Nevada Mutual Insurance Company

Physician or Surgeon Medical Professional Liability Insurance Application Form

With your completed application, you must submit the following information:

1. Current coverage summary, declarations page or certificate of insurance.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
3. Copy of current Nevada State Medical License
4. Copy of current curriculum vitae
5. Copy of current valued loss runs – minimum of five years required.
6. Current business letterhead.

Nevada Mutual Insurance Company Physician Application

Coverage will only become effective upon the completion of all underwriting functions and acceptance by Nevada Mutual Insurance Company.

If any space provided herein is insufficient for complete reply, please use the provided blank **REMARKS** section on Page 11, identifying the number of the question for which you are responding.

Primary coverage limits are $1,000,000 per claim with a $3,000,000 aggregate limit. Excess limits are not offered above underlying limits of less than $1,000,000/$3,000,000.

Requested Effective Date:_____
Month Day Year

Requested Retroactive Date:_____
Month Day Year

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why in the provided **REMARKS** section.

1. PERSONAL INFORMATION

A. Full name of Applicant:_____
First Middle Last Degree

B. Date of Birth:_____ C. Place of Birth:_____
Month Day Year

D. Social Security Number:_____

E. Home Address:_____

_____
City State Zip

F. Home Telephone:_____ G. E-mail Address: _____

2. OFFICE INFORMATION

A. Principal Office Address:_____

_____
City State County Zip

B. Office Phone Number: _____ C. Office Fax Number: _____

F. Preferred billing address: ☐ Principal Office ☐ Home ☐ Other_____

_____

Please list all additional practice locations in the **REMARKS** section.

3. LIST ALL STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE

State	License Number	% of Practice	Which County

4. PROFESSIONAL LIABILITY INSURANCE HISTORY

Name of Company (Current)	Policy Limits	Effective Date:_____ Expiration Date:_____ Retroactive Date:	☐ Claims-made ☐ Occurrence
Name of Company	Policy Limits	Effective Date:_____ Expiration Date:_____ Retroactive Date:	☐ Claims-made ☐ Occurrence
Name of Company	Policy Limits	Effective Date:_____ Expiration Date:_____ Retroactive Date:	☐ Claims-made ☐ Occurrence
Name of Company	Policy Limits	Effective Date:_____ Expiration Date:_____ Retroactive Date:	☐ Claims-made ☐ Occurrence
Name of Company	Policy Limits	Effective Date:_____ Expiration Date:_____ Retroactive Date:	☐ Claims-made ☐ Occurrence

A. Have you previously applied to Nevada Mutual for insurance? ☐ YES ☐ NO

B. Has any insurance company (including Lloyds of London, a risk retention group, or self-insured program) ever cancelled, declined, or refused to renew coverage? ☐ YES ☐ NO

Important information regarding questions 4C and 4D (including sub-questions):

1. The word "claim" as used in Questions 4C and 4D below refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to questions 4C through 4D (including sub-questions), please complete the attached **Supplementary Claims Information Form**.

C. Have you ever been involved in a malpractice claim or suit, directly or indirectly? ☐ YES ☐ NO

D. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? ☐ YES ☐ NO

i. A request for records from a patient and/or attorney related to an adverse outcome? ☐ YES ☐ NO

ii. A letter from an attorney regarding your medical treatment of a patient? ☐ YES ☐ NO

iii. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ☐ YES ☐ NO

iv. Patient or patient representative dissatisfaction with the outcome of a procedure treatment, or diagnosis? ☐ YES ☐ NO

v. Any other circumstances that might reasonably lead to a claim or suit? ☐ YES ☐ NO

vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ☐ YES ☐ NO

a. If Yes, how many?_____ Please attach documentation.

b. If No, please explain in the **REMARKS** section.

F. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ☐ YES ☐ NO

G. Have hospital staff privileges ever been denied, suspended, revoked, voluntarily surrendered, or in any way restricted? ☐ YES ☐ NO

H. Have you ever failed any licensing or Board Certification examinations? ☐ YES ☐ NO

I. Have you ever been required to appear before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? ☐ YES ☐ NO

J. Have you ever been convicted of a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol? ☐ YES ☐ NO

K. Have you ever been evaluated for, recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ☐ YES ☐ NO

L. Have you ever been accused of sexual misconduct of any kind? ☐ YES ☐ NO

M. Do you have any physical disability or any chronic illness which is likely to curtail your practice of medicine within the next 5 years? ☐ YES ☐ NO

N. Do you perform consultations utilizing telecommunications technology as the medium for rendering medical services (i.e. telemedicine)? ☐ YES ☐ NO

i. If “yes”, please indicate all states in which the patients being treated reside:

_____

ii. What percentage of your total practice does telemedicine constitute?_____%

O. Are you currently engaged in or planning to engage in any “moonlighting” activity? ☐ YES ☐ NO

i. If the answer is “yes”, do you wish coverage for your “moonlighting” activities? ☐ YES ☐ NO

Please provide details of your “moonlighting” activities in the **REMARKS** section.

P. Do you, or will you, staff an emergency room? ☐ YES ☐ NO

i. If "yes", how many hours per week?_____

ii. If "yes", in which hospital(s) or for what staffing company will you work:_____

_____

_____

iii. Is emergency room practice required for maintaining staff privileges? ☐ YES ☐ NO

iv. Will you be required to read your own X-rays? ☐ YES ☐ NO

a. If "yes", will they subsequently be read by a radiologist? ☐ YES ☐ NO

b. If "yes", how soon? Within_____hours.

v. Are you ACLS or ATLS certified? ☐ YES ☐ NO

Q. Do you perform surgical procedures? ☐ YES ☐ NO

Classify Your Surgical Practice, if Applicable:	**% of Practice as the Primary Physician Performing Surgery**	**% of Assisting in Major Surgery of Own Patients**	**% of Assisting in Major Surgery on Patients of Others**
☐ Bariatric*			
☐ Cardiac			
☐ Cardiovascular Disease			
☐ Colon and Rectal			
☐ General			
☐ Gynecology			
☐ Hand			
☐ Head and Neck			
☐ Laryngology			
☐ Neurology			
☐ Obstetrics/Gynecology			
☐ Normal Deliveries			
☐ C-Sections - _____# of deliveries/month			
☐ Ophthalmology			
☐ Orthopedic			
☐ Spine Surgery			
☐ No Spine Surgery			
☐ Otology			
☐ Otorhinolaryngology			
☐ Including elective cosmetic procedures			
☐ Not including elective cosmetic procedures			
☐ Plastic / Cosmetic*			
☐ Rhinology			
☐ Thoracic _____%			
☐ Urology			
☐ Vascular _____%			
☐ Other Surgical Procedures (Please List):			

*If Bariatric or Cosmetic/Plastic/Reconstructive surgeries represent more than 5% of your practice, please complete the appropriate specialty specific supplemental application form.

Check All of the Following Procedures You Will Perform:			
Procedures Performed	**% of Practice**	**Procedures Performed**	**% of Practice**
☐ **Abortions**		☐ Discography	
☐ **Anesthesia**		☐ Lasers – Used in Therapy	
☐ Local		☐ Lymphangiography	
☐ Caudal		☐ Myelography	
☐ Spinal		☐ Phlebography	
☐ General		☐ Pneumoencephalography	
☐ Other _____		☐ Radiation Therapy	
☐ **Cosmetic/Dermatological**		☐ Shock Therapy	
☐ Blephroplasty		☐ **Invasive Procedures – Class 2**	
☐ Botox Injections		☐ ERCP	
☐ Breast Implants		☐ Needle Biopsy – Lung & Prostate Only	
☐ Chemical Peels		☐ Pneumatic or Mechanical Esophageal Dilation	
☐ Chemabrasion			
☐ Dermabrasion		☐ **Minor Surgery Including but not Limited to:**	
☐ Fat Transfer		☐ Surgical removal of benign tumors (polyps and hemangiomas)	
☐ Hair Transplants			
☐ Laser Hair Removal		☐ Lithotripsy	
☐ Liposuction		☐ D & C	
☐ Plastic (Reconstructive Only)		☐ CT Scans	
☐ Silicone Injections		☐ Vasectomies	
☐ Other Aesthetic Procedures_____		☐ **Obstetrical Procedures:**	
☐ **Hospitalist 60% or More of Practice**		☐ **Pain Management**	
☐ **Invasive Procedures – Class 1**		☐ Medication Only	
☐ Angiography/Arteriography		☐ Nerve Block	
☐ Catheterization - Limited to:		☐ Implants	
a) Occasional insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers.		☐ Radiofrequency procedures	
		☐ Other_____	
b) Urethra catheterization.		☐ **Surgical Major**	
c) Umbilical cord catheterization for diagnostic purposes or monitory blood genes in newborns receiving oxygen		☐ **Weight Control (Non-Surgical)**	
		☐ **Other Procedures (List):**	
☐ Left-Heart Catheterization			
☐ Catheterization Other than Above			
☐ Cryosurgery – Other than External Lesions		☐ **None of the above procedures are performed**	

If the following procedures represent more than 5% of your practice, complete a supplemental application form for each procedure: (Bariatrics, Cosmetic/Plastic/Reconstructive, Pain Management, Radiological, or Weight Control).

5. RATING INFORMATION

A. What is your present specialty?_____

B. What percentage of your practice is devoted to your specialty?_____%

C. What is your present sub-specialty?_____

D. What percentage of your practice is devoted to your sub-specialty?_____%

E. Have there been any changes in your specialty, classification or practice activity within the past ten years. ☐ YES ☐ NO

If "yes," describe the nature of changes in specialty, classification or practice activities in the **REMARKS** section.

F. Are you American Board Certified? ☐ YES ☐ NO

i. If "yes", please list Specialty Board_____

ii. If "yes", please list date of most recent Board Certification_____

iii. If "no", are you Board eligible? ☐ YES ☐ NO

iv. If Board eligible, when do you plan to take your Boards?_____

G. Indicate the average number of:

Patients seen per week:_____ Hours practiced per week*:_____

(*Including on-call hours)

If less than 27 hours per week, complete the Part-Time Supplemental Application form.

H. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not under the direct supervision of an anesthesiologist? ☐ YES ☐ NO

If yes, explain the nature average number of cases per month:_____

_____

6. EDUCATIONAL INFORMATION

A. Medical School Data

Name of Medical School(s) Attended	Location of Medical School(s) Attended	Degree	Date Graduated

B. If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates: ☐ YES ☐ NO

If "no", please explain in the **REMARKS** section.

C. Residencies, Internships, Fellowships, Preceptorships

Name	Hospital Data Location	Department	Dates (Month/Year) Start	End	Completed?
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO

* If "no," explain fully in the **REMARKS** section

D. Are you current with regard to your licensure required CME credits? ☐ YES ☐ NO

E. What is the number of CME's completed in the past 3 years? _____

7. PRACTICE HISTORY

List the Locations Where You Have Practiced During the Last 10 Years or Since Residency Completion		
Business Name and Location	Dates (Month/Year)* Start	End

*** Explain any gaps in practice in the** REMARKS **section.**

8. HOSPITAL AFFILIATIONS AND PRIVILEGES

List the Hospitals Where You Have, or Have Had, Active Privileges During the Past 5 Years

Name	Location (City & State)	Department	Start	End	% of Patients Admitted to this facility

List the Hospitals Where You Have Applied for Privileges, But Have Not Yet Been Accepted

Name	Location (City & State)	Department

9. PRACTICE ORGANIZATION

A. Is entity coverage requested? ☐ YES ☐ NO

If "yes," please complete an Entity Supplemental Application for each entity for which you are requesting coverage.

10. INFORMATION ON PARAMEDICAL HEALTH CARE PROFESSIONALS

A. Do you employ any of the following healthcare paramedical professionals (CRNA, Cytotechnologist, Emergency Medical Technician, Nurse Practitioner, Nurse Midwife, Optometrist, Perfusionist, Physician's Assistant, Psychologist and Surgeon's Assistant)? ☐ YES ☐ NO

If "yes," please complete an Entity Supplemental Application and provide a Paramedical Application for each individual you employ.

B. Do you or any member of your group currently supervise a "paramedical health care professional" (as defined above) who is not in your employ? ☐ YES ☐ NO

C. Do you plan to do so in the future? ☐ YES ☐ NO

11. ADDITIONAL DATA

A. Do you, or does any partnership or corporation of which you are a member or shareholder, own or operate a surgicenter, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? ☐ YES ☐ NO

If "yes," please describe in the **REMARKS** section.

B. Do you perform medical or surgical procedures at a surgicenter or similar facility? ☐ YES ☐ NO

If "yes," please provide the names of the facilities, describe the types of procedures, and provide approximate distance to the nearest hospital in the REMAKRS section.

FOR YOUR PROTECTION THE FOLLOWING WARNING IS REQUIRED BY VARIOUS STATE LAWS: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or 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 may be subject to civil and/or criminal penalties.

SPECIFIC CONSENT
TO CONDITIONS OF CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application – regardless of whether or not I am granted insurance – and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed medical doctor who makes application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an application is not accepted, any such payment shall be returned to the applicant.

_____ _____

Applicant's Signature **Date**

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. **Please read carefully.**

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Nevada Mutual (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have been bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals or managed care entities in which he now holds or has held staff privileges or has been otherwise credentialed, the State Board of Medical Examiners for the State of Nevada and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

_____

Date: _____

REMARKS SECTION - (PLEASE COPY THIS FORM AND ATTACH ADDITIONAL SHEETS IF NEEDED)

Question #	Remarks

PHYSICIANS' & SURGEONS' SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please copy this form and attach the additional sheets.

1. Patient's name: _____

2. Date the claim was first reported to your insurance company: _____

3. Name of your Insurance Company: _____

4. Date of incident and your treatment: _____

5. Allegations :_____

_____

_____

6. What is the present condition of the patient? _____

_____

_____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ YES ☐ NO

8. Has a Medical/Dental Screening Panel reviewed the claim? ☐ YES ☐ NO
If "Yes," attach the panel's statement of findings. If "No," expected review date?_____

9. Status of Claim Check (Applicable Answer and Provide Details):

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary judgment in your favor

☐ Court outcome in your favor
- ☐ Jury Verdict
- ☐ Directed Verdict

☐ Court outcome in plaintiff's favor
- ☐ Jury Verdict
- ☐ Directed Verdict
- a. Loss payment amount: _____

☐ Suit settled out-of-court
- a. Date claim was paid_____
- b. Amount paid_____
- c. Did you want to settle this claim? ☐ YES ☐ NO

☐ Awaiting medical/dental screening panel review

☐ Awaiting mediation

☐ Awaiting court action
- a. Reserve amount: $_____

10. Name and address of the attorney assigned to your case: _____

_____

11. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., Partners, employees, etc.)? If "yes," amount was $_____. ☐ YES ☐ NO

Signature: _____ Date: _____

Name Printed: _____ Date: _____