HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

NEW ENGLAND EXCESS EXCHANGE
P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641
800-548-4301 • www.neee.com

APPLICATION FOR PHYSICIANS & SURGEONS AS EMPLOYED OR INDEPENDENT CONTRACTORS

(Of specified entities)

PROFESSIONAL LIABILITY INSURANCE

Notice: The policy for which application is made applies only to “Claims” first made during the "Policy Period.” The limits of liability shall be reduced by “Claim Expenses” and “Claim Expenses” shall be applied against the deductible. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: ______________________________

   (ii) Legal operating name: ______________________________

   (iii) Professional Degree: ______________________________

   (iv) Attach a copy of your letterhead and resume.

   (b) Are you applying for coverage as an independent contractor? .... ☐Yes ☐ No

   (c) Are you applying for coverage as an employed physician? .... ☐ Yes ☐ No

   (d) Principal address where services as an Independent contractor or employed physician are to be performed:

   ____
   (Street) (City)

   ____
   (County) (State) (Zip)

   (e) Name o entity at this location for which coverage as an independent contractor or employed physician is being sought? :______________________________

   If more than one location, list on separate sheet.

2. Average number of hours you practice each week: ________

3. What is your approximate gross annual income from your practice as **a**n independent contractor or employed physician? $_____
____

II. LICENSE INFORMATION

1. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

2. Federal DEA License No. and status: ______________________________

III. EDUCATION AND TRAINING

1. Provide your medical or surgical specialty: ____________________

2. Are you American Board certified? .... ☐ Yes ☐ No
   If Yes, what is the Medical specialty in which you are certified: ____________________

3. Provide the following information:

	Name of Institution	City	State	Date Completed
_____Medical School	____________	____________	________	________

IV. SCOPE OF PRACTICE AS INDEPENDENT CONTRACTOR OR EMPLOYED PHYSICIAN

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia? .... ☐ Yes ☐ No
   If Yes, complete 1.(b) below.

   (b) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed: **O** = Office or clinic or **S** = Surgi-center

Procedure	Location
☐ Abortions	______
☐ Acupuncture	______
☐ Adenoidectomy/Tonsillectomy	______
Anesthesia – Non-obstetrical:	
☐ General	______
☐ Spinal	______
☐ Epidural	______
☐ Anesthesia – Other (describe) ____________________	______
☐ Angiography	______
☐ Angioplasty	______
☐ Anti-aging procedures – other than use of human growth hormone (describe)____________________	______
☐ Arteriography	______
☐ Assisting in Surgery – on own patients or the patients of others	______
☐ Bariatrics	______
☐ Breast Implants	______
☐ Breast Reductions	______
☐ Catheterization - other than umbilical cord, urethral or arterial line in a peripheral vessel	______
☐ Chiropractic Manipulation	______
☐ Cryosurgery - other than on benign or pre-malignant dermatological lesions	______
☐ Chelation Therapy	______
☐ Dermabrasion/Chemical Peels	______
☐ Dilation & Curettage	______
☐ Discograms	______
☐ Electroconvulsive Therapy	______
☐ Erectile Dysfunction Therapy	______
☐ Endoscopic procedures	______
☐ Hair Transplants or Suturing of Hairpieces	______
☐ Herbal Medicine	______
☐ Homeopathy	______
☐ Hyperbaric Medicine	______
☐ Hysterectomies	______
☐ Laser skin resurfacing	______
☐ Laser Surgery (describe)________________	______
☐ Lymphangiography	
☐ Mesotherapy	
☐ Minimally invasive surgery (describe)	______
____________________	______
☐ Myelography	______
☐ Needle biopsies (describe)______________	______
☐ Obstetrics and Obstetric Care	______
☐ Open Reduction of Fractures	______
☐ Osteopathic Manipulation	______
☐ Pain Management (describe) ____________________	______
Plastic Sugery:	
☐ Silicone implants	______
☐ Silicone injections	______
☐ Pneumoencephalography	______
☐ Prolotherapy/proliterative therapy	______
☐ Radiation Therapy	______
☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	______
☐ Refractive surgery: LASIK, PRK, AK, PTK, ICR	
☐ Sex reassignment/sex change surgery	______
☐ Silicone injection	
☐ Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	______
☐ Temporomandibular Joint Dysfunction	______
☐ Trans Myocardial Laser procedures	______
☐ Weight Reduction	______
☐ Other (describe): ____________________	

3. Is general anesthesia administered for any of the procedures identified in 1. (a) or (b) above?................................ ☐ Yes ☐ No
If Yes, is anesthesia is administered by:
(a) you? .... ☐ Yes ☐ No
(b) an Anesthesiologist? .... ☐ Yes ☐ No
(c) a Certified Registered Nurse Anesthetist (CRNA)? .... ☐ Yes ☐ No
(i) If Yes, is the CRNA directed by or responsible to an Anesthesiologist?... ☐ Yes ☐ No
(ii) If No, explain the type of surgery and percentage of your surgeries or average number of such cases per month. _____
____
(d) Are Harvard Standards for the administration of all anesthesia adhered to?... ☐ Yes ☐ No

4. Do you use experimental procedures, devices, drugs or therapy in treatment or surgery?...................................... ☐ Yes ☐ No

5. Do you:
(a) Dispense prescription drugs?.. ☐ Yes ☐ No
If Yes, are you a registered dispensing practitioner?... ☐ Yes ☐ No
(b) Prescribe drugs via the internet?.. ☐ Yes ☐ No
If Yes, provide details. ____
(c) Provide diagnosis via the internet? .... ☐ Yes ☐ No
If Yes, provide details.____

6. Indicate the number of professional employees you employ or supervise for each of the following:
(none, check here [ ])

____ Physicians other than yourself ____ Podiatrists ____ Chiropractors ____ Optometrists
____ Physician's Assistants* ____ Nurses Midwives* ____ Nurse Anesthetists*_____Psychologists
____ Surgeon's Assistants* ____ Nurse Practitioners*______Other (describe) _______________________

*Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.

7. Do you anticipate any changes in your work as an independent contractor or employed physician in the next year?
.... ☐ Yes ☐ No
If Yes, attach a detailed explanation.

VI. AFFILIATIONS

1. Are you in the employ of or under contract to any individual, firm or corporation other than the facility named in I. General Information, 1(e).. ☐ Yes ☐ No
If Yes, provide a detailed explanation including a description of your responsibilities. ____________________________________
____

2. Are you in the employ of or under contract to any governmental entity?... ☐ Yes ☐ No
If Yes, provide a detailed explanation including a description of your responsibilities. ____________________________________
____

VII. CLAIM HISTORY

1. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

2. Has any claim or suit for malpractice ever been made against you? .... ☐ Yes ☐ No
If Yes, how many?_____________Complete a copy of our Supplemental Claim form for each one.

3. Has any claim or suit for malpractice ever been made against you that has not been reported to the current insurer or any prior insurer? .... ☐ Yes ☐ No
   If Yes, how many?_____________Complete a copy of our Supplemental Claim form for each one.

4. Are you aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? .... ☐ Yes ☐ No
   If Yes, how many?____________Complete a copy of our Supplemental Claim form for each one.

5. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges? .... ☐ Yes ☐ No

6. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?... ☐ Yes ☐ No

7. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct?.. ☐ Yes ☐ No

8. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance?
   .... ☐ Yes ☐ No

9. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? .... ☐ Yes ☐ No

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating there from shall be excluded from coverage under the proposed insurance.

______________________________	______________________________
Name of Applicant	Title
______________________________	______________________________
Signature of Applicant	Date