



Independent Insurance Wholesalers, Inc.
121 SW Morrison St., #325
Portland, OR 97204
Voice (503) 224-1956 Fax (503) 224-3010

**Application: Professional Liability Insurance for Physicians and Surgeons
(Claims Made Form)**

Applicant's Instructions:

1. If you have a Curriculum Vitae (C.V.), please attach to application and check here _____.
2. Please do not complete application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. A. Name of Applicant _____ Degree _____
B. Social Security No. _____
C. Date of Birth _____ Place of Birth _____
D. Are you a U.S. Citizen? Yes _____ No. If "No", please indicate your status and date of entry into USA on separate sheet and attach
2. A. Principal Office: _____
No. Street City County State Zip
Phone: () _____
B. Other Offices? (If any) _____ Phone: () _____
_____ Phone: () _____
3. A. Limits of Liability Desired: \$,000. Each claim
(Limits in policy will govern coverage) \$,000. Aggregate
B. Amount of deductible desired: \$ _____
4. Desired Effective Date (12:01 a.m.): _____
5. I practice as: _____ Solo Practitioner (unincorporated) _____ Solo Practitioner (incorporated)
_____ Professional Association _____ Partnership
_____ Professional Corporation _____ Employee of _____
(give name)
6. If you practice other than as an employee OR unincorporated solo practitioner:
A. List the names of ALL your partners, your employees, or members or your professional association or corporation who practice medicine: _____

B. Give the formal corporate, association, partnership or business name: _____

C. Attach a copy of your letterhead.
7. List states and license numbers where you practice _____

8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.
1. _____ %
2. _____ %
3. _____ %
B. Briefly describe type and extent of your hospital privileges: _____

D. Are you Chief or Head of a hospital department? Yes _____ No

9. Do you or the firm listed in Question 6.B. above own (wholly or in part) operate, or administer any hospital, nursing home, or other institution where medical services are customarily rendered? ____ Yes ____ No. If yes, give details, including name, location, size and number of beds.

CURRENT PRACTICE

10. A. What is your medical or surgical specialty? _____
 B. Do you limit your practice to the above specialty? ____ Yes ____ No
 C. Do you have a sub-specialty? ____ Yes ____ No. If yes, describe: _____

11. Do you perform one or more of the following:
- | | YES | NO |
|--|---------|------|
| A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)?
If "yes", describe below. If you perform any minimal incision surgery, check here _____
_____ | A. ____ | ____ |
| B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? Describe: _____ | B. ____ | ____ |
| C. Arteriography/lymphangiography/myelography/phenmoencephalography? | C. ____ | ____ |
| D. Interventional radiology-percutaneous transluminal angioplasty or embolization? | D. ____ | ____ |
| E. Radiation therapy – deep (includes radium implants)? | E. ____ | ____ |
| F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces? | F. ____ | ____ |
| G. Mohs micrographic surgery? Describe: _____ | G. ____ | ____ |
| H. Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____
_____ | H. ____ | ____ |
| I. Prenatal care and normal deliveries? If "yes",
Do you perform home deliveries? ____ Yes ____ No
Do you only perform prenatal care? ____ Yes ____ No
Do you supervise nurse midwives? ____ Yes ____ No. If "yes", indicate when you refer: ____ weeks gestation | I. ____ | ____ |
| J. Dilation and currettage? | J. ____ | ____ |
| K. Needle biopsies? Describe: _____ | K. ____ | ____ |
| L. Electroshock therapy or hypnosis? Describe: _____ | L. ____ | ____ |
| M. Radial keratotomy? Indicate where performed: ____ Hospital ____ Office
____ Surgicenter | M. ____ | ____ |
| N. Hexagonal keratotomy? Indicate where performed: ____ Hospital ____ Office
____ Surgicenter | N. ____ | ____ |

12. Do you perform any one or more of the following:
- | | | |
|--|---------|------|
| A. Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? | A. ____ | ____ |
| B. Non-spontaneous, induced abortions?
____ 1 st trimester (Not exceeding 14 weeks gestation)
____ 2 nd trimester (indicate where performed: ____ Hospital ____ Office
____ Surgicenter | B. ____ | ____ |
| C. Sterilization procedures? Describe: _____ | C. ____ | ____ |
| D. Cosmetic plastic surgery, cosmetic body contouring (Suction lipectomy), Implantations, injections and/or blepharopigmentation? Describe: _____
_____ | D. ____ | ____ |
| E. Spinal surgery. If you also perform chemonucleolysis, check here ____ | E. ____ | ____ |

and/or percutaneous lumbar discectomy, check here _____

YES NO

F. Open reduction of fractures? Describe: _____ F. _____

G. Administration of general, spinal or caudal block anesthesia? G. _____

H. Hysterectomies? Do you perform laparoscopic hysterectomies? H. _____

I. Cholecystectomies? Do you perform laparoscopic cholecystectomies?
Indicate number of laparoscopic cholecystectomies performed to date _____ I. _____

J. Tonsillectomies and/or Adenoidectomies? J. _____

K. Caesarian sections? K. _____

L. Organ transplantations? Describe: _____ L. _____

M. Weight reduction surgery? M. _____

N. Sex change operation? Describe: _____ N. _____

O. Experimental research or surgical research or experimental therapy in
human patients? Describe: _____ O. _____

P. Other surgery? Describe: _____ P. _____

13. A. Do you perform surgery in your office? _____ Yes _____ No. If "yes", list
surgical procedures: _____

B. Do you perform surgery in other non-hospital facilities? _____ Yes _____ No. If "yes", list facilities and surgical
procedures: _____

C. In course of surgery (described in A or B above) is general anesthesia administered? By you? _____ Yes
_____ No, By others? _____ Yes _____ No

14. A. Indicate number of hours per month devoted to hospital emergency room care: _____ hours per month

B. Is this emergency room care: 1. On you own patients only? _____ Yes _____ No
2. Required for staff privileges _____ Yes _____ No
3. Other _____ Yes _____ No

15. Do you assist in surgery: On your own patients? _____ Yes _____ No. Patients of others? _____ Yes _____ No

16. If your practice includes plastic surgery, specify percent of practice devoted to traumatic surgery _____%;
cosmetic surgery _____%

17. Do you practice weight reduction or control (other than by diet-exercise)? _____ Yes _____ No. If "yes",
percent of patients exclusively weight control _____% Do you dispense (as opposed to prescribe) any
weight control drugs? _____ Yes _____ No. If "yes", list drugs dispensed _____

Do you use injections for weight control? _____ Yes _____ No. If "yes", list drugs injected: _____

18. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered
to the public? _____ Yes _____ No. If "yes", please attach detailed explanation of this activity.

19. A. List number and type of professional employees: IF NONE, STATE NONE.
_____ Physicians (other than yourself) _____ Surgeon's Assistants*
_____ Nurse Practitioners*/Physician's Assistants*
_____ Nurse Anesthetists _____ Other (describe) _____

* Describe duties in detail, including extent supervised, on separate sheet

B. Are all of the above individuals licensed in accordance with applicable state and federal regulations?
_____ Yes _____ No. If "no", attach explanation.

20. Have you or any of the above employees: (Attach detailed explanation for any "yes" answers)

In _____ From _____ To _____
 In _____ From _____ To _____

29. Indicate membership in professional societies: _____

30. Have you participated in any continuing medical educational program within the past five years?
 _____ Yes _____ No. If "yes", describe separately.

31. Do you or the firm named in Question 6.B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? _____ Yes _____ No. If "yes", attach detailed explanation.

32. A. Has any claim or suit for alleged malpractice been brought against the applicant? _____ Yes _____ No. If "yes" how many _____? Please complete the **Claim Supplement** and provide currently valued company loss runs for the past 7 years.

B. Has any claim or suit for alleged malpractice been made against the applicant that has NOT been reported to a prior Insurer? _____ Yes _____ No. . If "yes" how many _____? Please complete the **Claim Supplement** and provide currently valued company loss runs for the past 7 years.

C. Is the applicant aware of any acts, errors, omissions or circumstances which may result in a malpractice claim, or suit being made or brought against the applicant? _____ Yes _____ No. . If "yes" how many _____? Please complete the **Claim Supplement** and provide currently valued company loss runs for the past 7 years.

33. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hr. walk-in clinic or birthing center? _____ Yes _____ No. If "yes", state location and describe _____

34. A. Average patient load: _____ Patients Weekly _____ Total Patients Annually

B. Average number of hours practice time: _____ Hours weekly

35. Do you anticipate changes in your practice in the next 12 months? _____ Yes _____ No. If "yes", explain _____

36. Approximate gross annual income from the practice (check one):
 _____ Less than \$50,000. _____ \$100,000 - \$149,999 _____ \$200,000 or more (please estimate)
 _____ \$50,000 - \$99,999 _____ \$150,000 - 199,999

37. List prior professional liability insurance carried to each of the past five years. If NONE, check here _____.

INSURANCE COMPANY	LIMITS OF LIABILITY	PREMIUM	INCEPTION MO/DAY/YR	EXPIRATION MO/DAY/YR	RETROACTIVE MO/DAY/YR	WAS THIS A CLAIMS MADE POLICY FORM?	
						YES	NO
1. _____						_____	_____
2. _____						_____	_____
3. _____						_____	_____

ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

 Date Signature of Applicant Title