Physician Application

- If a question does not apply to you, write "N/A". Do not leave any questions unanswered.
- Include a copy of the following: • Current Declarations Page • Loss Runs
• CV *(if information is not already provided in application)*

BROKER : _____

1. PERSONAL DATA

Last Name _____ **First Name** _____ **M.I.** _____ **Title** _____

Date of Birth: _____ Social Security No: _____ Gender: ☐ M ☐ F

Clinic Name/Employer: _____

Office Address: _____ Office Phone: _____

City/State/Zip: _____ County: _____

Number of years at current office location: _____ % of practice at this location: _____

List all other office locations where you will practice your profession:

Address: _____ City/State/County: _____

Address: _____ City/State/County: _____

Residence Address: _____ City/State/County: _____

Office Phone: _____ Email address: _____

2. INSURANCE COVERAGE REQUESTED

Requested Effective Date: _____ Prior Acts Date (Retroactive Date): _____

Requested limits of liability (per claim/aggregate): ☐ $1,000,000/$3,000,000 ☐ Other: $ _____

Deductible: (per claim/aggregate): ☐ $5,000 per claim ☐ Other: $ _____ ☐ None

3. MEDICAL SPECIALTY

Current Medical Specialty: _____ % of practice: _____

☐ Surgery ☐ Minor Surgery ☐ No Surgery

Sub-Specialty: _____ % of practice: _____

☐ Surgery ☐ Minor Surgery ☐ No Surgery

4. MEDICAL TRAINING AND HISTORY

1. Provide the following information:

	Name of Institution	City	State	Dates Completed
Medical School				
PGY-1/Internship				
Residency – Specialty: _____				
Residency – Specialty: _____				
Fellowship – Specialty: _____				
Others: _____				

2. If you are a graduate of a foreign medical school:

   Are you certified by the Education Council for Foreign Medical Graduates? ……. ☐ Yes ☐ No
   Have you passed the FLEX? …… ☐ Yes ☐ No

3. Medical License #: _____ State: _____ Expiration date: _____ Status: _____

   Medical License #: _____ State: _____ Expiration date: _____ Status: _____

   Medical License #: _____ State: _____ Expiration date: _____ Status: _____

4. Narcotics/DEA License #: _____ Expiration date: _____ Status: _____

5. BOARD CERTIFICATION

1. Are you Board Certified? ☐ Yes ☐ No

   Board Name: _____ Date Certified: _____ Expiration Date: _____

   Board Name: _____ Date Certified: _____ Expiration Date: _____

2. If you are not Board certified, are you eligible to take the boards in your specialty? ……. ☐ Yes ☐ No

   Do you plan to take the Board exam (both written and oral exams)? …… ☐ Yes ☐ No

   When do you plan to take the Board exam? _____

3. Have you ever been denied Board certification or recertification or have you allowed your certification to lapse? If "Yes", state reason: _____ ☐ Yes ☐ No

6. PRACTICE INFORMATION

1. Do you have hospital privileges? ☐ Yes ☐ No

   Type of Privileges

   Hospital Name: _____ ☐ Full ☐ Restricted

   City/State/County: _____ ☐ Courtesy ☐ Other

   Hospital Name: _____ ☐ Full ☐ Restricted

   City/State/County: _____ ☐ Courtesy ☐ Other

   Hospital Name: _____ ☐ Full ☐ Restricted

   City/State/County: _____ ☐ Courtesy ☐ Other

   (If you have answered "No", "Restricted" or "Other" to question #1 above, explain on your letterhead)

2. Average number of hours worked per week: _____ Average number of patient visits per week: _____

   Average number of surgeries per week: _____

3. Type of Practice (check all that apply):

   ☐ Individual / Solo corporation – Name of corporation: _____

   ☐ Partnership – Name of partnership: _____

   ☐ Employed doctor – Name of employer: _____

   ☐ Independent contractor – Name of physician, partnership or corporation with whom you contract: _____

   _____

4. Do you request coverage for your corporation? ☐ Yes ☐ No

5. Do you, your partnership or corporation, employ any of the following non-physician providers? If yes, please complete the information below. Indicate the number of each type of professional employed or contracted by the physician. Use a separate sheet, if necessary:

Number of Professional Employees			**Number of Other Healthcare Employees**		
	Employees	Independent Contractors		Employees	Independent Contractors
*Employed Physician/ Dentist			Marriage, Family & Child Counselor		
*Employed Resident			Nurse		
*Nurse Anesthetist			Optometrist		
*Nurse Midwife			Perfusionist		
*Nurse Practitioner			Physical Therapist		
*Physician Assistant			Athletic Trainer		
*Podiatrist			Chiropractor		
*Psychologist			Licensed Clinical Social Worker		
Other			Other		

(Complete a Small Group and Individual Physician or Employed Ancillary Provider Application for each Professional Employee)*

6. Have there been any changes in your specialty, classification or practice activity within the last 5 years? ☐ Yes ☐ No
   If "Yes", explain: _____

7. Does your current practice involve the treatment of nursing home residents? ……. ☐ Yes ☐ No
   If "Yes", what percentage of your practice involves treatment of nursing home residents? _____ *%*

8. Does your current practice involve the treatment of prison inmates? ……... ☐ Yes ☐ No
   If "Yes", what percentage of your practice involves treatment of prison inmates: _____ *%*

9. Do you have faculty appointment? …….. ☐ Yes ☐ No
   If "Yes", provide name of insurance carrier for the educational program: _____

10. Does your current practice involve work in an Emergency Department? ……. ☐ Yes ☐ No
    If "Yes", how many hours each week do you work in an Emergency Department? _____ *hours/week*

11. Do you perform or assist in any surgical procedure in a non-hospital setting during which any anesthesia is administered? …… ☐ Yes ☐ No

12. Are you employed or contracted to any facility as the medical director? ……. ☐ Yes ☐ No
    If "Yes", provide name of insurance carrier: _____

13. Do you have any medical related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ……... ☐ Yes ☐ No
    If "Yes", provide name of insurance carrier _____

7. MEDICAL PROCEDURES

☐ **No Surgery** – Includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery". This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done.

☐ **Minor Surgery** – Includes all listed in definition of "No Surgery", as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.

☐ **Major Surgery** – Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, any other operation, which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.

1. If you perform any of the following procedures, check all that apply. For each procedure performed, please indicate the type of facility(ies) where the procedure is performed:
H = Hospital **S** = Surgi-center **OF** = Office **OT** = Other (describe in comments section, see page # 7)

	Type of Facility
☐ Abortions – 1st Trimester	
☐ Abortions – 2nd/3rd Trimester	
☐ Acupuncture	
☐ Adenoidectomy/Tonsillectomy	
Anesthesia	
☐ General	
☐ Spinal	
☐ Epidural	
☐ Anesthesia – Other (describe) _____	
☐ Angiography	
☐ Angioplasty	
☐ Anti-aging procedures (describe) _____	
☐ Arteriography	
☐ Assisting in Surgery – on own Patients or the patients of others	
☐ Breast Implants	
☐ Breast Reductions	
☐ Catheterization – other than umbilical cord, urethral or arterial line in a peripheral vessel	
☐ Cosmetic implantation or injection of silicone or other material	
☐ Cryosurgery – other than on benign or pre-malignant dermatological lesions	
☐ Chelation Therapy	
☐ Dermabrasion/Chemical Peels	
☐ Dilation & Curettage	
☐ Discograms	
☐ Electroconvulsive Therapy	
☐ Endoscopic procedures	
☐ Hair Transplants or Suturing of Hairpieces	
☐ Hyperbaric Medicine	
☐ Hysterectomies	
☐ Laser skin resurfacing	

	Type of Facility
☐ Laser Surgery (describe) _____	
☐ Lymphangiography	
☐ Minimally invasive surgery (describe) _____	
☐ Moh's micrographic surgery	
☐ Myelography	
☐ Needle biopsies (describe) _____	
Obstetrics:	
☐ Prenatal care beyond the 1st trimester	
☐ Normal deliveries – annual #:	
☐ Caesarean sections – annual #:	
☐ VBAC deliveries - annual #:	
☐ Open Reduction of Fractures	
☐ Pain Management (describe) _____	
Plastic – Cosmetic Procedures: ***% of practice***	
☐ Blepharoplasty	
☐ Collagen injections	
☐ Botox injections	
☐ Liposuction under 3500 cc's volume	
☐ Liposuction 3500 cc's or more volume	
☐ Phalloplasty or penile implant	
☐ Rhinoplasty	
☐ Silicone Implants	
☐ Silicone Injections	
☐ Other plastic – cosmetic procedures (describe) _____	
☐ Pneumoencephalography	
Podiatry	
☐ Below Knee Surgery	
☐ Above Knee Surgery	
☐ Prolotherapy/proliterative therapy	
☐ Radiation Therapy	
☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	
☐ Refractive surgery:LASIK, PRK, AK, PTK, ICR	
☐ Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	

2. Do you perform any Weight Reduction procedures? ……. ☐ Yes ☐ No
"If Yes", please provide % of your practice and annual # of procedures performed _____

3. Do you prescribe any weight loss medication? ……..... ☐ Yes ☐ No
"If Yes", please describe _____

4. Do you perform surgery for obesity? ……..… ☐ Yes ☐ No
"If Yes", complete Bariatric Surgery Supplemental Application

5. Do you own a Medical Spa/Clinic or Anti-Aging Clinic? …….. ☐ Yes ☐ No
"If Yes", complete Medical Spa/Clinic or Anti-Aging Clinic Application

6. Do you practice at Medical Spa/Clinic or Anti-Aging Clinic? ……... ☐ Yes ☐ No
"If Yes", please provide name and location of Clinic _____

8. INSURANCE HISTORY

1. **Current Carrier:** _____ ☐ Claims-Made ☐ Occurrence

Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

Limits of Liabililty: _____ Per Claim/ _____ Aggregate

☐ Deductible ☐SIR $: _____ Per Claim/ _____ Aggregate

Current Annual Premium: _____

1st prior carrier name: _____ ☐ Claims-Made ☐ Occurrence

Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

Limits of Liabililty: _____ Per Claim/ _____ Aggregate

☐ Deductible ☐SIR $: _____ Per Claim/ _____ Aggregate

2nd prior carrier name: _____ ☐ Claims-Made ☐ Occurrence

Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

Limits of Liabililty: _____ Per Claim/ _____ Aggregate

☐ Deductible ☐SIR $: _____ Per Claim/ _____ Aggregate

2. If you are currently insured on a claims-made policy, are you obtaining Extended Reporting Period (tail) Coverage from your current insurance carrier? ☐ Yes ☐ No ☐ N/A *(have occurrence coverage now)*

Note: To prevent possible gaps in your claims-made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. ***Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.***

3. Where have you practiced your profession since completion of your formal training? (include military or any public service organization). **Account for all time since medical school. Explain any gaps in your education or professional practice history.** *If your attached CV provides the same information, you may go on to the next section.*

City/State: _____ From: _____ To: _____

☐ Solo Practitioner ☐ Part of a group Group Name: _____

City/State: _____ From: _____ To: _____

☐ Solo Practitioner ☐ Part of a group Group Name: _____

City/State: _____ From: _____ To: _____

☐ Solo Practitioner ☐ Part of a group Group Name: _____

9. UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

1.	Are you being investigated or have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	☐ Yes ☐ No
2.	Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program?	☐ Yes ☐ No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis?	☐ Yes ☐ No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility?	☐ Yes ☐ No
5.	Have you ever resigned from a health care facility while under investigation or to avoid possible disciplinary action?	☐ Yes ☐ No
6.	Has any hospital, as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	☐ Yes ☐ No
7.	Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	☐ Yes ☐ No
8.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	☐ Yes ☐ No
9.	Have you provided any care that resulted in a formal incident report or investigation by any healthcare facility?	☐ Yes ☐ No
10.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	☐ Yes ☐ No
11.	Have you provided any professional services without professional liability insurance?	☐ Yes ☐ No
12.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	☐ Yes ☐ No
13.	Have you ever treated any patients by means of unconventional therapeutics, or have you utilized non-FDA approved experimental drugs other than through Institutional Review Board (IRB) approved research programs?	☐ Yes ☐ No
14.	Have you had or do you currently have any physical or mental condition, illness or defect?	☐ Yes ☐ No

10. CLAIMS INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

Within the past 10 years:

1.	Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years? If "Yes", how many? _____	☐ Yes ☐ No
2.	Are you aware of any circumstances that may result in a malpractice claim or suit being made or being brought against you?	☐ Yes ☐ No
3.	Are you aware of any outstanding incidents, claims, or suits (even if you believe the outstanding claim or suit would be without merit) that have <u>not</u> been reported to your current or prior professional liability carrier?	☐ Yes ☐ No
4.	Have you been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case you have been involved with, and you have not been specifically named in the suit or claim?	☐ Yes ☐ No

COMMENTS

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:

A. A change in specialty or medical procedures performed;
B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
C. Investigation, restriction, suspension or surrender of any state medical, DEA license or hospital privileges;
D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing.
E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

Applicant's Signature	Print Name	Date

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia and Louisiana: "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 for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Florida and Oklahoma: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New York: 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

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 purposes 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.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

_____ _____

Signature **Date**

_____

Print Name/Title

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

HUDSON INSURANCE COMPANY
Supplement Claim Information Form

(make copies of this page as needed)

1. Name of patient: _____ Age: _____ ☐ Male ☐ Female
2. Describe the allegation made by claimant: _____

_____

_____

_____

3. Date claim was made or filed: _____
4. Date of alleged incident: _____
5. Insurance company: _____
6. Additional defendants: _____
7. Disposition of claim: ☐ Open ☐ Closed

If open: Claimant's settlement demand: $ _____

Defendant's offer for settlement: $ _____

Insurer's loss reserve: $ _____

Deductible amount: $ _____

Is claim in suit? ☐ Yes ☐ No If "Yes", amount asked in summons: $ _____

If closed: Date closed: _____ ☐ Court judgment ☐ Out of court settlement ☐ Dismissed with prejudice ☐ Dismissed without prejudice

Total indemnity paid (including deductible): $ _____

Total defense costs/expenses paid: $ _____

Total costs incurred: $ _____

Provide complete and detailed information for evaluation. Use reverse side or additional sheets if required.

8. Condition and diagnosis at time of incidents (include dates of visits)

_____

_____

9. Description of treatment rendered (include dates of visits)

_____

_____

10. Condition of patient subsequent to treatment (include dates of follow-up treatment)

_____

_____

_____ _____ _____

Signature Print Name Date