



ProNational
INSURANCE COMPANY
www.ProNational.com

Customer Service Center
2600 Professionals Drive, Box 150
Okemos, Michigan 48805-0150
800/292-1036 517/349-6500 Fax 517/347-6319

GENERAL

For Company Use Only
Agent # _____
Agent _____

PHYSICIAN PROFESSIONAL LIABILITY APPLICATION

SECTION 1

1. Name of Applicant: _____
(LAST) (FIRST) (M.I.)

Mailing Address: _____
(STREET) (CITY/STATE) (ZIP)

Office Address: _____
(STREET)

(CITY) (COUNTY)

(STATE) (ZIP)

Office Telephone #: (_____) _____ Office Facsimile #: (_____) _____

Residence Address: _____

Residence Telephone #: (_____) _____ Social Security #: _____

Date of Birth: _____ Sex: Male Female

Medical License No.: _____ State: _____ Expiration: _____

Name of Partnership or Professional Corporation: _____

Business Manager or contact person in your office: _____ Telephone # (_____) _____

Is there an address, other than the mailing address above to which you would prefer all correspondence to be sent?

If yes, indicate: _____
(STREET) (CITY/STATE) (ZIP)

2. Describe your medical school education:

Medical School: _____
(SCHOOL) (CITY/STATE) (COUNTRY)

Degree: _____ Year Completed: _____

3. If you have graduated from a medical school located outside of the United States or Canada, are you ECFMG certified?

Yes No

4. Internship:

(Hospital) _____ (City & State) _____
(Year Completed) _____

5. Residencies:

(Hospital) _____ (City & State) _____
(Specialty) _____ (Year Completed) _____
(Hospital) _____ (City & State) _____
(Specialty) _____ (Year Completed) _____

6. Fellowships:

(Hospital) _____ (City & State) _____
(Specialty) _____ (Year Completed) _____
(Hospital) _____ (City & State) _____
(Specialty) _____ (Year Completed) _____

7. Board Certifications:

(Board) _____ (Date Certified) _____
(Board) _____ (Date Certified) _____

8. If you are not Board Certified, are you Board eligible? Yes No

9. Current Hospital Staff Appointments:

(Hospital) _____
(Hospital) _____
(Hospital) _____

10. Medical Specialty Society Affiliations:

(Society) _____
(Society) _____
(Society) _____

SECTION 2

1. Medical Specialty: _____

Sub-specialty(ies): _____

2. Indicate the above specialty(ies) you are currently practicing:

3. Check box appropriate to your practice:

No surgery — permits incision of boils and superficial abscesses, or suturing of skin or superficial fascia.

Minor surgery - and/or assisting in major surgery on own patients — includes minor obstetrical procedures, D&C's, vasectomies, or any minor operation done under local anesthesia.

Major surgery — includes any operation done under general anesthesia, including tonsillectomies, adenoidectomies, caesarean sections, and assisting in major surgery on patients other than your own. (The term "Major Surgery" does not include D&C's.)

4. List the surgical procedures you perform in your office or other non-hospital facility:

5. List any procedures you perform in the office or other non-hospital facility for which you do not have hospital privileges:

SECTION 3

1. Do you provide prenatal services? Yes No

2. Do you perform deliveries? Yes No

a) If yes, please indicate number of:

_____ Annual vaginal deliveries

_____ C-Sections

3. Do you perform elective abortions? Yes No

If yes, please indicate:

a) Suction - weeks gestation maximum _____

D&C - weeks gestation maximum _____

b) List hospitals, clinics or other facilities where you perform elective abortions: _____

4. If you use any anesthesia (other than local) please complete the following:

- a) ANESTHESIA LOCATION TYPE (i.e. office, hospital, other facility)
- GENERAL _____
- REGIONAL _____
- SPINAL/CAUDAL _____
- ACUPUNCTURE _____

b) Do you administer any of the types of anesthesia listed above? Yes No

If yes, explain:

c) Do you supervise CRNA's or Inhalation Therapists? Yes No

d) Are you an Anesthesiologist by Specialty? Yes No

If no, please indicate residency training or other training in anesthesiology:

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

e) Which of the following methods do you use in monitoring patients?

- Manual monitoring of blood pressure and heart rate
- Electronic/automatic monitoring of blood pressure and heart rate
- Precordial stethoscope
- EKG monitor
- Pulse-oximeter
- Other: _____
- None of the above

f) Are you trained in CPR? Yes No

Certification: _____

Expiration Date: _____

g) Are any of your employees trained in CPR? Yes No

Job Position: _____

Certification: _____

Expiration Date: _____

5. If your specialty is anesthesiology, do you practice medicine or surgery other than anesthesiology? Yes No

If yes, please indicate:

a) Specialty: _____

b) Are you requesting coverage for your activities outside the practice of anesthesiology? Yes No

6. Do you perform acupuncture? Yes No

If yes,

a) Submit certificates of completion from courses taken, indicating the number of hours of clinical and/or didactic instruction.

b) Are you certified by the American Academy of Medical Acupuncture? Yes No

7. Do you perform heart catheterization? Yes No

If yes, please indicate:

Left Side

Right Side

8. Do you perform any diagnostic or therapeutic procedures which have been introduced to you and/or the medical profession within the past 18 months? Yes No

a) If yes, explain:

9. Do you practice weight reduction/control? Yes No

If yes, please indicate:

a) Dietary means: Yes No

Surgery: Yes No

Injections: Yes No

If yes, type _____

Drugs: Yes No

If yes, type _____

b) What percentage of your patient volume is involved in the above weight reduction/control procedures? _____%

10. Do you practice Homeopathy? Yes No

If yes, please indicate:

a) What percentage of your practice is devoted to homeopathy: _____%

b) What type of formal homeopathic education (schools, courses) have you had? _____

c) What type of homeopathic clinical training (preceptorship/experience) have you had? _____

d) Do you participate in any study groups pertaining to homeopathy? Yes No

SECTION 4

1. Indicate the average number of patients seen weekly: _____

2. Do you work in a hospital emergency department? Yes No

If yes, please answer the following:

a) How many hours do you work per week (average)? _____

b) Are you an employee of a hospital or corporation? Yes No

c) Is coverage provided by hospital or corporation? Yes No

If yes, name of hospital or corporation: _____

3. Are you medical director of any nursing home, health care facility, or business enterprise providing medical services?

Yes No

4. Do you practice in any other state? Yes No

If yes, list state(s) and amount of time you practice in each: _____

5. Do you employ/supervise any of the following assistants? Yes No

a) If yes, indicate number of each:

- | | |
|----------------------------|-----------------------------|
| _____ EKG Technician | _____ LPN |
| _____ Nurse Midwife | _____ Psychotherapist |
| _____ Nurse Practitioner | _____ Respiratory Therapist |
| _____ Optometrist | _____ Surgical Assistants |
| _____ Optician | _____ Technicians: |
| _____ Physicians Assistant | _____ Lab |
| _____ Physical Therapist | _____ X-ray |
| _____ Psychologist | _____ Medical |
| _____ RN | _____ Ultrasound Technician |

Other _____

6. Location(s): Please list all offices or clinics where you practice. If additional space is needed, please attach separate sheet.

_____ (ENTITY)	_____ (ADDRESS)
_____ (TELEPHONE #)	_____ (BUSINESS MGR./CONTACT PERSON)
_____ (ENTITY)	_____ (ADDRESS)
_____ (TELEPHONE #)	_____ (BUSINESS MGR./CONTACT PERSON)

7. Identify physicians, surgeons and dentists working at above locations. If additional space is needed, please attach separate sheet.

SECTION 5

1. ANSWER THE FOLLOWING QUESTIONS: If the answer is yes to any of the questions below, attach separate submission showing particulars or use last page where additional space is provided.

	Yes	No
a) Have you ever been diagnosed/treated for alcoholism, narcotics addiction or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you ever been convicted of any civil or criminal act by any State or Federal authority?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you ever had a complaint filed against you by any State Board of Medicine?	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you ever had any State medical license or Federal narcotic license revoked, restricted, limited, denied, suspended, subject to probationary conditions, voluntarily relinquished or voluntarily surrendered?	<input type="checkbox"/>	<input type="checkbox"/>
e) Have you ever had your hospital staff or similar privileges refused?	<input type="checkbox"/>	<input type="checkbox"/>
f) Have you ever had your defined hospital staff or similar privileges restricted, modified, suspended or voluntarily surrendered?	<input type="checkbox"/>	<input type="checkbox"/>
g) Have you ever had your membership in a professional society refused, suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you ever had a claim or been sued for medical professional liability? (If yes, please submit on the supplemental claims form attached. Make additional copies of the form if needed.)	<input type="checkbox"/>	<input type="checkbox"/>
i) Have you ever had professional liability insurance refused, cancelled or non-renewed?	<input type="checkbox"/>	<input type="checkbox"/>
j) Are you a member of a capitation program?	<input type="checkbox"/>	<input type="checkbox"/>
k) Have you ever been diagnosed as having or tested positive for Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>
l) Have you tested positive for the antibody?	<input type="checkbox"/>	<input type="checkbox"/>
m) Have you ever been diagnosed as having or tested positive for HIV or Acquired Immunodeficiency Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6

FOR CONSIDERATION OF PART-TIME COVERAGE, PLEASE COMPLETE THE FOLLOWING:

1. Has your practice been reduced because of any of the following? (Check all that apply)

- Semi-retirement
- Disability
- Majority of practice is conducted in a teaching role which is insured elsewhere
- Majority of practice is insured through another entity such as an employer
- Pregnancy or dependent care
- Maintenance of another practice in bordering state which is insured elsewhere

a) List Employer(s) and/or Hospital(s) for which coverage is needed.

If additional space is needed, please attach separate sheet.

Name/Address _____

1) Number of hours worked per week at the above location: _____

2) Specialty practiced at the above location: _____

b) List all other locations of employment for which coverage is not needed.

If additional space is needed, please attach separate sheet.

Name/Address: _____

1) Number of hours worked per week at the above location: _____

2) Specialty practiced at the above location: _____

3) Insurance carrier providing coverage at the above location: _____

(NOTE) PLEASE SIGN AND DATE NEXT PAGE

APPLICANT'S AUTHORIZATION AND CERTIFICATION

I authorize the release of all information to ProNational Insurance Company (hereafter "ProNational") from any medical school or hospital where I have received training; any person(s) who has information concerning my fitness to practice, including persons with whom I received training; any hospital at which I have applied for privileges, whether those privileges were granted or not; past and present medical associations, societies, specialty boards and any regulatory body granting me a license to practice medicine in any state; any insurance company to which I have applied for medical malpractice coverage, whether such coverage was granted or not; and any employer for whom I performed medical services, whether as an employee or an independent contractor.

I understand that information requested by ProNational may include, but not necessarily be limited to, any occurrence, incident, claim or suit in which I may be or may have been involved; any denial, suspension, revocation, or disciplinary investigation, recommendation or action relating to staff privileges at a hospital, clinic, employer or any other person connected with my providing medical services; any disciplinary action taken by any medical licensing authority; or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities. I understand that the information will be used in addition to my application in determining whether ProNational will issue insurance to me.

I agree that the persons providing the information and their agents, directors and employees, shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I understand that this is an application for insurance, and shall not bind ProNational to the issuance of insurance, nor shall it bind me to the acceptance of a policy.

Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania

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.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files for an application for insurance 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.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT: (1) IF THE POLICY IS ISSUED, THIS IS DONE BY PRONATIONAL IN RELIANCE UPON THESE REPRESENTATIONS; AND (2) ANY POLICY OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION IS VOID.

SIGNATURE OF APPLICANT

DATE OF SIGNATURE

PLEASE PRINT NAME

SOCIAL SECURITY NUMBER

SUPPLEMENTAL CLAIMS INFORMATION FORM

As indicated in Section 5, Question 1h of the Physician Professional Liability Application (Form ProNational GN01A), the following information is required. Please complete a separate form for each claim or suit reported. Note: THERE IS NO NEED TO REPORT CLAIMS ALREADY BEING HANDLED BY PRONATIONAL.

1. Name, age and sex of patient: _____

2. Date of first consultation: _____

3. Physical condition and diagnosis at above date: _____

4. Dates of treatment given and nature of same: _____

5. Date of claim, and allegations made against you: _____

6. Disposition of claim, amount of judgement or settlement: _____

7. What insurance company, if any, was involved: _____

8. Subsequent condition of health of patient: _____

9. Names of other doctors, if any, involved in the claim or suit: _____

10. To whom may we refer for further information about the suit: _____

DATE COMPLETED

SIGNATURE OF APPLICANT

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- 10. To whom may we refer for further information about the suit: _____

DATE COMPLETED

SIGNATURE OF APPLICANT