



Physician and Surgeon Professional Liability Application

Each question of this application is material and must be completed in detail. If a question does not apply, please indicate accordingly. If additional space is needed, please use the Additional Remarks Section at the end of the application.

Section I - Personal Information

Name of Applicant (First, Middle, Last)		<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.
Date of Birth	Place of Birth	Social Security Number
Type of Practice: <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Owner <input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Intern/Resident/Fellow <input type="checkbox"/> Other		
If owner, employee, shareholder, partner, independent contractor, indicate name of facility/entity: _____		

Section II - Practice Locations

Primary Practice Address (Street, City, State, Zip Code)		
County	Primary Practice Phone Number	Primary Practice Fax Number
Home Address (Street, City, State, Zip Code)		
County	Home Phone Number	Home Fax Number
Secondary Practice Address (Street, City, State, Zip Code)		
County	Secondary Practice Phone Number	Secondary Practice Fax Number

- | | | | | |
|----|---|------------------------------|-----------------------------|----------------------|
| 1. | May we communicate with you by fax? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 2. | May we communicate with you by e-mail? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | E-Mail Address _____ |
| 3. | Do you have additional office locations not listed above? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

<u>For Agent's Use Only (If applicable)</u>			
Name of Agency: _____	Name of Agent: _____		
Address: _____	Phone Number: _____		
Signature: _____	Date: _____		
Are you licensed as a property/casualty insurance agent by the Mississippi Department of Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	License Number: _____	Renewal Date: _____
Do you have active Errors and Omissions Insurance Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number: _____	Policy Term: _____ to _____

Section III – Claims-Made Coverage Selection

Important: Coverage offered by the Advocate, MD Medical Malpractice Availability Plan is written on a claims-made form. Coverage will not apply to any medical incident, as defined by the Company, which occurred prior to the date. Failure to obtain Reporting Coverage/Tail Coverage from your expiring carrier may leave you without complete coverage.

Upon cancellation of this claims-made policy it is necessary to purchase either Prior Acts Coverage from your new carrier or Reporting Coverage from the Advocate, MD Medical Malpractice Availability Plan.

1. Requested Effective Date of Coverage: _____ (12:01 a.m. Standard Time)
 Month Day Year

Important: Coverage will become effective only after the completion of all underwriting functions, acceptance by the Company, and receipt of the appropriate payments.

2. Coverage Limit Sought

- \$1,000,000 each medical incident/\$3,000,000 annual aggregate
- \$500,000 each medical incident/\$2,000,000 annual aggregate

3. Type (select one)

- Private/Group Practice
- Political Subdivision or Employee of Political Subdivision

Section IV - Insurance History

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<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

- 1. Have you ever practiced without professional liability coverage? Yes No
- 2. Has your professional liability coverage ever been written with a non-admitted carrier? Yes No
- 3. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? Yes No
- 4. Have you ever had your request for coverage denied, your policy cancelled or non-renewed or had a policy issued to you that contained restrictions or special exclusions? Yes No
- 5. Are you engaged in moonlighting activities? Yes No
 If yes, do you have other professional liability insurance for the work that you perform elsewhere? Yes No
 If yes, is coverage desired for moonlighting activities? Yes No

If the answer to questions 1 - 5 above is "Yes", please provide dates and explanations below:

Section V - Medical Training

Name of Medical School(s) Attended	Location	Degree	Date Graduated

Name of Hospital Where Internship Served		Location of Hospital Where Internship Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Name of Hospital Where Residency Served		Location of Hospital Where Residency Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Name of Hospital Where Fellowship Served		Location of Hospital Where Fellowship Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- If you are a Foreign Medical School Graduate, are you certified by the Educational Council for Foreign Medical Graduates or have you completed the Fifth Pathway Program? Yes No
(If Yes, please provide copy of Certificate)
- Do you average fewer than 40 hours of Category I CME units every two years? Yes No
in your specialty (ies)?

Section VI - Practice Information

List all states where you are licensed to practice and license numbers:

State	License Number	Status Code	% of Patients seen, examined or treated in each state
Mississippi			

Status Code - A = Active, I = Inactive, P = Pending, T = Temporary

List all locations where you have practiced in the last five years. Do not include training programs but include all moonlighting positions.	Start Date and End Date (m/y)

Please provide the name and location of all hospitals where you hold active staff or courtesy privileges. Indicate below if you want a Certificate of Insurance issued to these facilities, on your behalf.

Name	Complete Mailing Address	Nature of Privileges	Certificate Desired? <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

1. How many scheduled patients do you see per week? _____
2. How many walk-in patients do you see per week? _____
3. How many hours do you work per week? _____
4. Do you provide services to Medicaid recipients, State and School Employees Health Insurance Program participants and Children's Health Insurance Program participants? Yes No
5. Do you market, advertise, or practice medicine outside Mississippi? Yes No
6. In the past 5 years, has there been a change in your medical specialty, sub-specialty or the procedures you perform? Yes No
7. In the past 5 years, has there been a change in the number of hours you work per week? Yes No
8. Are you subject to the Federal Tort Claims Act? Yes No
9. DEA License Number: _____

If the answer to questions 5 -8 above is "Yes", please provide dates and explanations below:

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Section VII – Paramedical Health Care Providers

Following is list of Paramedical Health Care Providers for which coverage does not extend automatically. Shared limits of liability or Separate limits of liability may be available, for an additional premium charge, to your employees while acting within the scope of their employment to you. Each employed Paramedical Health Care Provider listed below is required to complete an individual Paramedical Health Care Provider Application if coverage is desired.

Physician Assistants, Surgeon Assistants, Certified Nurse Midwives, Certified Nurse Practitioners, Psychologists, Emergency Medical Technicians, Perfusionists, Chiropractors, Certified Registered Nurse Anesthetists, Cytotechnologists, Optometrists, Podiatrists.

1. Do you employ, contract, or provide supervision (to non-employees) to any of the above listed Paramedical Health Care Providers? Yes No
2. If you supervise CRNAs, what is the average CRNA/MD Ratio? (____ / ____) NA

List all such Paramedical Health Care Providers and indicate if you employ, contract, or only provide supervision:

Name	Designation	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted <input type="checkbox"/> Supervise Only
Name	Designation	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted <input type="checkbox"/> Supervise Only
Name	Designation	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted <input type="checkbox"/> Supervise Only
Name	Designation	<input type="checkbox"/> Employed <input type="checkbox"/> Contracted <input type="checkbox"/> Supervise Only

Section VIII -Business Entity

Name of Business Entity		
Type: <input type="checkbox"/> Partnership <input type="checkbox"/> L.L.C. <input type="checkbox"/> Association or Corporation <input type="checkbox"/> Solo Incorporated (No Employed or Contracted Physicians) <input type="checkbox"/> Other		
Retroactive Date Used by Current Carrier	Corporate Tax Identification Number	Date of Incorporation

List the full name, status, current professional liability carrier and coverage information for each and every other physician or surgeon affiliated with the business entity:

Full Name	Status Code *	Name of Current Carrier	Is Coverage Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name	Status Code *	Name of Current Carrier	Is Coverage Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name	Status Code *	Name of Current Carrier	Is Coverage Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name	Status Code *	Name of Current Carrier	Is Coverage Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full Name	Status Code *	Name of Current Carrier	Is Coverage Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No

* Status Codes - E = Employee, P = Partner, C= Independent Contractor **(Each member is required to submit an individual application)**

- Do you have any office or expense sharing arrangements with any other physician(s) or practice group(s) not disclosed above? Yes No
- Are there any subsidiaries of this business entity that provide health care related services? Yes No
- Is the entity eligible to be licensed to provide medical professional services? (If yes, has licensed been issued and by whom?) Yes No
- Is coverage desired for a business entity? Yes No
If yes, is a separate limit or shared limited of liability desired for the business entity? Separate Limit Shared Limit

Remarks Section for Questions 1-4:

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Section IX - Rating Information

- What is your medical specialty? _____ What is your medical sub-specialty? _____
- Are you American Board Certified in your specialty? Yes No
(If yes, please provide copy of Certificate. If No, please provide explanation)
- Are you American Board Certified in your Sub-Specialty? Yes No
(If yes, please provide copy of Certificate. If No, please provide explanation)
- Indicate percentage of time devoted to the following medical and/or surgical activities: (total should equal 100%)

% _____ Abdominal Surgery _____ Allergy _____ Anesthesiology _____ Bariatric Medicine _____ Cardiac Surgery _____ Cardiovascular Diseases _____ Cardiovascular Surgery _____ Colon & Rectal Surgery _____ Dermatology _____ Dermatology-Surgery _____ Emergency Medicine _____ Endocrinology _____ Family/General Practice _____ Family/General w/ OB _____ Family/General w/ Surgery _____ Forensic Medicine _____ Gastroenterology _____ General Surgery	% _____ Gynecology _____ Gynecology-Surgery _____ Hand Surgery _____ Head & Neck Surgery _____ Hematology _____ Hospitalist _____ Infectious Diseases _____ Intensive Care Medicine _____ Internal Medicine _____ Legal Medicine _____ Neonatology _____ Neonatology-Surgery _____ Nephrology _____ Nephrology w/ Dialysis _____ Neurology _____ Neurosurgery _____ Nuclear Medicine _____ Nutrition	% _____ Obstetrics _____ Obstetrics/Gynecology _____ Occupational Medicine _____ Oncology-Medical _____ Oncology-Surgery _____ Ophthalmology _____ Ophthalmology-Surgery _____ Office Orthopedics _____ Orthopedic Surgery _____ Otolaryngology _____ Otorhinolaryngology _____ Otorhinolaryngology/Plastic _____ Otorhinolaryngology/Surgery _____ Pathology _____ Pain Management _____ Pain Management-Surgery _____ Pediatrics _____ Pharmacology-Clinical	% _____ Psychiatry _____ Physical Med. & Rehab. _____ Plastic Surgery _____ Psychiatry _____ Psychoanalysis _____ Public Health _____ Pulmonary Diseases _____ Radiology-Diagnostic _____ Radiology-Therapeutic _____ Rheumatology _____ Thoracic Surgery _____ Traumatic Surgery _____ Urgent Care Medicine _____ Urological Surgery _____ Vascular Surgery _____ Other: _____
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5. Do you perform? (Check all boxes that apply)

- No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia
- Perform minor surgical procedures
- All other types of surgery and procedures performed under general anesthesia and assisting in surgery on own patients and patients of others
- Obstetrics including normal deliveries and c-sections

6. Indicate which of the following medical or surgical procedures you perform:

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Amputations <input type="checkbox"/> Anesthesia <ul style="list-style-type: none"> <input type="checkbox"/> Spinal <input type="checkbox"/> Caudal <input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <ul style="list-style-type: none"> <input type="checkbox"/> Coronary <input type="checkbox"/> Peripheral <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Assist in Surgery <ul style="list-style-type: none"> <input type="checkbox"/> On own patients <input type="checkbox"/> On patients of others <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implants <ul style="list-style-type: none"> <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Cancer Chemotherapy <input type="checkbox"/> Catheterization <ul style="list-style-type: none"> <input type="checkbox"/> Arterial, Cardiac, or Diagnostic <input type="checkbox"/> Occasional emergency insertion of pulmonary wedge, Pressure recording catheter, temporary pacemakers, Urethral catheterization, umbilical cord catheterization For diagnostic purpose or for monitoring blood gases in Newborns receiving oxygen <input type="checkbox"/> Cervical Conization <input type="checkbox"/> Cesarean Sections # per year _____ <input type="checkbox"/> Chelation Therapy <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Circumcision <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cosmetic Injections <input type="checkbox"/> Cryosurgery <ul style="list-style-type: none"> <input type="checkbox"/> On benign dermatological lesions <input type="checkbox"/> Other <input type="checkbox"/> Dilation and Curettements <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Diagnostic Sonography | <ul style="list-style-type: none"> <input type="checkbox"/> Dermatological Surgery <ul style="list-style-type: none"> <input type="checkbox"/> Chemical Peels <input type="checkbox"/> Chemabrasion <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Fat Transfer <input type="checkbox"/> Hair Transplants <input type="checkbox"/> Silicone Injections <input type="checkbox"/> Tumescent Liposuction <input type="checkbox"/> Cosmetic/Reconstructive Skin Flaps and Skin Grafts <input type="checkbox"/> Other <input type="checkbox"/> Elective Abortions <input type="checkbox"/> Electroshock Therapy <input type="checkbox"/> Encephalography <input type="checkbox"/> Endoscopic Laser Therapy <input type="checkbox"/> Endoscopy <ul style="list-style-type: none"> <input type="checkbox"/> Proctoscopy, Sigmoidoscopy, Colposcopy, Cystoscopy <input type="checkbox"/> Other <input type="checkbox"/> ERCP <input type="checkbox"/> Exchange Transfusions in Newborns <input type="checkbox"/> Fertility or Reproductive Surgery <input type="checkbox"/> Fiberoptic Bronchoscopy <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reductions <ul style="list-style-type: none"> <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hair Transplant <input type="checkbox"/> Hip Nailings <input type="checkbox"/> Hyperbaric Medicine <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Intensive Care for Newborns within a Tertiary Care Unit <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopic Cholecystectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Laser Skin Resurfacing <input type="checkbox"/> Laser Surgery <input type="checkbox"/> Left Heart Catheterization <input type="checkbox"/> Liposuction <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Lumbar Fusion <input type="checkbox"/> Mammography <input type="checkbox"/> Minimal Invasive Endoscopic Surgery <input type="checkbox"/> Myelography | <ul style="list-style-type: none"> <input type="checkbox"/> Needle Biopsy <ul style="list-style-type: none"> <input type="checkbox"/> Lung, Liver, Kidney, or Prostate <input type="checkbox"/> Other <input type="checkbox"/> Nerve Blocks <input type="checkbox"/> Norplant Insertion/Extraction <input type="checkbox"/> Obesity Surgery <input type="checkbox"/> Obstetrical Procedures <ul style="list-style-type: none"> <input type="checkbox"/> Normal Deliveries # per year _____ <input type="checkbox"/> C-Sections # per year _____ <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Pain Management <ul style="list-style-type: none"> <input type="checkbox"/> Medication Only <input type="checkbox"/> Dorsal Root Gangliotomies <input type="checkbox"/> Epidural Injections <input type="checkbox"/> Thoracic Sympathectomies <input type="checkbox"/> Spinal Cord Stimulators <input type="checkbox"/> Drug Infused Pumps <input type="checkbox"/> Sphenopalatine Lesioning <input type="checkbox"/> Cordotomies <input type="checkbox"/> Trigeminal Lesioning <input type="checkbox"/> Pedicle Screws for Spinal Surgery <input type="checkbox"/> Penile Implants <input type="checkbox"/> Percutaneous Disc Surgery <input type="checkbox"/> Peritoneoscopies <input type="checkbox"/> Permanent Pacemaker <input type="checkbox"/> Plastic Surgery <ul style="list-style-type: none"> <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Polypectomy <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Radial Keratotomy <input type="checkbox"/> Radiation/X-Ray Therapy <input type="checkbox"/> Radiopaque Dye <input type="checkbox"/> Scoliosis Surgery <input type="checkbox"/> Shock Therapy <input type="checkbox"/> Spinal Surgery <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomies/Adenoidectomies <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Trigeminal Lesioning <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Weight Control <ul style="list-style-type: none"> <input type="checkbox"/> Gastric Bubble <input type="checkbox"/> Gastric Stapling <input type="checkbox"/> None of the above apply to my practice |
|---|--|---|

7. If you are applying for coverage for an obstetrical practice, do you have privileges to perform C-sections at each hospital you staff? NA Yes No
8. Other than local or topical anesthesia, do you administer any anesthetics or parenteral sedation outside of a hospital setting? NA Yes No
(If yes, please explain type and emergency equipment and/or procedures)
9. Do you perform any procedure not usual or customary to your specialty? Yes No
10. Do you perform any diagnostic or therapeutic procedures which have been introduced to you and/or the medical profession within the past 18 months? Yes No
11. Do you participate in pharmaceutical testing /clinical investigation studies that are not FDA approved? Yes No
12. Do you practice any forms of alternative medicine, including chiropractic, holistic, Chinese, naturopathic, Homeopathic, ayurvedic? Yes No
13. Have you performed and/or do you currently perform silicone breast implants? Yes No
14. Do you practice in or staff an urgent care center, walk-in urgi-center or similar minor emergency clinic? Yes No
15. Do you work in an emergency room?
If yes, is coverage being requested for this work? (Please provide verification of separate coverage)
If yes, are you: ATLS Certified? ACLA Certified? PALS Certified? Yes No
16. Are you employed full time by the Federal Government or are you in active duty in the military service? Yes No
17. Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? Yes No
18. Do you own or operate a surgery center, facility, laboratory, or other outpatient facility? Yes No
19. Do you do outside peer reviews or medical exams, or have a contract with an insurance company to do reviews? Yes No
20. Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program? Yes No
21. Do you provide any diagnostic, consulting or other professional services to patients in states other than those in which you are currently licensed, including but not limited to the use of telecommunication technology? Yes No
22. Do you treat or review treatment of any state, local federal correction facility, jail or prison? Yes No
23. Do you perform any coroner duties? Yes No
24. Do you serve as a Medical Director? Yes No
25. Do you practice as a Company Physician? Yes No
26. Do you or your employees make home health care, nursing home or similar facility visits? Yes No
27. Do you presently advertise via internet, yellow pages, newspaper, radio, television, etc?
(Please provide copies of your written advertisements) Yes No
28. Do you use a collection agency, which has the authority to file collection suits without your knowledge? Yes No

If the answer to questions 7 - 28 above is "Yes", provide detailed explanation below.

29. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation or reprimand ever been invoked? Yes No
30. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation or reprimand ever been invoked? Yes No
31. Have you ever been evaluated, recommended for treatment, diagnosed with, treated, or received medication for: alcohol or narcotics dependency, any other substance abuse, sexual addiction, or a mental, physical, or emotional condition? Yes No
If yes, have you had a relapse following your initial treatment? Yes No
32. Have you ever been asked to participate in or have you volunteered to participate in an impaired physician program? (If yes, please attach a copy of your recovery plan) Yes No

33. Have you ever been denied a medical license or been denied certification by a specialty board? Yes No
34. Have you ever been accused of sexual misconduct of any kind? Yes No
35. Has a patient or his representative ever filed a complaint or grievance against you with a hospital committee, state licensing or regulatory agency or other medical review committee? Yes No
36. Other than a minor traffic offense, have you ever been indicted for, charged with, convicted of, pled guilty to, or entered into a plea agreement for a violation of any law or ordinance? Yes No
37. Have you had any injury, illness, or other event occur that may impair, lessen, or diminish your physical or mental ability to practice medicine? Yes No
38. Have you ever appeared before, been investigated by (including ongoing investigations), or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes No
39. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees or has your ability to participate been revoked, suspended, placed on probation or voluntarily surrendered? Yes No

If the answer to questions 29 - 39 above is "Yes", provide detailed explanation below.

Section X - Loss Information

1. Are you now, or have you ever been involved, directly or indirectly in a claim, potential claim, or a suit arising out of the rendering or failing to render professional services? Yes No
- If "Yes" A. Indicate number closed, dropped, dismissed _____
- B. Indicate number pending or open _____
- C. Total number of cases (A+B) _____
- If "Yes," Have all claim/suits indicted in "C" above been reported to your current or prior professional liability carrier? Yes No
2. Other than those claims/suits indicated in question 1 above, do you have knowledge of any incident, potential claim, suit, or circumstances that might reasonably lead to a claim or suit being brought against you arising out of the rendering or failing to render professional services? Yes No
- If "Yes" How many? _____
- If "Yes" Have all 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 prior professional liability carrier? Yes No

Important: For each loss indicated in questions 1 and 2 above, please complete the attached Supplementary Loss Information Form and please provide a 5-Year Carrier Loss Run from your current and/or previous professional liability carrier(s). The Loss Run should include date of occurrence, date of report, description, indemnity amount paid, indemnity amount reserved, defense amount paid, defense amount reserved and current status.

Additional Remarks Section

Please Read and Sign

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS COMPLETE, ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MISREPRESENTATIONS IN THIS APPLICATION MAY RESULT IN CANCELLATION OR RESCISSION OF COVERAGE. I FURTHER AGREE TO REMIT PREMIUMS FOR COVERAGE IN A TIMELY MANNER TO THE ADVOCATE, MD MEDICAL MALPRACTICE AVAILABILITY PLAN AND UNDERSTAND THAT FAILURE TO PAY SUCH PREMIUM IN A TIMELY AGREED MANNER MAY RESULT IN CANCELLATION OF COVERAGE.	
_____ Applicant Signature	_____ Date

Application Checklist:

- Copy of most current Professional Liability Declarations Page
- Five-year Company Loss History
- Copy of Mississippi Medical License
- Curriculum Vitae
- Copy of Business Letterhead
- Supplemental Loss Information for each loss
- Signature and Date on Application
- Certification Form
- Verification of Extended Reporting Coverage, if applicable
- Copy of American Board Certification, if applicable
- Copy of Education Council for FMG or Fifth Pathway Program Certification, if applicable

Return Application to the Underwriting Department at:

**Advocate, MD
811 Barton Springs Road
Suite 800
Austin, TX 78704
Phone: 888-239-2501
Fax: 512-275-1240**

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section X - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

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

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only Suit threatened, no action taken Suit filed but dropped by claimant
- Summary judgment in your favor Jury verdict in your favor Jury verdict in favor of the plaintiff
- Suit settled out of court Suit filed awaiting mediation Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

-
If open, amount of loss reserve: _____

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section X - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

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

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only Suit threatened, no action taken Suit filed but dropped by claimant
- Summary judgment in your favor Jury verdict in your favor Jury verdict in favor of the plaintiff
- Suit settled out of court Suit filed awaiting mediation Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____