Schuylkill Crossing

Reciprocal Risk Retention Group

Please complete and return to Local Office:

1601 Cherry Street, Suite 10627, Philadelphia, PA 19102 ■ TEL 215.255.7841 FAX 215.255.7856

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

1. Personal and Demographic Information	Requested policy effective date:
Name: Last First Middle	Office Phone: ( )
Office Practice Locations and Percentages of Practice for Drexel University College of Medicine, Drexel University, Drexel Research Foundation (identify below):	Office Fax: ( )

Street Address	City	State	Zip	County	Percentage of Practice
1.					
2.					
3.					
4.					

Residence Address (identify below):	E-mail:
	Social Security #:
	Date of Birth:
	Gender: Female Male (circle one)
Preferred Mailing Address (check one) Residence ☐ Office ☐ Other	If "other" provide here:

2. Professional Education

Please indicate the name of the medical school and/or hospital and the city and state where located.	Degree and/or specialty	Completed? Yes	Completed? No	Date Completed (or expected)
Medical School:				
Internship:				
Residency:				
Residency:				
Fellowship:				

3. Certification

What is your specialty?			Subspecialty?		
Are you Board Certified (by a member-board of the American Board of Medical Specialties or Osteopathic Specialties?	Yes	No	Are you Board Eligible and currently in the exam process?	Yes	No
Have you been recertified? If "Yes," indicate date:	Yes	No	Have you ever failed a specialty or sub-specialty exam? Number:	Yes	No
Name of Specialty Board:			Name of Specialty Board (if dual certified):		
General and/or Sub-specialty Certificate in:			General and/or Sub-specialty Certificate (or other training, e.g., laser or laparoscopic procedures) in:		
Date of Certification:			Date of Certification:		

4. Licensure

Please indicate in which states you are presently licensed to practice and indicate what percentage of your total practice is spent in each. For surgeons and obstetricians, base your percentages on surgeries or deliveries.

State	License Number	Date of License	% of Total Practice

D.E.A. Registration Number:

If you answer "Yes" to any of the following questions, please attach an explanation.	Yes	No
Has your medical license in any state ever been suspended, revoked or limited?		
Are you currently under investigation by any state licensing board or agency?		
Has your federal or state registration to prescribe controlled medications ever been refused, revoked or limited?		

5. Hospital Privileges

Please state the name and location (City and State) for each hospital where you hold staff privileges.

1.

2.

3.

4.

5.

Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges or your application or reapplication for medical staff privileges?	Yes	No
Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action?		

If "Yes to either, please attach a complete explanation.

6. Professional Liability Insurance History

	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior
Insurance Co					
Limits of Insurance					
Type of Policy (Claims-made or Occurrence					
Policy Period					
Retroactive Date					

If your previous policy was claims-made, did you obtain extended reporting period ("tail") coverage? (circle answer) YES NO
If yes, please enclose a copy.

Have you ever practiced without professional liability insurance (circle answer)?
If answer is "Yes," fill in dates: _____ and provide information on following page. YES NO

Has your professional liability insurance ever been cancelled or nonrenewed (other than at your request)?
Has your policy premium ever been surcharged?
Has your application for professional liability insurance ever been declined? YES NO
Has there ever been a gap in your professional liability insurance coverage?
If "yes," give dates and complete explanation on following page.

Note: If you practice as a primary care physician or as a general surgeon, obstetrician/gynecologist or orthopedic surgeon, you must also complete the specialty questionnaire under section 11 of this application.

7. Practice Profile at Drexel University College of Medicine, Drexel University or the Drexel Research Foundation

Practice Profile Please indicate average number per week:		**Principal Medical or Surgical Practice** Please describe below the practice for which this insurance is needed.
Practice hours (total hours – not just patient contact)		
Patient visits (in office, hospital, etc.)		
Surgeries (major – in hospital)		
Obstetrical deliveries		

First Date of Practice: Please indicate your first date of practice (for physicians or surgeons entering practice for the first time after completing a residency or fellowship program or service in a government-funded health care program, such as the U.S. Public Health Service or the U.S. Military, as repayment of a medical education funding obligation, this is the date you first entered practice after the residency or fellowship program or service in the government-funded healthcare program). **Date:**

8. Additional Underwriting Information

		Yes	No
Other Procedures?	Do you perform any procedures, techniques or treatment modalities that are not typical to the specialty in which you received your residency and/or fellowship training? If yes, please describe below.		
Other Coverage?	Are you now covered under any malpractice insurance or indemnity agreement that will continue even after you are approved for the coverage to which this application applies? If Yes, explain who will provide this coverage and what professional services it will cover?		
Illegal Acts?	Have you ever been arrested for, charged with or convicted of a crime (other than a traffic violation)? If Yes, please explain in detail below.		
Obstacles to Practice?	Have you ever suffered from or been treated for any substance abuse, disability, mental illness or serious physical injury or illness that has or might affect your ability to practice medicine or surgery? If Yes, please explain in detail below.		

Please use the space below to give details for any question to which you answered "Yes" on previous page. Attach additional sheets as needed. Lack of sufficient detail may delay an underwriting response to your application.

9. Claim History

	Yes	No
In the past ten years, has any claim or suit been made against you arising from your practice of medicine or surgery? If Yes, please indicate the number of claims or suits here: _____.		
Besides any claim or suit made against you, have you reported any medical incidents, adverse outcomes or other circumstances, including requests for patient records from an attorney, to any of your previous insurers?		
Are you aware of any medical incidents, adverse outcomes or other circumstances that you expect to give rise to a claim in the future?		

If you have answered "Yes" to any of the preceding questions in this section, please provide answers below.

Claim or Incident No. ____ of ____ Name of Patient:

1. Date of medical/surgical incident:			8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	Yes	No
2. Date claim reported to your insurer (if applicable):					
3. Has a suit been filed?	Yes	No	9. Are there circumstances that you think may result in a claim but have not previously been reported to your insurer?		

4. Current Status

Open	Closed	Date Closed

Amount paid on your behalf: $_____

6. Amount paid on behalf of all defendants: $_____

7. Amount of reserve, if an open claim: $_____

10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):

11. Describe the alleged injury or problem that led to the claim made against you.

12. Loss Run attached. (circle) Yes No

Claim or Incident No. ____ of ____ Name of Patient:

1. Date of medical/surgical incident:			8. Is this an incident that you reported to your insurer even though a claim has not yet been made?	Yes	No
2. Date claim reported to your insurer (if applicable):					
3. Has a suit been filed?	Yes	No	9. Are there circumstances that you think may result in a claim but have not previously been reported to your insurer?		

4. Current Status

Open	Closed	Date Closed

5. Amount paid on your behalf: $_____

6. Amount paid on behalf of all defendants: $_____

7. Amount of reserve, if an open claim: $_____

10. What medical or surgical treatment led to the alleged injury to the patient? (Note: include CPT code, if known):

11. Describe the alleged injury or problem that led to the claim made against you.

12. Loss Run attached. (circle) Yes No

Note: You may be requested to provide additional information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.

Please use multiple copies of this form if you have had more than two claims or incidents.

10. Primary Care Physicians Specialty Application

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, you perform or engage in. Please indicate the number you performed in the past year.	Yes	No	How Many?
1. Obstetrical deliveries			
2. Prenatal or postnatal care			
3. Any procedure using any type of fiber optic scope			
4. Any invasive procedure (incision, excision, puncture, tap, etc.) of any organ, including the skin			
5. Any procedure performed while the patient is under any type of anesthesia (local, general, regional, acupuncture, etc.)			
6. Any procedure involving withdrawal by needle of bodily fluids (other than blood products) such as amniocentesis, lumbar puncture, abdominal tap, etc.			
7. Biopsy of any type (excisional or needle)			
8. Catheterization:			
Swan Ganz			
Right Heart?			
Left Heart?			
9. Weight reduction procedures, treatments or medications			
10. Cervical/vaginal smears			
11. Hair transplants and or restorations			
12. Any procedure involving injection and/or diagnosis using any radiopaque contrast material			
13. Any imaging procedure that you perform and/or results that you interpret (x-ray, mammogram, etc.)			
14. Laser therapy or surgery			
15. Polyp removal (from any mucous membrane)			
16. Dialysis therapy (hemodialysis or peritoneal dialysis			
17. Liposuction			
18. Diabetes management			
19. Electrocardiography, echocardiography, cardiac stress tests or implantation of any pacemaker			
20. Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			
21. Assist at any major surgical procedure as first assistant: (making incisions, excising or handling organs, suturing, etc.)			
22. Assist at any major surgical procedure other than as first assistant			
23. Any procedure not typical to the specialty in which you received your residency or fellowship training			
24. Teach, supervise or proctor medical students, residents or fellows (indicate number of hours per week)			

<u>Kindly attach sheets as necessary</u> to provide details about any item above to which you provided a "yes" answer. Attach additional sheets as needed. Include sufficient detail so as to avoid delay in processing your application.

11. Specialty Application for:

General Surgery **Obstetrics & Gynecology** **Orthopedic Surgery**

Please check off "Yes" or "No" for each of the following procedures or activities, to indicate which, if any, you perform or engage in. Please indicate the number you performed in the past year and provide a description on the following page.

General Surgery	**Yes**	**No**	**How Many?**
Breast surgery (excision of tumors, etc.)			
Bariatric surgery			
Cosmetic procedure (liposuction, abdominoplasty, rhinoplasty, breast reduction or augmentation, etc.)			
Any surgical procedure performed in a non-hospital setting			
Any non-hospital procedure using anesthesia (other than local)			
Any laparoscopic procedure			
Any laser procedures			
Vascular or peripheral vascular surgery			
Transplant surgery (lung, kidney, liver, heart, etc.)			
Any orthopedic procedures			
Any obstetrical or gynecologic procedures, including, but not only, termination of pregnancies, etc.			
Any surgical procedure or treatment method that you have trained for after finishing your residency or fellowship			
Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			

Obstetrics & Gynecology	**Yes**	**No**	**How Many?**
Termination of pregnancies after the first trimester			
Termination of pregnancies (or any invasive or surgical procedure) in a non-hospital setting (indicate type and number of procedures and location where performed)			
In-vitro fertilization			
If you perform mammography (or other methods of imaging), are these reviewed by a radiologist?			
Vaginal birth after a cesarean delivery			
Any surgical procedure outside the scope of your training in obstetrics and gynecology			
Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			

Orthopedic Surgery	**Yes**	**No**	**How Many?**
Spine surgery			
Microsurgical procedures			
Hip replacement surgery			
Any surgical procedure outside the scope of your training in orthopedics			
Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company			

Kindly attach sheets as necessary to provide details about any question to which you answered "Yes."
Include sufficient detail so as to avoid delay in processing your application.

Specialty Application (continued)

Please use this space to provide details about any question to which you answered "Yes" on the previous page. Include sufficient detail so as to avoid delay in processing your application.

12. Certification, Authorization and Signature

Conditions of Insurance

There are several conditions to the undersigned's insurance. Failure to comply with any of these conditions is grounds for non-renewal of the undersigned's insurance policy. These conditions include, but are not limited to, that the undersigned hereby agrees to:

(1) Accept and cooperate with defense to the extent ethically permissible.

(2) Participate in and cooperate with programs that promote intensive risk management, quality improvements and best practices whenever requested by Schuylkill Crossing Reciprocal Risk Retention Group.

(3) Report incidents at the time they become known to the undersigned.

The undersigned agrees to fully comply with Schuylkill Crossing Reciprocal Risk Retention Group's conditions of insurance, including those listed above, and agrees that the undersigned's policy may be non-renewed by Schuylkill Crossing Reciprocal Risk Retention Group if the undersigned fails to comply.

The undersigned certifies that the information in this application is true and correct and authorizes the release and Exchange of any information regarding the undersigned's medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which the undersigned is or has been a member and Schuylkill Crossing Risk Retention Group.

The undersigned further agrees to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

The insurance policy issued by Schuylkill Crossing Reciprocal Risk Retention Group will only be for your Scope of Duties as defined by Drexel University College of Medicine, Drexel University or the Drexel Research Foundation.

Any person who knowingly and with intent to defraud any insurance company or other 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 subjects such Person to criminal and civil penalties.

Please note that the policies issued by Schuylkill Crossing Reciprocal Risk Retention Group provides that it has the right to rescind its policy from its inception upon discovery that the policy was obtained through statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the Company. Accordingly, by signing this Application, the undersigned represents that the statements contained herein are complete and accurate, and that the undersigned is not aware of any fact about his/her practice that is not disclosed in this application.

Applicant's signature _____ **Date:** _____