FOR COPIC USE ONLY	UW Date
Last Name	Class
COPIC ID #	Specialty

Facility Employed/Contracted Physician Application for Medical Professional Liability Insurance

Claims-made coverage

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

- Curriculum Vitae (C.V.)

COPIC Insurance Company
7351 E Lowry Boulevard, Ste.400 ■ Denver, CO 80230
phone 720/858-6000 ■ *fax* 720/858-6004 ■ *toll free* 800/421-1834 ■ www.callcopic.com

APPLICANT DATA

1. Last name	First name	M.I.
2. DOB / /	3. SSN - -	4. Gender ❑ M ❑ F
5. Facility Employer		

COVERAGE REQUESTED

Liability Limits: Physician shares in the limit of liability available to the facility under HPL Coverage A.

6. Requested Effective Date ____ / _____ / ________

LICENSES

7. List all states in which you have ever been licensed to practice medicine, the license number for that state, the date the license was issued and the number of hours you will work in each state as of the requested effective date of coverage. (Please use the **Notes Section** if additional space is needed.)

State ______________ License #________________Date issued_____________# hours/week __________

State ______________ License #________________Date issued_____________# hours/week __________

State ______________ License #________________Date issued_____________# hours/week __________

PROFESSIONAL LIABILITY INSURANCE

8. Are you canceling your current policy?.. ❑ Yes ❑ No

9. If your current insurance is claims-made, will "tail" coverage be purchased?................. ❑ Yes ❑ No

* This facility policy will NOT provide any coverage for any past medical practice. Coverage will only apply while the physician is acting within the course and scope of duties for the facility.

PRACTICE HISTORY

10. Percentage of your employment devoted to your Specialty ____

11. Percentage of your employment devoted to your Subspecialty ______________________________________

12. Are you board eligible by a member board of the American Board of Medical Specialties or the American Osteopathic Association?.. ❑ Yes ❑ No

PRACTICE CHARACTERISTICS

13. Average number of hours worked per week for the facility ❑ ≤ 15 ❑ 16-20 ❑ 21-25 ❑ ≥ 26

If you are practicing part time (less than 26 hours/week), please describe all other professional or business activities. ____

____

14. Do you maintain professional liability coverage for your "other professional or business activities?"... ❑ Yes ❑ No

15. Will you participate in telemedicine? ❑ Yes ❑ No

(For purposes of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual patient as a result of transmission of individual patient data by electronic means." Telemedicine does not include an informal consultation provided without compensation or expectation of compensation, nor does it include those services described above which are rendered in a bona fide emergency.)

If "yes," please explain in the Notes Section and include a list of state(s) and license number(s).

16. If you are a radiologist or pathologist, do you or will you read, interpret or diagnose films, slides or specimens taken of patients who reside outside your principal state of practice? ❑ Yes ❑ No ❑ N/A

If "yes," please indicate the state(s) or foreign country(ies) in which the patients being treated reside:

____

And the number of hours per week you will devote in each state or foreign country: ______________________

____

17. Have there been any changes in your specialty, classification or practice activity within the past ten years? ❑ Yes ❑ No

If "yes," please describe the nature of changes in specialty, classification or practice activities. _____________

____

____

If additional space is needed, please use the Notes Section.

PROCEDURES PERFORMED

All "yes" answers require explanation in the Notes Section.

18. Will you perform bariatric surgery? ❑ Yes ❑ No

If "yes," please indicate the percentage of your time devoted to your bariatric practice.______________ %

19. Will you assist at surgery? ❑ Yes ❑ No

20. Will you perform procedures or use equipment not used by a majority of physicians in your specialty? ❑ Yes ❑ No

21. Will you provide surgical services to patients in any setting in which another person provides the post-op follow-up care for that procedure? ❑ Yes ❑ No

22. Will you supervise CRNAs who provide general anesthesia? ❑ Yes ❑ No

23. Will you perform obstetrical procedures? ❑ Yes ❑ No

24. If you answered "yes" to question 23, please indicate the anticipated average number of deliveries performed per year_______ and the anticipated average number of C-sections performed per year._______

25. If you are a Family Practitioner performing obstetrics, will you have privileges to perform C-sections at the facility where you are employed/contracted? ❑ Yes ❑ No

Important: *If "no," please provide full details of the back-up arrangements including coverage for VBAC patients.*

26. Will you practice in an Emergency Department (ED)? .... ❑ Yes ❑ No

If "yes," please indicate number of hours per week ___________ and answer the following:

a. Do you only provide on-call coverage to the ED? .... ❑ Yes ❑ No

b. Do you provide ED specialty backup/consult only? .... ❑ Yes ❑ No

c. Do you work in the ED just to maintain hospital privileges?.................................... ❑ Yes ❑ No

d. Do you work in the ED for compensation for activities other than those described in 26 a, b, and c above? .... ❑ Yes ❑ No

27. Will you perform "invasive" procedures? .... ❑ Yes ❑ No

"Invasive" refers to procedures by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation. If "yes," list all such procedures:

Procedure	**Resident-Trained?**		**Hospital Privileges?**	
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No
______________________________	❑ Yes	❑ No	❑ Yes	❑ No

28. Will you perform:

Prenatal care beyond the first trimester?.. ❑ Yes ❑ No

Second-trimester abortions?.. ❑ Yes ❑ No

C-Sections? .... ❑ Yes ❑ No

Angiography?.. ❑ Yes ❑ No

Breast biopsy by surgical incision?... ❑ Yes ❑ No

Cardiac catheterization?.. ❑ Yes ❑ No

Liposuction surgery using the tumescent technique?... ❑ Yes ❑ No

Liposuction surgery using any technique other than tumescent?....................................... ❑ Yes ❑ No

Reduction of open fractures? .... ❑ Yes ❑ No

Reduction of undisplaced closed fractures?.. ❑ Yes ❑ No

Reduction of displaced closed fractures?.. ❑ Yes ❑ No

"Undisplaced" refers to fractures in which a fracture line is visible, but the alignment of the bone has not been displaced. "Displaced" refers to fractures in which the alignment of the bone has been displaced, but the continuity of the bone has not been altered.

29. Please describe your practice (choose only one): ❑ Hospitalist ❑ Intensivist/Critical Care Specialist ❑ None of the above

If you answered "None of the above" to question #29, please skip the next two questions and proceed to question #32.

30. Please indicate the percentage of your total practice devoted to in-patient care of hospitalized patients:_________ % and indicate the ________ % in intensive or critical care and the _______ % hospitalized, but not in intensive or critical care.

31. Please describe your practice's policy regarding continuity of care with patient "handoffs" at the end of shifts: ____

____

32. What percentage of your practice will be devoted to aesthetic or cosmetic procedures?________% ❑ N/A

NON-COVERED PROCEDURES

33. **COPIC will not insure the following procedures.**

- Autologous fat injections into penises
- Chelation therapy (other than for treatment of heavy metal poisoning)
- Chymopapain disc injection
- Elective home delivery
- Intravascular absolute alcohol embolization except for renal pathology
- Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity
- Mesotherapy
- Rapid opiate detoxification
- Sclerotherapy (the injection of sclerosing agents) into the vertebral column
- Sperm banks for other than interim storage for insemination of your own patients
- Transsexual surgery
- For non-physicians you supervise or employ, the management of active labor and any subsequent delivery for Vaginal Birth after Caesarean (VBAC) patients unless a responsible physician is physically on premises and immediately available for the entire course of care
- Obstetric ultrasound images or videos created solely for nonmedical reasons or without an ultrasound report for the medical record or any nonmedical use of ultrasound imaging, such as "keepsake ultrasounds"

OTHER INFORMATION

All "yes" answers require explanation in the Notes Section.

34. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate or required that you accept a deductible, or issued coverage with any restrictions or exclusions?	❑ Yes	❑ No
35. Has any disciplinary action ever been taken regarding any healing arts license which you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure and any allegations which are currently pending).	❑ Yes	❑ No
36. 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
37. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified?	❑ Yes	❑ No
38. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? **Note**: You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs.	❑ Yes	❑ No
39. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity?	❑ Yes	❑ No
40. Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry?	❑ Yes	❑ No
41. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action?	❑ Yes	❑ No
42. Have you ever failed any licensing or Board certification examinations?	❑ Yes	❑ No
43. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, health plan, managed care organization or other medical review committee?	❑ Yes	❑ No
44. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness?	❑ Yes	❑ No
45. Have you ever been accused of sexual misconduct or harassment by one of your employees, an associate's employee or an employee of a hospital or surgery center; or have you been accused by a patient of or been investigated by any state regulatory authority in connection with boundary violations of a sexual nature?	❑ Yes	❑ No
46. Have you ever been reported to the National Practitioners Data Bank?	❑ Yes	❑ No

47. Do you recommend medical marijuana? .... ❑ Yes ❑ No

If "yes," please answer all of the following questions:

a. For all patients for whom you recommend medical marijuana, do you have a physician-patient relationship in which you have completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination? .... ❑ Yes ❑ No

b. For all patients for whom you recommend medical marijuana, are you available to provide follow-up care and treatment, including examination of the patient, to assess the efficacy of the medical marijuana? .... ❑ Yes ❑ No

c. For all patients for whom you recommend medical marijuana, do you specify the chronic or debilitating disease or condition and, if known, the cause or source of the disease or condition? .... ❑ Yes ❑ No

d. Do you maintain documentation of the subjective and objective information gathered from your examination of each patient which supports your diagnosis and recommendation for medical marijuana? .... ❑ Yes ❑ No

e. What percent of your total practice is devoted to recommending medical marijuana? ________________ %

f. In the past 12 months, for how many patients have you recommended medical marijuana? _____________

CLAIMS INFORMATION

Important information regarding questions 48 and 49 (including sub-questions):

1. The word "claim" as used in Questions 48 and 49 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 question 48 or 49 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 8).

48. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? ❑ Yes ❑ No

49. Please indicate if you are 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:
    a. A request for records from a patient and/or attorney related to an adverse outcome? ❑ Yes ❑ No
    b. A letter from an attorney regarding your medical treatment of a patient?................ ❑ Yes ❑ No
    c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities?... ❑ Yes ❑ No
    d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis?.. ❑ Yes ❑ No
    e. Any other circumstances that might reasonably lead to a claim or suit?.................. ❑ Yes ❑ No

50. 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 ❑ N/A*

    **For purposes of this question, "N/A" means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

    a. If "yes," how many?_____________ Please attach documentation of all such reports.
    b. If "no," please explain in the Notes Section.

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.

SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy these pages. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: ______________________________
2. Date reported to insurance company: ______________________________
3. Name of 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. Status of claim (check applicable answer):

❑ Suit threatened, no action taken
❑ Suit filed but dropped by claimant
❑ Summary judgment in your favor

❑ Suit settled out of court
a. Date claim paid: ___________
b. Amount paid: $___________
c. Did you want to settle this claim? ❑ Yes ❑ No

Court outcome in your favor:
❑ Yes ❑ No

Court outcome in favor of plaintiff:

Amt. of Loss Payment:
$ _______________

❑ Awaiting mediation

❑ Awaiting court action

Reserve Amount:
$ _______________

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ❑ Yes ❑ No

If "yes," amount was $ _______________

Signature: ______________________________ **Date**: _______________

Name (Printed): ______________________________

NOTES

Question #

FACILITY EMPLOYED/CONTRACTED PHYSICIAN/SURGEON STATEMENT OF UNDERSTANDING SHARED LIMIT OF LIABILITY

I hereby understand and agree that the attached application is not an application for an individual policy of insurance. I understand that I will not be extended any individual limits of insurance, but rather I will share in the limit of insurance available to the facility, who is the named insured on the policy.

I further understand that the insurance available under this policy only applies to me as an employed or contracted physician of the facility while I am acting within the course and scope of duties for the facility.

Physician signature ______________________________________ Date __________________________

Please PRINT your name ____

UNDERSTANDING, AUTHORIZATION, AND RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! I understand and agree that as a condition of being insured, I accept the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare and warrant that all answers and statements herein given are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and as such will be relied upon in the determination by the company to grant my liability insurance. If I or any other person making application or providing information on my behalf misstate or fail to disclose any pertinent information, my application may be declined. If my application is approved and it includes any misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC Insurance Company and/or its assigns may conduct a peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by Practice Quality, as COPIC may request or direct. I agree to abide by any recommendations arising from that review. I have been provided, understand, and will comply with the Participatory Risk Management Guidelines of COPIC Insurance Company.

I authorize any state board of medical examiners or licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC Insurance Company or its assigns. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC Insurance Company policy, I hereby consent to COPIC Insurance Company's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations, professional liability insurance carriers, and state and federal regulatory entities, including but not limited to boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank and to the fullest extent permitted by law, hereby release all providers of such information, including COPIC Insurance Company, its employees and agents, from any and all liability therefore. This release applies to the following information: my name, business address, social security number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank.

Physician signature ____ Date ________________________

Please PRINT your name ____

WE SUGGEST YOU RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.