material misrepresentation will cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that the policy being applied for does not cover the liability of others that I may have assumed under any contract or agreement.
(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, inter-indemnity arrangement, underwriter, and insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for the furnishing such information.

AGREEMENT: I agree that in order to maintain insurance coverage I will comply with the Company's established risk management programs and requirements.

Upon acceptance by PPIX this Application will be made a part of any policy issued.

Commonwealth of Pennsylvania Fraudulent Insurance Acts: 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 in a crime and subjects such person to criminal and civil penalties.

Applicant (print): _____

Applicant Signature | Date

A competed application must include the following attachments:

_____ **Current and Prior carrier(s) loss history for 10 years, including open & closed claims**

_____ **Current CV**

_____ **Current policy Declarations page**

_____ **Copy of your letterhead and any advertisements**.

PPIX Supplemental applications are necessary if coverage for Corporations, Partnerships or Associations is desired.

Edition: 7/1/04

CLAIM INFORMATION FORM

Photocopy and complete this form for each open and/or closed claim for the past 10 years. If more space is needed on each report, continue information on your letterhead. Please write legible.

1) Name of Patient _____ 2) Age _____ 3) Sex_____

4) Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon, etc.)

_____

5) Other Defendants _____

6) Allegation _____

7) Date of Incident _____/_____/_____ 8) Report Date _____/_____/_____

9) Location _____

10) Insurance Carrier _____

11) Was a Suit ever filed? _____ When?_____/_____/_____

12) Present Status ☐ Open Claim Loss of $ _____ ☐ Settlement

☐ Closed Claim Date Closed _____ ☐ Judgment

13) Condition and diagnosis at time of incident:

_____
_____
_____

14) Dates and description of professional services rendered:

_____
_____
_____
_____

15) Condition of patient subsequent to professional services (and dates of follow-up visits) if known:

_____
_____
_____
_____

I hereby declare the above information is complete and true to the best of my knowledge and belief. I understand the information submitted herein becomes part of my application as submitted.

Signature _____ Date _____

PLEASE READ THE FOLLOWING BEFORE COMPLETING THE PRIOR ACTS APPLICATION!!!

Any item reported on the previous page must be reported to your current carrier prior to expiration of your present policy. Additionally, if you have received any requests for records from attorneys or from dissatisfied patients, or if you have received either verbal or written patient complaints about care rendered, these occurrences ***MUST*** be reported to your current carrier and recorded on the preceeding page. If these matters are not reported to your current carrier, the chance of an uninsured claim is greatly increased!

_____ _____

Signature of Physician Date

POSITIVE PHYSICIANS INSURANCE EXCHANGE

SUPPLEMENTAL APPLICATION – CLAIMS MADE PRIOR ACTS COVERAGE

Name of Applicant _____

Requested Retroactive Effective Date:_____/_____/_____

ATTACH A COPY OF THE CURRENT DECLARATION PAGE SHOWING THE RETROACTIVE DATE

I hereby represent that I am requesting Claims Made coverage. Except as indicated below, I have no knowledge of any professional liability claims, circumstances, occurrence, incidents or conduct which has been or likely to be asserted against me or any corporation association or partnership for which I am making application, which occurred on or after the requested Retroactive Effective Date.

Report below any such incidents involving serious injury including, but not limited to: brain injury, unexpected death, blindness (in one or both eyes), significant burns (including overexposure to radiation), significantly diminished life expectancy, injury to the spinal cord, significant sensory and motor loss, or loss of a significant portion of an arm or leg. Please give a brief description of each such claim, occurrence, incident or circumstance.

Incident #1
Name of Patient/Claimant:_____Age:_____ Sex:_____
Date(s) of Incident resulting in injury/demand:_____
Location of Incident:_____
Summary of Incident:_____
_____
Current Status:
_____Claim/Suite Made. Date ___/___/___ Open _____ Closed _____ No Claim/Suit Made ____
Amount of Reserve _____ Amount of settlement of Judgement _____
Amount paid on applicant's behalf:_____ If no payment, was claim/suit withdrawn?_____

Name of Insurer:_____
Additional Defendants or Medical Professionals Involved:_____
_____

Incident #2
Name of Patient/Claimant:_____Age:_____ Sex:_____
Date(s) of Incident resulting in injury/demand:_____
Location of Incident:_____
Summary of Incident:_____
_____
Current Status:
_____Claim/Suite Made. Date ___/___/___ Open _____ Closed _____ No Claim/Suit Made _____
Amount of Reserve _____ Amount of settlement of Judgement _____
Amount paid on applicant's behalf:_____ If no payment, was claim/suit withdrawn?_____

Name of Insurer:_____
Additional Defendants or Medical Professionals Involved:_____

Please note that no coverage will be provided under the applied-for policy, for any such claim, occurrence, incident or circumstance permitted to be reported to your current insurance provider*. (*Insurance Provider includes any self-insurance, or any other financial mechanism, whether public or private, established for the purpose of paying awards, judgments or settlements for loss or damages against insured entitled to participate in such mechanism).

The above is true to the best of my knowledge, information and belief. I understand that misrepresentations, omissions, concealment of facts, or incorrect statements in this application which are fraudulent, or material either to acceptance of the risk or to any hazard assumed by PPIX. may result in denial of coverage under the applied for insurance for any claims(s) arising there from. This application will become part of the policy.

Date_____ Applicant Signature _____

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