



811 Barton Springs Road, Suite 800
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 800-686-2734
 512.275.1830 (Main)
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**APPLICATION FOR PHYSICIAN
 MEDICAL PROFESSIONAL LIABILITY INSURANCE
 CERTIFIED REGISTERED NURSE ANESTHETISTS**

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed. **A curriculum vitae must be attached to this application.**

IF APPROVED, THIS APPLICATION BECOMES PART OF YOUR POLICY

I. PERSONAL INFORMATION

Full Name: _____ CRNA

Home Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Telephone: _____ Cellular Telephone: _____

Primary Office Address: _____

Primary Office Telephone: _____ Primary Office Fax: _____ Tax ID Number: _____

Email Address: _____ Social Security No. _____ Date of Birth: _____

Preferred mailing address Office Home Other _____

II. HOSPITAL PRIVILEGES

Hospital at which you have staff membership or privileges:	City	Nature of Privileges (active, courtesy, etc.):
1).		
2).		
3).		

Have your hospital privileges been expanded during the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or your Board Specialty? Yes No If "Yes," explain: _____

III. COVERAGE REQUESTED

Requested Effective Date: _____ Requested Retroactive Date: _____
 See Certificate or Dec provided

Limits of Liability: _____

Have you purchased or will you be purchasing a Reporting Endorsement --Tail (from Current Carrier) Prior Acts Coverage (from Advocate, MD) Other **please explain** _____

NOTE: Prior Acts Coverage is subject to separate underwriting approval. For your Protection, do not forfeit your right to purchase extended reporting coverage from your current carrier until you are specifically notified in writing that your request for Prior Acts Coverage has been approved.

IV. CURRENT PRACTICE

MEDICAL SPECIALTY: _____ % OF PRACTICE: _____

SUB-SPECIALTY: _____ % OF PRACTICE : _____

Average weekly patient load: _____ Number of weekly practice hours: _____

Have there been any significant changes in your practice during the past 5 years, i.e. changes in specialty, changes in location, addition or deletion of procedures, etc. Yes No If "Yes," please explain: _____



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Medical Professional Liability Insurance
 TYPE OF PRACTICE:

- Are you:
- Yes No Solo PA If yes, do you desire coverage for your Solo Professional Association? Yes No Name _____
 - Yes No Employee of _____
 - Yes No Partner or Shareholder of _____
 If yes, please check one: Partnership Professional Association Limited Liability Partnership Other _____
 - Yes No Locum Tenens

List all partners: _____

V. LICENSURE

A. STATE: LICENSE NO.: EXPIRATION DATE:	STATE: LICENSE NO.: EXPIRATION DATE:
B. NARCOTICS LICENSE NO.:	

VI. CERTIFICATION (Please Check at Least One)

Certified? Yes _____ No _____ on what date? mo/yr _____ / _____	AANA Number#: _____
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VII. CLAIMS INFORMATION

Claims include intent to sue, written demand from patient or lawyer, incidents, withdrawn, settled, etc.

Has any claim or suit for alleged malpractice **ever** been brought against you or are you aware of circumstances that might reasonably lead to such a claim or suit? Yes No **If yes, complete a claim/incident report for each claim.**

Total Number of Claims _____ # of Open / Reserved _____ # of Closed _____

Have you reported all claims and circumstances that might reasonably lead to a claim or suit to your current carrier? Yes No

Attach current letter(s) from prior carrier(s) verifying claims reported.

VIII. MEDICAL PROCEDURES

- A.** Check the appropriate box, indicating the extent of anesthesia you perform: Percentage of time?
- | | |
|--|---------|
| <input type="checkbox"/> Direct Supervision, at all times, by anesthesiologist <u>not</u> involved in own case | _____ % |
| <input type="checkbox"/> Undirect Supervision, at all times, by anesthesiologist involved in own case | _____ % |
| <input type="checkbox"/> No anesthesiologist available at hospital, ambulatory setting, out patient surgical center , etc. | _____ % |

B. Check the following procedures which you administer anesthesia: _____

<input type="checkbox"/>	Abortions - # per year: _____
<input type="checkbox"/>	Acupuncture or acupressure
<input type="checkbox"/>	Adenoidectomies
<input type="checkbox"/>	Anesthesia, general
<input type="checkbox"/>	Angiography, angioplasty, arteriography, cardiac catheterization
<input type="checkbox"/>	Appendectomies
<input type="checkbox"/>	Banding hemorrhoids
<input type="checkbox"/>	Blepharoplasty
<input type="checkbox"/>	Bronchoscopy
<input type="checkbox"/>	Cesarean sections - # per year: _____
<input type="checkbox"/>	Chemabrasion
<input type="checkbox"/>	Circumcision - Other than newborn
<input type="checkbox"/>	Colonoscopy

<input type="checkbox"/>	Cosmetic injection or implants of any kind, including botox, collagens, free fat, silicone
<input type="checkbox"/>	Cosmetic plastic surgery or procedures (elective)
<input type="checkbox"/>	Cosmetic plastic surgery (reconstructive)
<input type="checkbox"/>	Cryosurgery
<input type="checkbox"/>	D & C's
<input type="checkbox"/>	Dermabrasion or laser skin resurfacing
<input type="checkbox"/>	Electro Convulsive Therapy
<input type="checkbox"/>	Endoscopic procedures
<input type="checkbox"/>	Endoscopic Retrograde Cholangiopancreatography
<input type="checkbox"/>	Esophageal Gastro Dilation
<input type="checkbox"/>	Facelift
<input type="checkbox"/>	Fertility / Infertility treatment
<input type="checkbox"/>	Gastric by-pass / stapling or other weight control surgery or procedures
<input type="checkbox"/>	Hair growing, transplants or scalp reduction surgery
<input type="checkbox"/>	Hemorrhoidectomy
<input type="checkbox"/>	Hernias
<input type="checkbox"/>	Hyperbaric Chamber treatment
<input type="checkbox"/>	Hysterectomies
<input type="checkbox"/>	Hypnosis
<input type="checkbox"/>	Insertion of intrauterine or subcutaneous contraceptive devices
<input type="checkbox"/>	Laparoscopy
<input type="checkbox"/>	Lasers – used in therapy or surgery
<input type="checkbox"/>	Liposuction
<input type="checkbox"/>	Lumbar puncture - # per year _____
<input type="checkbox"/>	Needle biopsy
<input type="checkbox"/>	MOHS microscopic surgery
<input type="checkbox"/>	Obstetrical deliveries – # per year: _____
<input type="checkbox"/>	OB deliveries at other than a licensed acute care hospital
<input type="checkbox"/>	Office x-rays – Over read: <input type="checkbox"/> Yes <input type="checkbox"/> No By Whom: _____
<input type="checkbox"/>	Open reductions of fractures
<input type="checkbox"/>	Pain Management – Please explain _____
<input type="checkbox"/>	Prenatal care
<input type="checkbox"/>	Radial keratotomy, LASIX, PRK, AKL, or PTK
<input type="checkbox"/>	Radiation therapy
<input type="checkbox"/>	Spinal anesthesia
<input type="checkbox"/>	Spinal surgery
<input type="checkbox"/>	Telemedicine
<input type="checkbox"/>	Tonsillectomies
<input type="checkbox"/>	Thoracic Surgery _____%
<input type="checkbox"/>	Tubal Ligation
<input type="checkbox"/>	Transplant Surgery
<input type="checkbox"/>	Trigger point injections
<input type="checkbox"/>	Vascular Surgery _____%
<input type="checkbox"/>	Vasectomies
<input type="checkbox"/>	V.B.A.C.'s – # per year _____

IX. ADDITIONAL PROFESSIONAL INFORMATION	
Please give a complete explanation of "Yes" answers below or on additional paper and attach.	
1. Has membership in any professional association or society ever been revoked or refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has any hospital suspended, restricted or refused your staff privileges, or have you voluntarily or involuntarily surrendered or limited your privileges anytime while under peer investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are there or have there ever been any pending actions, proceedings or investigations related to your practice of medicine, to include state Board action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever voluntarily surrendered, been investigated or had a narcotics license refused, suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been treated for alcoholism, narcotic addiction, or mental illness? If "yes," provide a current letter from treating physician, details of rehabilitation program, including dates of treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been indicted, charged or convicted of a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever suffered from or been treated for any chronic illness or physical defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever had any professional liability insurance surcharged, restricted, refused, canceled or non-renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you work in an emergency room, other than to maintain hospital privileges? If "yes," who is coverage provided through?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you work in any free-standing Emergency Center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you work in any free-standing "Birthing Center" or similar facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No

13. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer or medical director of any of the following (please circle where applicable)? Hospital, Sanitarium, Nursing Home, Surgi-Center, Clinic with bed and board facilities, Laboratory (Independent or outside), Blood Bank, Prepaid Health Plan or Health Maintenance Organization, Other medical facility. If you have answered "Yes" by circling any of the foregoing, please list the names of the facilities and your affiliation with them in the space provided at the bottom of the page.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do you practice medicine at this/these institution(s)? Please explain at bottom.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you practice medicine, in whole or in part, as an employee or consultant to a commercial enterprise, governmental body, military service, educational facility or professional sports organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Are you using any advertising or marketing tools or materials? Please provide copies.	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Do you currently have a website? If so, please provide address: http://www.	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Do you render patients unconscious for treatment in your office or other non-hospital facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Do you ever enter into arbitration or similar agreements with your patients? If "yes," submit copies and describe circumstances in which they are used.	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Do you spend more than 50% of your practice time supervising medical students, residents or fellows?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Do you practice or have you previously practiced outside of Texas? Please list all states and dates.	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Are you aware that your present insurer plans to deny, restrict, surcharge, cancel or non-renew?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Have you ever practiced without insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. To your knowledge have you ever been with an insolvent carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Do you employ any other physicians?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Are you an Independent Contractor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanations of "Yes" answers:

Please include Question number with explanation:

X. PRACTICE HISTORY (Please complete if applying for prior acts coverage.)

Did you practice with other physicians/CRNAs in an employer-employee relationship, ostensible or formal partnership, medical association or medical corporation during the period for which you are requesting Prior Acts Coverage? Yes No

If "yes," list the full name(s) of the entity(ies) and physician/CRNA(s) with whom you practiced and the period of each such association. Attach additional pages as needed.

NAME OF ENTITY(IES)	NAME OF PHYSICIAN/CRNAS)	DATES	
		FROM	TO

CHANGES IN PRACTICE:

Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this application for Medical Professional Liability Claims-Made Coverage? Yes No

Did any of your policies contain any coverage restrictions? Yes No

If "Yes," please describe, including all applicable dates. Attach additional pages as needed.

NOTE: Adequate Prior Acts Coverage is contingent upon your description of your former practice.

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 1 of this application to (present date) have been reported to my current Insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

WARRANTY

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

ACKNOWLEDGED AND AGREED:

APPLICANT (Signature Required)

Date:

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Hawaii, Nebraska, Ohio, Oklahoma, Oregon, Utah and Vermont)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, 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.

Applicant's Signature in Full:	Date
Name, including title – Please Print	

THIS APPLICATION IS NOT VALID WITHOUT YOUR COMPLETE SIGNATURE, DATE, TITLE AND PRINTED NAME ABOVE.



SUPPLEMENT TO APPLICATION

CLAIM / INCIDENT REPORT

Please complete this form for **each** claim or incident to which you responded 'YES' on your application. Answer in adequate detail to allow proper evaluation. Attach copies of patient's charts, operative notes or other documents as appropriate.

1. Name of Patient _____ Age _____ Sex _____

2. Incident Request for records Demand for money / Notice of Intent Suit / Legal Proceeding

3. Date of incident ___ / ___ / ___ Date reported ___ / ___ / ___ Date closed ___ / ___ / ___

Location of Incident _____

4. Allegation _____

5. Summary of condition/diagnosis at time of incident _____

6. Narrative description to include your involvement (attending, consultant, surgeon or assistant)

7. Insurance carrier defending your claim _____

8. Other physicians or entities involved _____

9. Disposition of Claim:

Open

Closed without indemnity payment

Settled amount: Yourself - \$ _____ Codefendant - \$ _____ Total: \$ _____ Date: ___ / ___ / ___

Judgment/Verdict: Defense Plaintiff - \$ _____ Yourself - \$ _____ Codefendant - \$ _____

I understand this information is a part of my Professional Liability Insurance application.

Please type or print your name _____

Signature _____ Date ___ / ___ / ___