



Medical PL EZApp™

PHYSICIAN EDITION **(MD's & DO's)**

The Medical PL EZ App™ is designed to be completed in 3 EZ steps:

Step 1 – user must first have this pdf attachment saved to their own computer file folder.

Step 2 - from their computer the user must then open the saved EZ App pdf file with **Adobe Reader 9** which will be needed in order to utilize Adobe's "extender save data" format.

Step 3 - user can now begin to **enter data** into the application fields right from their computer keyboard. By utilizing Adobe Reader 9 the **input data is permanently saved** providing an application data file you can **reuse year after year as needed** - once fully completed the user will need to **sign and date page 6, close and save the attachment and then email it as an attachment directly back to their broker or agent for fast processing.**

(ADOBE offers a free download for Reader 9 on their web site and we have created a link below which may take a few seconds to connect you with the Adobe web link)



Adobe® Reader® 9 FREE DOWNLOAD LINK

1. PERSONAL INFORMATION

Full Name of Applicant: _____
 FIRST MIDDLE LAST SUFFIX

PROFESSIONAL DESIGNATION: MD DO Date of Birth: _____ Gender: MALE FEMALE
 MONTH DAY YEAR

Place of Birth: _____ Social Security Number: _____

2. OFFICE INFORMATION

Principal Office Address: _____

 CITY COUNTY STATE ZIP

Office Phone Number: _____ Office Fax Number: _____

Email Address: _____ Office Manager: _____

Secondary Office _____

Locations (if any): _____

 CITY COUNTY STATE ZIP

3. COVERAGE REQUEST

Requested Effective Date: _____ Retroactive Date: _____
 MONTH / DAY / YEAR MONTH / DAY / YEAR

Please indicate your desired level of coverage in the appropriate box.

- \$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000 \$500,000/\$1,500,000 \$1,000,000/\$3,000,000
 \$1,300,000/\$3,900,000 (New York Only) \$2,000,000/\$6,000,000 (Virginia Only) \$2,300,000/\$6,900,000 (New York Only)

4. CLASSIFICATION, LICENSING AND BOARD CERTIFICATION INFORMATION

A. What is your present specialty? _____

B. What is your present sub-specialty? _____

C. What percentage of your practice is devoted to your specialty? _____ Sub-specialty? _____

D. Indicate the average number of: Patients seen per week: _____ Hours practiced per week: _____

E. Licensing (List all states in which you are currently licensed.)

STATE	MEDICAL LICENSE NUMBER	% OF PRACTICE	FEDERAL DEA LICENSE NUMBER & STATUS	MEMBER OF STATE MEDICAL ASSOCIATION?	
_____	_____	_____	_____	YES <input type="checkbox"/>	NO <input type="checkbox"/>
_____	_____	_____	_____	YES <input type="checkbox"/>	NO <input type="checkbox"/>
_____	_____	_____	_____	YES <input type="checkbox"/>	NO <input type="checkbox"/>

F. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates? YES NO N/A

G. Are you American Board Certified? YES NO

i. If "yes," list Specialty Board(s): _____ (Indicate allopathic or osteopathic)

ii. If "yes," list date of initial Board Certification: _____

H. Please indicate the number of Continuing Medical Education (CME) credit hours you have attained over the past 12 months: _____

5. MEDICAL PROCEDURES INFORMATION

<input type="checkbox"/> Abortion, elective <input type="checkbox"/> Acupuncture <input type="checkbox"/> Anesthesia <input type="checkbox"/> Caudal <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> Other _____ <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Assist in Major Surgery <input type="checkbox"/> On own patients <input type="checkbox"/> On patients of others <input type="checkbox"/> Bariatric Surgical procedures <input type="checkbox"/> Gastric banding <input type="checkbox"/> Gastric bubble <input type="checkbox"/> Gastric bypass <input type="checkbox"/> Gastric stapling <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implants <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Cardiac surgery <input type="checkbox"/> Cataract surgery <input type="checkbox"/> Chelation therapy <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Circumcision <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryosurgery, other than external lesions <input type="checkbox"/> Dermatological procedures <input type="checkbox"/> Botox injection <input type="checkbox"/> Chemical peels <input type="checkbox"/> Chemobrasion <input type="checkbox"/> Collagen injection <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Fat transfer <input type="checkbox"/> Hair transplant <input type="checkbox"/> Laser hair removal <input type="checkbox"/> Laser skin resurfacing <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Silicone injection <input type="checkbox"/> Other _____	<input type="checkbox"/> D & C <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Echocardiography <input type="checkbox"/> Endoscopic laser therapy <input type="checkbox"/> Endoscopy <input type="checkbox"/> Cystoscopy <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> EGD <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> Proctoscopy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Other _____ <input type="checkbox"/> ERCP/ERC <input type="checkbox"/> Exchange transfusion <input type="checkbox"/> Facial plastic surgery <input type="checkbox"/> Elective cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reduction <input type="checkbox"/> Closed <input type="checkbox"/> Open <input type="checkbox"/> Hand surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia repair <input type="checkbox"/> Hip nailing <input type="checkbox"/> Hyperbaric medicine <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Intensive care for newborns <input type="checkbox"/> Intensive care medicine for adults <input type="checkbox"/> Infertility treatment <input type="checkbox"/> Medical <input type="checkbox"/> In vitro fertilization <input type="checkbox"/> Other surgical <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> LASIK <input type="checkbox"/> Left heart catheterization <input type="checkbox"/> Liposuction <input type="checkbox"/> Tumescent <input type="checkbox"/> Other _____ <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Mammography <input type="checkbox"/> Mesotherapy <input type="checkbox"/> Myelography <input type="checkbox"/> Myomectomy <input type="checkbox"/> Neonatology	<input type="checkbox"/> Organ transplantation <input type="checkbox"/> Orthopedic surgery <input type="checkbox"/> Including spinal surgery <input type="checkbox"/> Without spinal surgery <input type="checkbox"/> Osteopathic manipulative medicine <input type="checkbox"/> Pain management <input type="checkbox"/> Cordotomy <input type="checkbox"/> Dorsal root gangliotomy <input type="checkbox"/> Facet blocks <input type="checkbox"/> Medication only <input type="checkbox"/> Nerve root blocks <input type="checkbox"/> Pump implantation and removal <input type="checkbox"/> Rhizotomy <input type="checkbox"/> Sphenopalatine lesioning <input type="checkbox"/> Spinal injections <input type="checkbox"/> Thoracic sympathectomy <input type="checkbox"/> Trigeminal lesioning <input type="checkbox"/> Other _____ <input type="checkbox"/> Percutaneous vertebroplasty <input type="checkbox"/> Pacemaker placement <input type="checkbox"/> Polyectomy <input type="checkbox"/> Prenatal care – 1 st Trimester <input type="checkbox"/> Prenatal care – 2 nd Trimester <input type="checkbox"/> Prenatal care – 3 rd Trimester <input type="checkbox"/> Prolotherapy <input type="checkbox"/> Provertin retinal therapy <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Radiopaque dye injection <input type="checkbox"/> Roux-en-Y <input type="checkbox"/> Sclerotherapy <input type="checkbox"/> Spinal fusion <input type="checkbox"/> Spinal surgery, other <input type="checkbox"/> Thoracic surgery _____% <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy/adenoidectomy <input type="checkbox"/> Transgender surgery/hormonal gender conversion <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vascular surgery _____% <input type="checkbox"/> Vasectomy <input type="checkbox"/> None of the above apply to my practice (Initial) _____ <input type="checkbox"/> Other procedures not listed above (Please list) _____ _____ _____
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A. If applying for Obstetrical coverage, indicate:

- i. Average number of deliveries per year _____ Percentage of high-risk deliveries _____
- ii. Average number of VBAC deliveries per year _____ What induction agents do you use on VBAC patients? _____
- iii. Do you have privileges to perform C-sections at each hospital you staff? YES NO
- iv. If you employ a Nurse Midwife, how many deliveries does that individual perform annually? _____ N/A

B. Do you or will you staff an emergency room? YES NO

- i. If "yes," how many hours per week? _____
- ii. If "yes," in what facilities or for what staffing company? _____
- iii. Is this emergency room practice required solely to maintain hospital staff privileges? YES NO

6. ADDITIONAL PROFESSIONAL INFORMATION - If you answer "yes" to any of these questions please provide details.

A. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? YES NO

B. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? YES NO

C. Have you ever been refused hospital privileges? YES NO

D. Have you ever failed any licensing or Board Certification examinations? YES NO
If yes, how many times? _____

E. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? YES NO

F. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? YES NO

G. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? YES NO

H. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue?
YES NO

I. Have you ever been accused of sexual misconduct of any kind?..... YES NO

J. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? YES NO

K. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years?
YES NO If YES, please provide details _____

L. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year?.....
YES NO If YES, please provide details _____

M. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty?..... YES NO

N. Do you provide medical services within the confines of any state, local or federal correctional facility, jail or prison?..... YES NO

O. Do you treat patients in a nursing home or similar facility? YES NO
If YES, how many patients do you treat there per month, on average? _____
Are you contracted with facility or are these your own private practice patients? _____

P. Do you serve as a medical director of a hospital, nursing home, or other facility? YES NO
If YES, please provide details: _____

Q. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (i.e. teleradiology, telemedicine or internet medicine)?.....
YES NO If YES, please provide details: _____

7. EDUCATIONAL INFORMATION

MEDICAL SCHOOLS			
NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING					
INSTITUTION	LOCATION	SPECIALTY OR DEPARTMENT	DATES (MONTH/YEAR)		WAS THE TRAINING FULLY COMPLETED?
			START	END	
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>

8. PRACTICE LOCATIONS HISTORY

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY		
LOCATIONS	DATES (MONTH/YEAR)*	
	START	END

9. PRACTICE ORGANIZATION

- If a Solo Practice: Name of your Corporate entity and/or DBA name: _____
- If a Member of a partnership or multi-shareholder corporation / Partnership/Group Name: _____
- Work as an Employee or Independent Contractor for Other - please explain and provide name of Entity/Practice you are working for: _____

10. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any Ancillary or Allied Health Care Professionals associated with your practice:

Please indicate if coverage is desired for these individuals. A separate application will be required for each individual for whom coverage is requested. N/A Coverage is not required as there are no Ancillary or Allied Health Care providers in the practice.

NAME	SPECIALTY	EMPLOYMENT STATUS	TO BE CONSIDERED FOR SHARED LIMITS COVERAGE?
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No

- B. Do any of your employees practice at a location geographically separate from yours?..... N/A YES NO
- If "yes," please explain. _____

11. HOSPITAL AFFILIATIONS AND PRIVILEGES

HOSPITALS WHERE YOU HAVE, OR HAD, ACTIVE PRIVILEGES OR WHERE YOU HAVE APPLIED						
HOSPITAL DATA			DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE?
NAME	MAILING ADDRESS		START	END		
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

12. PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

Insurance Company Name	# of Closed Claims	# of Pending Open Claims	Policy Dates		Retroactive Date	Tail Coverage Purchased?
			From	To		
Current						
Previous						
Previous						
Previous						
Previous						
Previous						

- A. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? YES NO
- B. In the past 10 years, have you ever been involved in a malpractice claim or suit, either directly or indirectly? (THIS INCLUDES ANY WHICH HAVE BEEN CLOSED or DISMISSED) YES NO
 If "yes," how many? _____
- C. Other than the claims/suits indicated in 12B, are you 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? **If you respond to questions C i. through C v. with a YES response you must provide additional specific details on a separate page.**
 - i. A request for records from a patient and/or attorney related to an adverse outcome?..... YES NO
 - ii. A letter from an attorney regarding your medical treatment of a patient?..... YES NO
 - iii. Intra-operative or post-operative complications or any other type complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? YES NO
 - iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? YES NO
 - v. Any other incidents or circumstances that might reasonably lead to a claim or suit? YES NO

D. HAVE ALL INCIDENTS & 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 PREVIOUS PROFESSIONAL LIABILITY INSURANCE CARRIER? N/A YES NO

IMPORTANT!!!! Please note that a NO answer to question D indicates that you are aware of a potential CLAIM OR SUIT but have not yet reported it to your current insurance company. Using a separate page, please provide the name of the patient you are referring to along with a detailed narrative as to what transpired and the date that the incident in question took place.

I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT MY ANSWERS AND STATEMENTS WILL BE THE BASIS FOR DETERMINING MY INSURABILITY AND PREMIUM FOR THE PROFESSIONAL LIABILITY INSURANCE BEING APPLIED FOR. I FURTHER UNDERSTAND THAT THE COMPLETION AND SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.

ANY PERSON WHO KNOWINGLY OR WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

ACKNOWLEDGED AND AGREED:

Applicant Name (Printed)

Applicant Signature (Required)

Date Signed

PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING – THANKS!

- APPLICATION MUST BE SIGNED AND DATED AT TIME FIRST COMPLETED AND SENT BACK TO US.
- Please provide your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.
- Please provide copies of any applicable current policy endorsements that affect basis of coverage so that we are able to try and obtain coverage aspects equal to or better than what you currently have in place.
- Please provide a copy of an Up-to-date CV (curriculum vitae - also known as a resume).
- Please provide current (*i.e. obtained within 60 days of requested effective date*) Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years – WE WILL BE GLAD TO TRY AND HELP YOU OBTAIN THESE IF NECESSARY.

If you have the need to provide additional info or to elaborate on previous YES responses please do so in the space provided below:

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each. Attach additional sheets if needed for adequate explanation. 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:

- Jury verdict
- Directed verdict

Court outcome in favor of plaintiff:

- Jury verdict
- Directed verdict
- Amt. of loss payment: _____

Unresolved/Open Claim:

- Awaiting mediation
- Awaiting court action

Reserve Amount: _____

9. Name and address of the attorney assigned to your case: _____

10. 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 _____

11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

Signature: _____ **Date:** _____

Name (Printed): _____