TMLT
TEXAS MEDICAL LIABILITY TRUST
P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmlt.org

ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION

Thank you for choosing to apply with TMLT. We know that you have choices when purchasing liability insurance to protect your reputation and your medical practice. We appreciate the opportunity to earn your business.

A few items that are especially helpful to know at the start of the application process:

Completing and submitting your application:

- You must be a member of the Texas Medical Association or have a membership application pending to obtain coverage through TMLT. To start this process, please visit the TMA web site **www.texmed.org** or call 1-800-880-1300.
- Remember to sign and date your application once it is complete.
- Please review the *Business Associate Agreement.*
- If you need coverage for a partnership or group, please complete an *Entity Application* at www.tmlt.org/policyholder/applications
- Please enclose any documentation requested in the application and include your current CV, Office Letterhead, or current declarations page.
- Please complete your Trust Rewards enrollment form. For information please visit www.tmlt.org/trustrewards

Our website has a wealth of information on products and services we offer, including Coverage types, Risk Management, Claims, and information about TMLT. Be sure and check out our FAQs**.**

We want to make your application experience as simple as possible. If you have any questions during the process, we will be happy to assist you. Call 1-800-580-8658 and ask for Sales and Business Development.

Payment Options

Consider which billing and payment options are right for you. Billing can be invoiced monthly or quarterly as a recurring automatic draft using your Visa, MasterCard, American Express credit cards or by bank draft. If no billing option is chosen, you will be invoiced quarterly. Please visit www.tmlt.org to select and set up your payment option or call Customer Service at 1-800-580-8658 ext. 5050 for assistance.

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INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE

PLEASE TYPE OR PRINT IN BLACK INK.
ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER: _____
(For Trust Use Only)

I. GENERAL INFORMATION

A. _____ _____ _____ ☐ M.D. ☐ D.O.
First name | Middle name | Last name

_____ _____ _____ _____
Maiden / Other names | Date of birth | Texas medical license | Social security number

_____ _____ _____ _____
Office phone | Office fax | Home phone | Cell phone

_____ _____
Professional email address | Personal email address

_____ Preferred method of contact:
Professional website address ☐ Phone ☐ Fax ☐ Personal email ☐ Professional email

_____ _____ _____ _____
Home address | City | State | Zip

B. Please list all **Texas office locations** where you currently practice or intend to practice. Indicate the percentage of time spent at each location.

1. _____
Address

_____ _____ _____
City | State | Zip

_____ _____
County | %

2. _____
Address

_____ _____ _____
City | State | Zip

_____ _____
County | %

C. Preferred **billing** address: ☐ home ☐ primary office ☐ other

_____ _____ _____ _____
Other billing address | City | State | Zip

Preferred **mailing** address: ☐ home ☐ primary office ☐ other

_____ _____ _____ _____
Other mailing address | City | State | Zip

D. Please list all Texas hospitals where you currently practice or intend to practice. *If "other" privileges, please provide details on page 8 Section VI.

_____ _____ Privileges : ☐ full ☐ courtesy ☐ other*
Hospital name | City

_____ _____ Privileges : ☐ full ☐ courtesy ☐ other*
Hospital name | City

E. Is any part of your practice outside of Texas? ☐ Yes ☐ No If yes, where/percentage? _____

F. Texas Medical Association membership is required. Are you currently a member or is membership pending? ☐ Yes ☐ No

II. PROFESSIONAL LIABILITY COVERAGE

A. Previous insurance history (Minimum of 3 years)

Insurance company	Coverage dates	Limits of liability each claim/All claims	☐ Claims-made ☐ Occurrence
Insurance company	Coverage dates	Limits of liability each claim/All claims	☐ Claims-made ☐ Occurrence
Insurance company	Coverage dates	Limits of liability each claim/All claims	☐ Claims-made ☐ Occurrence

B. **Requested coverage effective date 12:01 a.m.** _____ (Month) _____ (Day) _____ (Year)

C. **Professional Liability Coverage**: Please check type of coverage and the limits of liability requested.

Occurrence: (limits indicated are the only limits available and are for each claim/all claims)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $500,000/$1,000,000

OR

Claims-made: (limits indicated are for each claim/all claims)

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $300,000/$900,000 ☐ $500,000/$1,000,000

☐ $500,000/$1,500,000 ☐ $750,000/$1,500,000 ☐ $1,000,000/$3,000,000

(Limits of liability in excess of $500,000 require special approval by our Underwriting Department.)

If your current insurance is written on an Occurrence policy, please skip to page 3 - Section IV.

D. **If your current insurance is written on a Claims-made policy, it is necessary to purchase a Reporting Endorsement (tail coverage) from your present insurer or Prior Acts (nose coverage) from TMLT to reduce the chances of having a gap in coverage. Any known incident or circumstance that might reasonably be expected to lead to a claim being made against you must be reported to your prior carrier.**

Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer for all of your previous exposures? ☐ Yes ☐ No

If yes, please skip to page 3 - Section IV.

Are you requesting Prior Acts (nose coverage) from TMLT? ☐ Yes ☐ No

III. PRIOR ACTS COVERAGE

The following questions apply to your past Claims-made coverage and must be answered for the entire time period following your retroactive date.

A. Has any portion of your practice been performed outside the state of Texas? ☐ Yes ☐ No

If yes, please list details and the percentage of practice below.

City/State	Dates	%	City/State	Dates	%

B. Has your Claims-made policy ever included coverage for any other individual or for an Entity other than a Solo PA? ☐ Yes ☐ No

If yes, please explain below and attach a copy of any endorsement providing coverage for other individuals (including locum tenens) or Entity. Each is subject to separate underwriting consideration.

C. Are you aware of any incidents or legal actions not reported to previous carriers which you have reason to believe may lead to a claim or suit against you? (i.e. subpoena, attorney request for patient records, etc.) ☐ Yes ☐ No

If yes, report these incidents to your current carrier.

D. Have you reported any incidents to another insurance carrier which have not yet resulted in a claim or suit? ☐ Yes ☐ No

If you answered yes to C or D above, please provide details below.

Patient name	Date of incident	Date incident report sent to insurance carrier (provide copies)

IV. UNDERWRITING AND RATING INFORMATION

A. Medical practice history / Education

Medical school | Degree/Specialty

City/State | Dates attended

Internship school/Hospital | Specialty

City/State | Dates attended

Residency school/Hospital | Specialty

City/State | Dates attended

Fellowship school/Hospital | Specialty

City/State | Dates attended

1. a. Did you complete residency training? ☐ Yes ☐ No

   b. Are you entering practice for the first time immediately following residency training, military service, or an academic position? ☐ Yes ☐ No

2. a. Are you currently American Board Certified? ☐ Yes ☐ No

   Specialty Board | Date(s) Certified

   b. Have you ever failed to pass a board exam or been denied certification? ☐ Yes ☐ No

   Specialty Board | Which portion?/Date(s)

3. Where have you practiced your profession since completion of your formal training, including military or any public service organization? PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF MEDICAL SCHOOL WITH THE EXCEPTION OF YOUR RESIDENCY OR FELLOWSHIP TRAINING.

Name of practice	City/State	Country	Dates
Name of practice	City/State	Country	Dates
Name of practice	City/State	Country	Dates

4. Please provide an explanation for any gaps greater than six months in your work history.

Gap dates	Explanation
Gap dates	Explanation

B. Medical practice structure / Operations

1. Do you practice as a:

☐ Solo Incorporated (PA/ LLC) (This coverage is automatically provided under the individual policy with shared limits of liability.)

☐ Solo Unincorporated (Individual)

List any other name(s) under which you practice (i.e. DBA): _____

2. Do you practice with a group or clinic? ☐ Yes ☐ No

If yes, please provide the exact name: _____

Are you an ☐ Employee ☐ Independent contractor ☐ Shareholder / partner

Please list the names of all partners, members and shareholders: (if more than nine, please add to page 8 Section VI.)

1.	2.	3.
4.	5.	6.
7.	8.	9.

3. Do other licensed physicians work for you on an employment or contract basis? If yes, how many? _____ ☐ Yes ☐ No

4. Average number of patients seen per week: #_____

5. Average number of practice hours per week involved in direct patient care, including related administrative activities: #_____

6. Indicate the number of professional licensed personnel in each category employed or supervised by you.

CRNA/Anesthesia Assistant: _____ Physician Assistant: _____ RN/LVN: _____

Nurse Midwife: _____ Nurse Practitioner: _____ Medical Technician: _____

Please list the names of their current insurance provider: _____

*PLEASE NOTE, COVERAGE IS NOT PROVIDED FOR ANY OF THE ABOVE LICENSED PERSONNEL UNDER THE PHYSICIAN'S INDIVIDUAL POLICY. SEPARATE COVERAGE MAY BE OBTAINED THROUGH TEXAS MEDICAL INSURANCE COMPANY **(WWW.TMIC.BIZ).**

C. Medical practice description

1. What is your medical specialty? _____ Sub specialty? _____

2. Please check any of the following procedures you perform:

☐ Cardiac catheterization	☐ Interventional radiology	☐ Silicone breast implant
☐ Swan Ganz	☐ Open fracture reduction	☐ Autopsies
☐ Myringotomy	☐ Spinal surgery	☐ Adult circumcision
☐ Adenoidectomy	☐ Tubal ligation	☐ Vasectomy
☐ Tonsillectomy	☐ Abortion	
☐ ERCP	☐ D & C	

3. Do you perform minor surgery in an office setting including procedures performed under a local anesthetic? ☐ Yes ☐ No

4. Do you perform major surgery? ☐ Yes ☐ No
   If yes, # per year: _____ Cardiovascular:_____% Thoracic: _____% Vascular: _____%

5. Do you assist in major surgery on your own patients? ☐ Yes ☐ No
   If yes, # per year: _____

6. Do you assist in major surgery on patients other than your own? ☐ Yes ☐ No
   If yes, # per year: _____

7. Do you perform major surgery in a freestanding facility or your office? ☐ Yes ☐ No
   If yes, please provide details on page 8 Section VI.

8. Do you perform autopsies? ☐ Yes ☐ No
   If yes, percentage of practice: _____%

9. Do you perform bariatric surgery? (Limits are restricted to a maximum of $200,000/$600,000 or less) ☐ Yes ☐ No
   If yes, please request a **bariatric surgery questionnaire** for completion.

10. Do you perform pain management procedures in an office? ☐ Yes ☐ No
    If yes, please request a **pain management questionnaire** for completion.

11. Is laser equipment utilized in your practice? ☐ Yes ☐ No
    If yes, please provide details on page 8 Section VI.

12. Do you perform plastic surgery? ☐ Yes ☐ No

13. Does your practice include cosmetic/aesthetic procedures other than Botox or derma filler injections? ☐ Yes ☐ No
    If yes, please request a **cosmetic/aesthetic questionnaire** for completion.

14. Does your practice include telemedicine? ☐ Yes ☐ No
    If yes, please request a **telemedicine questionnaire** for completion.

15. Do you adhere to or follow written protocols that demonstrate a "good-faith effort" to prevent fraud and abuse of electronic patient health information (PHI)? ☐ Yes ☐ No

16. Do you access electronic patient data from a health information exchange? ☐ Yes ☐ No

17. Do you function as a hospitalist (i.e. hospital-based practice, admit and/or round on patients other than your own)? ☐ Yes ☐ No
    If yes, please provide details on page 8 Section VI.

18. Do you perform emergency medicine other than for maintaining privileges? ☐ Yes ☐ No
    Is insurance provided for this exposure? (If yes, please provide verification of insurance for each facility.) ☐ Yes ☐ No

19. Do you provide patient care in a nursing home or other residential care facility? ☐ Yes ☐ No
If yes, what percentage of these visits represent your total annual patient visits? _____%

20. Are you a medical director of a nursing home or other residential care facility? ☐ Yes ☐ No
If yes, how many? _____
Please provide verification of insurance for each facility.
Note: TMLT's policy provides coverage for direct patient care, but does not cover your administrative liability as a medical director.

21. Do you provide prenatal care? ☐ Yes ☐ No
If yes, does it include high-risk pregnancy? ☐ Yes ☐ No

22. Do you deliver infants? ☐ Yes ☐ No
Vaginal deliveries: #/year_____ VBAC: #/year _____ C-sections: #/year _____

23. Do you spend greater than 50% of your practice time supervising medical students, residents, or fellows? ☐ Yes ☐ No
Is insurance provided for this exposure? ☐ Yes ☐ No
If yes, please provide verification of insurance.

24. Which of the following methods of advertising do you use? Please provide samples or transcripts of all advertisements.
☐Yellow pages ☐Radio / Television ☐Newspaper / Print media
☐Internet / Email ☐Billboard ☐Other:_____

D. Additional Information

1. Have any of the following ever been under review or investigation, revoked, denied, suspended, voluntarily surrendered, or limited in any way:
a. Your medical license or permit to prescribe drugs? ☐ Yes ☐ No
b. Your privileges at any hospital, clinic, or other facility? ☐ Yes ☐ No
c. Your Medicare / Medicaid accreditation or certification? ☐ Yes ☐ No

2. Have you ever been:
a. Treated for alcohol or substance abuse? ☐ Yes ☐ No
b. Diagnosed with any mental illness? ☐ Yes ☐ No
c. Diagnosed with or had a chronic illness or physical impairment that affected your ability to practice medicine? ☐ Yes ☐ No

3. Have you ever been indicted, charged, or convicted of a crime other than a minor traffic violation? ☐ Yes ☐ No

4. Do you dispense or prescribe medications or use medical devices that have been disapproved by the FDA in the treatment or care of human beings? ☐ Yes ☐ No

5. Have any professional relations or fee complaints ever been made against you by a medical association, hospital or licensing authority? ☐ Yes ☐ No

6. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled, or non-renewed? ☐ Yes ☐ No

7. Are you aware that your present carrier plans to restrict, surcharge, cancel, or non-renew your coverage? ☐ Yes ☐ No

8. Have any lawsuits (other than medical and auto liability suits) been filed against you in the last 10 years? ☐ Yes ☐ No

9. How many professional liability claims have **ever** been brought against you? #_____
This includes notice of intent to sue and written demand from a patient or a lawsuit.
Complete the information for each claim or suit on page 8 Section VII.

V. AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding. **I understand any policy issued by TMLT will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMLT any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: Texas Medical Board; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability and/or Premises Liability Coverage. I further authorize TMLT and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

This application incorporates by reference the terms and conditions of TMLT's HIPAA-HITECH Business Associate Agreement (reviewable at www.tmlt.org/appdocs), copies of which will be provided to me upon request. By signing and accepting below, I consent to the terms and conditions of these documents and agreements.

By submission of this application, or by acceptance of coverage from TMLT, I hereby release TMLT and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

Physician's Signature	Printed Name	Date Signed

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

Coverage will not be considered until this application is completed, signed and dated.

Failure to provide complete information and/or attachments as requested will cause delay.

VI. ADDITIONAL DETAILS (Please use this area if additional space is needed for answers to any questions.)

PAGE NUMBER	QUESTION NUMBER	ANSWER AND/OR DETAILS

VII. CLAIM/SUIT INFORMATION

If additional space is required, please photocopy this form as needed. PLEASE TYPE OR PRINT IN BLACK INK. Note: Additional documentation may be requested by the Underwriting Department.

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

Is the claim still pending? ☐ Yes ☐ No

Method of resolution

☐ Settled ☐ Dismissed (with prejudice) ☐ Dismissed (without prejudice) ☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month / Day / Year

Location: _____ _____ Hospital: _____
City State

Insurance company defending your claim: _____ Date reported: _____
Month / Day / Year

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

_____

_____

_____

Co-defendants: _____

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☐ Mediation or arbitration Total amount paid to claimant on **your** behalf: $ _____

Date of resolution: _____ Total amount paid to claimant for **all** defendants: $ _____
Month / Day / Year

TMLT TRUST REWARDS PROGRAM

Enrollment Request & Acknowledgment Form

Please fill in all information below. Incomplete forms cannot be processed.

First Name _____ MI _____ Last Name _____

Date of Birth (mm/dd/year) _____/_____/_____ Policy Number(s) _____

_____

E-mail Address _____ Telephone Number _____

As of the date indicated below, I, the undersigned policyholder of Texas Medical Liability Trust (TMLT), hereby:
(Please indicate your selection by checking one of the boxes below)

☐ **Request** to participate in the TMLT Trust Rewards Program.

☐ **Decline** to participate in the TMLT Trust Rewards Program.

If I have requested to participate in the TMLT Trust Rewards Program, I acknowledge and agree that my request may be accepted or rejected in TMLT's sole discretion in accordance with the eligibility criteria for participation in the program in effect on or after the date hereof. In addition, I acknowledge and agree that my participation in the program will be governed by certain policies and guidelines adopted by TMLT's Board of Trustees from time to time, including, without limitation, the TMLT Trust Rewards Program Plan Document. I hereby acknowledge that I have read the TMLT Trust Rewards Program Plan Document and agree to its terms and conditions and I understand that the TMLT Trust Rewards Program Plan may be amended or terminated in the sole and absolute discretion of TMLT's Board of Trustees.

Signature _____ Date _____

Mail
TMLT
P.O. Box 160140
Austin, TX 78716-0140

Fax
(512) 425-5999

Email
trustrewards@tmlt.org

Customer Service: (512) 425-5050
(800) 580-8658 ext. 5050

For Company Use Only

Accepted by _____ Date _____