



# Voluntary Attending Physicians (VAP) Application for Professional Liability Insurance

Please return the original application, along with a **copy of your New York State professional license**, and the primary and excess **declaration page(s) from your current insurance policy** (if applicable). **All questions must be answered.** If a question is not applicable, write "NONE." \*Insurance cannot be placed until application is approved and premium is received.

## General Information

1. Name: \_\_\_\_\_  
LAST FIRST MD, DO, DDS, DMD

2. I currently have privileges at (this hospital will be designated as your Sponsor Hospital): \_\_\_\_\_

- Bronx Lebanon Hospital Center
- Mount Sinai Beth Israel
- Mount Sinai Roosevelt
- Maimonides Medical Center
- Mount Sinai Beth Israel Brooklyn
- Mount Sinai St. Luke's
- Montefiore Medical Center
- Mount Sinai Hospital
- New York Eye & Ear Infirmary of Mount Sinai
- Montefiore Mount Vernon
- Mount Sinai Queens
- White Plains Hospital
- Montefiore New Rochelle

3. The desired effective date of coverage is: \_\_\_\_\_

4. Residence: \_\_\_\_\_  
STREET APT CITY STATE ZIP CODE

PHONE NUMBER FAX EMAIL ADDRESS

Date of Birth: \_\_\_\_\_ Sex:  Male  Female  
MM DD YYYY

Federal DEA Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

New York State Professional License Number: \_\_\_\_\_

Do you have a license to practice outside of New York State?  Yes  No

If yes, provide state(s) and license #(s)? \_\_\_\_\_

Status of other license(s) \_\_\_\_\_

What percentage (%) of your practice is located outside of New York State? \_\_\_\_\_

5. Principal Office (the office where you see the majority of your patients)

ADDRESS APT/SUITE

CITY STATE ZIP CODE

OFFICE PHONE OFFICE FAX OFFICE EMAIL

All correspondence will be sent to your principal office unless you specify your residence by checking here

6. Other office locations:

_____	_____	_____	_____
STREET	CITY	STATE	ZIP CODE
_____	_____	_____	
OFFICE PHONE	OFFICE FAX	OFFICE EMAIL	
_____	_____	_____	_____
STREET	CITY	STATE	ZIP CODE
_____	_____	_____	
OFFICE PHONE	OFFICE FAX	OFFICE EMAIL	

An **Occurrence Policy covers** claims brought against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice during the policy period, regardless of when the claim is made. As long as you provided (or failed to provide) those professional services during the policy period, a related claim is covered no matter when it is brought against you.

A **Claims Made Policy covers** claims made against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice as long as the claim is first made against you and reported during the policy period or within 60 days after expiration of the policy or any renewal thereof. You must have provided (or failed to provide) these professional services on or after the retroactive date and before the end of the policy period **and** the claim must first be reported to the company during the policy period or within 60 days following any termination of coverage. A claim is not covered under this policy unless **both** conditions are met. (See page 10.) An Optional Extended Reporting Period Endorsement may be purchased, which would provide an unlimited time period to report claims.

7. Coverage type requested:  Occurrence  Claims made (complete pages 10 and 11)

**Professional Activities**

1. Specialty (ies): \_\_\_\_\_

a. Coverage requested for Code (see page 12) \_\_\_\_\_ Specialty \_\_\_\_\_

b. Sub-specialty: \_\_\_\_\_

c. Board Certification(s) \_\_\_\_\_

_____	_____
SPECIALTY	DATE ACQUIRED
_____	_____
SPECIALTY	DATE ACQUIRED

2. Date first licensed as a professional: \_\_\_\_\_

MM DD YYYY

Medical School: \_\_\_\_\_ Degree Year \_\_\_\_\_

Internship/Residency: \_\_\_\_\_ Year Completed \_\_\_\_\_

Residency: \_\_\_\_\_ Year Completed \_\_\_\_\_

Fellowship: \_\_\_\_\_ Year Completed \_\_\_\_\_

If you have completed a residency or fellowship in the past 90 days, please check here

3. Licensing board/governmental agency disciplinary proceedings:

- a. Has your license to practice ever been revoked in any state?  Yes, specify MM/YY \_\_\_\_\_  No
- b. Has your license to practice ever been suspended/restricted in any state?  Yes, specify MM/YY \_\_\_\_\_  No
- c. Has your license to practice ever been voluntarily surrendered?  Yes, specify MM/YY \_\_\_\_\_  No
- d. Have you ever been placed on probation in any state?  Yes, specify MM/YY \_\_\_\_\_  No
- e. Has your permit to prescribe medications ever been denied/revoked?  Yes, specify MM/YY \_\_\_\_\_  No
- f. Has your permit to prescribe medications ever been restricted/ voluntarily surrendered?  Yes, specify MM/YY \_\_\_\_\_  No
- g. Are there any investigative or disciplinary actions by any governmental agency currently pending against you in any state?  Yes, specify MM/YY \_\_\_\_\_  No

Please provide details for any 'Yes' answers above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?  Yes, specify MM/YY \_\_\_\_\_  No

5. Healthcare facility/professional medical association disciplinary proceedings (exclude disciplinary proceedings for lateness in record keeping and/or lateness in submitting proof of insurance coverage.)

- a. Have your privileges been revoked by any hospital/other institution/managed care organization?  Yes, specify MM/YY \_\_\_\_\_  No
- b. Have your privileges ever been restricted or suspended by any hospital/other institution/managed care organization?  Yes, specify MM/YY \_\_\_\_\_  No
- c. Are you aware of any disciplinary proceedings pending against you?  Yes, specify MM/YY \_\_\_\_\_  No
- d. Have you ever voluntarily relinquished privileges at any hospital/other institution/managed care organization?  Yes, specify MM/YY \_\_\_\_\_  No

Please provide details for any 'Yes' answers above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. As of the effective date of this insurance, will you be practicing as:

- a. A solo private practitioner?  Yes  No
- b. An employee of a partnership, professional corporation, group or physician/surgeon?  Yes  No
- c. A full-time or part-time hospital employee?  Yes  No  
If yes, provide hospital name and hours worked per week \_\_\_\_\_
- d. A full-time or part-time employee of a nursing home, managed care facility or other health care facility?  Yes  No
- e. An independent contractor?  Yes  No If yes, with whom are you under contract? \_\_\_\_\_

7. Indicate each hospital, nursing home, managed care facility and/or other health care facility where you **have had** privileges to treat patients during the past 12 months or to which you are (applying for privileges.) Provide the number (not percentage) of admissions, consultations and/or procedures performed at each facility.

**It is a requirement of the Hospitals Insurance Company Inc. (HIC) VAP Program that physicians who admit 50 or more patients per year, admit at least half of their patients who require hospitalization to his/her sponsor hospital.**

FACILITY	POSITION	NUMBER OF ADMISSIONS	NUMBER OF CONSULTS	NUMBER OF SURGERIES/DELIVERIES/PROCEDURES

AMBULATORY SURGERY CENTER	NUMBER OF SURGERIES/PROCEDURES

8. Indicate average number of patients seen at your office locations per week \_\_\_\_\_

## Insurance History

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1. List your insurance history for the past ten (10) years (new graduates should include residency).

Insurer \_\_\_\_\_ Policy Number \_\_\_\_\_ From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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Insurer \_\_\_\_\_ Policy Number \_\_\_\_\_ From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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Insurer \_\_\_\_\_ Policy Number \_\_\_\_\_ From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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Insurer \_\_\_\_\_ Policy Number \_\_\_\_\_ From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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2. Is your current policy Claims Made?  Yes (If yes, complete pages 10 and 11)  No
3. Has any insurer ever canceled, declined, refused to renew, or restricted professional liability insurance to you, or offered such insurance to you with a deductible or at higher than regular rates?  Yes  No Date \_\_\_\_\_  
If yes, explain, include name of company \_\_\_\_\_
4. Have you ever been surcharged by any insurer?  Yes  No  
If yes, explain, and provide date \_\_\_\_\_  
Have you received notice that a surcharge will be imposed in a future period?  Yes  No  
If yes, explain, and provide name of company \_\_\_\_\_
5. Have you ever practiced without professional liability insurance?  Yes  No  
If yes, provide details, including dates \_\_\_\_\_

## Claim Information

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6. Have you ever had a malpractice claim or suit (closed or pending) asserted against you?

Yes, provide number of claims \_\_\_\_\_  No

**If yes, complete the Claim Information section on pages 17-19 for each case.**

7. Are you aware of any event(s) or incident(s) that may or will result in a claim against you?  Yes  No

If yes, provide details of each and specify which have been reported to your current professional liability insurer.

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## Business Entities

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1. Are you a medical director, department head or chief of staff at a hospital, nursing home, HMO, managed care facility or other health care facility?  Yes  No

If yes, please provide the following information for *each* facility

Facility \_\_\_\_\_

Insurance carrier \_\_\_\_\_

2. Do you own or operate a hospital, nursing home, clinic, laboratory, sanitarium, dispensary or other medically related business?

Yes  No

If yes, provide official corporate name \_\_\_\_\_

Type of operation/services offered \_\_\_\_\_

Your relationship to business \_\_\_\_\_

Insurance carrier \_\_\_\_\_

3. Are you a partner, shareholder, owner or officer of a medical partnership, professional corporation, association, joint venture or other health care facility?  Yes  No

a. Please specify type:  medical partnership  professional corporation  association  joint venture  other

b. What is the name of the entity?

\_\_\_\_\_  
NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

c. Date of formation \_\_\_\_\_

d. Professional liability insurance carrier of the entity \_\_\_\_\_

4. Are you an employee, member or independent contractor of a medical partnership, professional corporation, association, joint venture or other health care facility?  Yes  No
- a. Please specify type:  medical partnership  professional corporation  association  joint venture  other
- b. What is the name of the entity?

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

- c. Date of formation \_\_\_\_\_
- d. Professional liability insurance carrier of the entity \_\_\_\_\_

**Your individual Hospitals Insurance Company, Inc. (HIC) policy will provide professional liability coverage for the professional entity only if 50% or more of the entity owners (e.g., shareholders, partners, members, etc.) maintain primary professional liability coverage with HIC. Therefore, you must list the name of each entity owner and his/her respective primary professional liability carrier. Incomplete information or a change in the relevant percentage of entity owner to below 50% after the date of your application may preclude HIC from providing liability coverage to your corporation.**

Entity owner (if there are additional owners, please attach additional pages)

Name \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Name \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Name \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

5. Do you individually, or does your professional entity, employ or contract with other physicians, surgeons or dentists?  
 Yes  No

If yes, please list: Name \_\_\_\_\_ Relationship to entity \_\_\_\_\_

Medical specialty \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Name \_\_\_\_\_

Medical specialty \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Relationship to entity \_\_\_\_\_

Name \_\_\_\_\_

Medical specialty \_\_\_\_\_

Primary liability carrier \_\_\_\_\_

Relationship to entity \_\_\_\_\_

6. Do you individually, or does your professional entity, employ or contract with any nurse-midwife, nurse-anesthetist, nurse practitioner, podiatrist, chiropractor, radiation therapist, physician's assistant or registered specialist's assistant?

Yes  No

**Please note that your HIC policy will not provide you with coverage for your liability arising out of the acts or omissions of any employed physicians, dentists, nurse-midwives, nurse-anesthetists, nurse-practitioners, podiatrists, chiropractors, radiation therapists, physician's assistants or registered specialist's assistants.**

If yes, provide name, profession and license number of each such person:

Name \_\_\_\_\_

Profession \_\_\_\_\_ License \_\_\_\_\_

Name \_\_\_\_\_

Profession \_\_\_\_\_ License \_\_\_\_\_

7. Have you signed, or will you sign, any contract or agreement to assume the liability of others?  Yes  No

**Please note that your HIC policy will not provide you with coverage for liability of others that you assume by contract or agreement.**

### Part-time Private Practice Coverage

Hospitals Insurance Company, Inc. (HIC) provides a discounted premium to part-time physicians and surgeons whose total practice covered under a HIC policy does not exceed **20 hours in any given week**. Part-time private practice coverage is not available to the following premium classes: **Cardiothoracic Surgery, Neurosurgery, Obstetrics and Orthopedic Surgery**.

Use the table below to record the number of hours spent weekly in the portion of your practice to be covered by the HIC part-time policy for which you are applying. (Include all professional activity as a physician or surgeon, including patient care, record keeping, consultation, hospital rounds, accreditation and other review functions on behalf of a hospital, long-term care facility, medical group or professional society.) A change in status may be considered after a six month period has elapsed.

**Hours by Day of Week**

	IN OFFICE	IN HOSPITAL	OTHER	HOSPITAL/FACILITY NAME(S) (Please Print)	TOTAL HOURS
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
<b>TOTAL</b>					

Number of hours per week that are or will be covered by insurance **other** than HIC \_\_\_\_\_ (if none, write none).



Describe all activities covered by such insurance and name the insurance company (ies) and policy number(s) \_\_\_\_\_

Number of hours per week for which you require coverage under a HIC policy \_\_\_\_\_

This is to certify that my practice (including all locations), other than time devoted to teaching activities, is limited to not more than 20 hours per week. As a further condition for a reduced premium, I herein consent to an audit of my records to substantiate the limited hours of practice to be covered by Hospitals Insurance Company, Inc.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

**NOTE:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 WILL INVALIDATE YOUR INSURANCE COVERAGE.

## Discounts

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### No Consent Discount

I hereby authorize Hospitals Insurance Company, Inc., in exchange for a discount to my basic premium, to settle any and all claims brought against me without my consent.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

## Certifications

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### Risk Management Course

I have completed a New York State Insurance Department approved risk management course with my present carrier.

Provider \_\_\_\_\_ Date of completion \_\_\_\_\_

### Submit proof of course completion

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

## For Claims Made Policies *Only*

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If coverage is selected on a Claims Made basis (individual and professional partnership/corporation/association), please note the following:

1. The policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts that took place prior to the retroactive date stated in the policy.
2. The policy covers only claims against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice. You must have provided (or failed to provide) these professional services on or after the retroactive date and before the end of the policy period **and** the claim must be first reported to the company during the policy period or within 60 days following any termination of coverage. (A claim is not covered under this policy unless **both** conditions are met.)
3. The automatic extended reporting period coverage is not unlimited and potential coverage gaps may arise upon its expiration unless the named insured purchases Optional Extended Reporting Endorsement Coverage. Optional Extended Reporting Endorsement coverage covers you for claims which are first reported to the company **after** the 60<sup>th</sup> day following any termination of coverage. **Optional extended reporting endorsement coverage does not extend the period during which you may provide professional services.** Optional extended Reporting Endorsement Coverage is valid for an unlimited time period, except that it may be cancelled by the company if you fail to pay the premium for this coverage when it is due.
4. During the first several years of the Claims Made relationship, Claims Made rates are comparatively lower than occurrence rates. The named insured can expect substantial annual premium increases, independent of overall rate level increases, until the Claims Made relationship reaches maturity.

5. Prior acts (nose/retroactive) coverage

- a. Is this policy to replace an existing Claims Made policy?  Yes  No
- b. Do you wish (nose) coverage beginning on the initial issue date of your expiring Claims Made policy  Yes  No

The desired effective date of coverage is (see general Information page 1, number 3) \_\_\_\_\_

The desired retroactive date of policy is: \_\_\_\_\_

- c. Do you know of any events or incidents that may lead to potential claims, for medical services you provided that occurred during the period for which prior acts coverage is desired, that have not been reported to the previous carrier of record?  
 Yes  No

If yes, please explain (attach additional pages if necessary) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- d. If prior acts (nose/retroactive) coverage is desired for a time period covered by another insurer, list the following

_____	_____	_____
CARRIER	POLICY NUMBER	DATES OF POLICY

_____	_____
SIGNATURE OF APPLICANT	DATE

- e. Indicate if and how any classification (*i.e.* specialty, full-time to part-time) or territory has been modified since you **first** entered into the Claims Made program.

Type of change \_\_\_\_\_

Effective date of change \_\_\_\_\_

Type of change \_\_\_\_\_

Effective date of change \_\_\_\_\_

If you ever made changes to your specialty classification (as noted above) and changes have occurred or if you are requesting a change now, please provide your prior insurance history for all Claims Made policies including name and address of insurance carrier, policy numbers and dates of coverage since you first entered into the Claims Made program.

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

Insurer name and address \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage dates \_\_\_\_\_

I authorize the Hospitals Insurance company, Inc. to verify the above information with my prior insurance carriers.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

## Specialty Classifications

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### PREMIUM CLASS 1

- 80152 Neurosurgery

### PREMIUM CLASS 2

- 80144 General Surgery (*including* bariatric surgery)

### PREMIUM CLASS 3

- 80153 Obstetrics and Gynecology

### PREMIUM CLASS 4

- 80143 General Surgery (*excluding* bariatric surgery)

### PREMIUM CLASS 5

- 80154 Orthopedic Surgery

### PREMIUM CLASS 6

- 80143 Cardiothoracic Surgery

- 80146 Vascular Surgery

### PREMIUM CLASS 7

- 80167 Gynecology Only (*excluding* prenatal care; obstetrical deliveries of any kind except for assistance at Cesarean sections; induced abortions except for those in the first trimester; or treatment of spontaneous abortions except for those in the first trimester)

- 80291 Otolaryngology (*including* cosmetic plastic surgery)

- 80156 Plastic and Reconstructive Surgery

### PREMIUM CLASS 8

- 80155 Colon and Rectal Surgery and/or Proctology

- 80145 Urology (*including* major surgery)

### PREMIUM CLASS 9

- 80102 Emergency Medicine

### PREMIUM CLASS 10

- 80280 Computerized Tomography

- 80280 Diagnostic Radiology Only

- 80280 Diagnostic Radiology and Radiation Oncology

### PREMIUM CLASS 11

- 80157 Family/General Practice (*including* limited major surgery) and/ or Anesthesiology

- 80288 Neurology and/or Psychiatry (*including* the supervision, direction or performance of myelography and/or angiography)

- 80159 Otolaryngology, (*excluding* cosmetic plastic surgery)

### PREMIUM CLASS 13

- 80284 Internal Medicine (*including* cardiac catheterization)

### PREMIUM CLASS 14

- 80421 Family/General Practice (*including* Minor surgery)

- 80421 Gynecology, Only *including* Minor surgery

- 80421 Occupational Medicine and Minor surgery

- 80285 Otolaryngology *including* minor procedures *excluding* T&A

### PREMIUM CLASS 15

- 80261 Neurology (*excluding* the supervision, direction or performance of myelography and/or angiography)

### PREMIUM CLASS 16

- 80282 Dermatology (*including* dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using phenol, Mohs microsurgery and all procedures listed in Class 22)

- 80257 Internal Medicine (*excluding* cardiac catheterization but *including* cardiology, gastroenterology, rheumatology, pulmonary disease, endocrinology and medical oncology)

- 80253 Radiation Oncology Only

- 80294 Urology (*including* Minor surgery)

### PREMIUM CLASS 17

- 80114 Ophthalmology (*including* major surgery)

### PREMIUM CLASS 18

- 80151 Anesthesiology

### PREMIUM CLASS 19

- 80420 Family/General Practice (*excluding* surgery)

- 80420 Occupational Medicine (*excluding* surgery)

### PREMIUM CLASS 20

- 80266 Pathology and/or Hematology

### PREMIUM CLASS 21

- 80293 Pediatrics (*excluding* tonsillectomy and adenoidectomy, other major surgery or general or spinal anesthesia)

- 80289 Ophthalmology (*including* minor procedures)

### PREMIUM CLASS 22

- 80256 Dermatology *excluding* dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using Phenol, Mohs microsurgery but *including* the use of laser, face peels with agents other than Phenol, collagen injections and sclerotherapy,

- 80235 Physical Medicine and Rehabilitation *including* pain medicine

### PREMIUM CLASS 23

- 80254 Allergy (*including* pediatric allergy)

- 80256 Dermatology *excluding* use of laser, dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using Phenol, Mohs microsurgery, but *including* face peels with agents other than Phenol collagen injections and sclerotherapy,

- 80263 Ophthalmology (*excluding* surgery)

- 80235 Physical Medicine and Rehabilitation *excluding* pain medicine

- 80235 Preventive Medicine, Public Health

- 80249 Psychiatry (*excluding* supervision, direction and/or performance of myelography and/or angiography)

### PREMIUM CLASS 54

- 80210 Oral Surgery (*including* dentists engaged in oral surgery or operative dentistry on patients rendered unconscious through the administration of any anesthesia or analgesia)

**\*NOTE:** For insurance purposes, tonsillectomies, adenoidectomies, Cesarean sections, and abortions (other than the treatment of spontaneous abortions and those performed in the first 12 weeks) are considered major surgery.

A physician will not qualify for a Family/General Practice classification if he/she (1) performs open orthopedic procedures or elective intra-abdominal surgery including hysterectomies, cholecystectomies, or gastrectomies or (2) in the opinion of the underwriters, represents a risk similar to that of a specialist.

**Practice and Underwriting Information**

Classification code (see page 12) \_\_\_\_\_ Specialty \_\_\_\_\_

Have your practice procedures or your specialty changed in the past five years? If yes, please explain, including dates of changes.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Indicate any procedures or therapies you perform in your practice. Provide additional information as requested and **answer all questions. If you do not perform a procedure check No.**

	Yes	No
Abortion .....	<input type="checkbox"/>	<input type="checkbox"/>
By suction curettage up to 12 _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Where is it performed (circle one)?   Office   Hospital   Clinic		
Acupuncture (If yes, enclose certificate) .....	<input type="checkbox"/>	<input type="checkbox"/>
Alternative medicine .....	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
_____		
Anesthesia .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify where administered _____		
Distance to nearest hospital _____		
Equipment available in the event of emergency _____		
Written transfer agreement with nearby hospital? .....	<input type="checkbox"/>	<input type="checkbox"/>
Angiography .....	<input type="checkbox"/>	<input type="checkbox"/>
Botox, Restylane, Juvederm .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac catheterization.....	<input type="checkbox"/>	<input type="checkbox"/>
Colon and rectal surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Limited to colon, rectum, anus _____	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal approach _____	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
_____		
Dermabrasion.....	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology .....	<input type="checkbox"/>	<input type="checkbox"/>

Continued from previous page: Indicate any procedures or therapies you perform in your practice. Provide additional information as requested and **answer all questions. If you do not perform a procedure check No.**

	Yes	No
Dilatation and curettage .....	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic dilatation and curettage _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Electric shock therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy .....	<input type="checkbox"/>	<input type="checkbox"/>
Type _____		
If you perform endoscopic retrograde cholangiopancreatography, where is it performed (circle one)?	Office	Hospital    Clinic
Facial peels .....	<input type="checkbox"/>	<input type="checkbox"/>
Hair transplants .....	<input type="checkbox"/>	<input type="checkbox"/>
Laparoscopy .....	<input type="checkbox"/>	<input type="checkbox"/>
Procedures _____		
Laser therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Laser type(s): _____		
Eye .....	<input type="checkbox"/>	<input type="checkbox"/>
Hair removal .....	<input type="checkbox"/>	<input type="checkbox"/>
Skin .....	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Liposuction .....	<input type="checkbox"/>	<input type="checkbox"/>
Lithotripsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Mohs microsurgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Myelography .....	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical/Gynecological care .....	<input type="checkbox"/>	<input type="checkbox"/>
Limited to gynecological surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, provide full details _____		
Prenatal .....	<input type="checkbox"/>	<input type="checkbox"/>
Deliveries .....	<input type="checkbox"/>	<input type="checkbox"/>
Home deliveries .....	<input type="checkbox"/>	<input type="checkbox"/>
VBACs .....	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplants (excluding corneal) .....	<input type="checkbox"/>	<input type="checkbox"/>
Type _____		

Continued from previous page: Indicate any procedures or therapies you perform in your practice. Provide additional information as requested and **answer all questions. If you do not perform a procedure check No.**

	Yes	No
Pacemaker insertion.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain management _____		
Invasive.....	<input type="checkbox"/>	<input type="checkbox"/>
Non-invasive.....	<input type="checkbox"/>	<input type="checkbox"/>
Describe procedures performed _____		
_____		
Pain management training: provide preceptor/training details and number of years of experience: _____		
_____		
_____		
Plastic/cosmetic surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery limited to hand and upper extremities .....	<input type="checkbox"/>	<input type="checkbox"/>
Radiological studies.....	<input type="checkbox"/>	<input type="checkbox"/>
Interventional radiology.....	<input type="checkbox"/>	<input type="checkbox"/>
Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
General (specify type and percentage) _____		
Other (specify type and percentage) _____		
In non-hospital setting (specify where, type, percentage, equipment available in the event of emergency, and if there is a written transfer agreement with a nearby hospital) _____		
_____		
Telemedicine.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify location of telemedicine patient population _____		
Thoracic surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Vascular surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Weight control therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Medications prescribed _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight control surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Procedures _____		
_____		
X-ray therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Deep and superficial (if yes, provide preceptor training details and number of years of experience)		
_____		
Isotope (if yes, provide preceptor training details and number of years of experience)		
_____		

**Family/General Practice Specialties *Only*** (This section does not apply to surgical specialties.)

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Indicate which of the following procedures you currently perform, or anticipate performing in the next 12 months, and the number you anticipate performing (include office and hospital practice).

	Yes	No	Number
Deliveries .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoidectomies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pilonidal cysts (I&D only).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Open reduction of fractures .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closed reduction of fractures .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excision of superficial growths.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diagnostic dilatation and curettage.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herniorrhaphies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsillectomy and adenoidectomy .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abortions (suction curettage through 12 weeks).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vasectomies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose vein surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Assistance at major surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prenatal care.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other major/minor procedures .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
(other than those listed in Practice and Underwriting Information)			

Specify type \_\_\_\_\_





**Claim/Lawsuit Information – Answer all questions**

Patient Name \_\_\_\_\_  
LAST FIRST MI

Age \_\_\_\_\_ Sex  Male  Female

Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Nature of allegation in the claim or suit \_\_\_\_\_

Date of Incident \_\_\_\_\_

Report Date \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Name of other doctor(s) and hospital(s), if any, involved in claim or suit: \_\_\_\_\_

\_\_\_\_\_

**Disposition of the claim**

- Abandoned (no activity over 3 years)
- Won by defense
- Judgment or verdict vs. co-defendant(s) only
- Settled or  won by claimant If so, how much was paid on your behalf \_\_\_\_\_
- Open (current status) \_\_\_\_\_

Location of Incident \_\_\_\_\_

Narrative description of the medical facts: (must include, but not be limited to the type of treatment and/or surgery; your involvement, i.e. consultant, assistant

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above information is complete and true to the best of my knowledge and belief.

\_\_\_\_\_  
SIGNATURE OF APPLICANT



**Statements of Insurance** are sent to your sponsor hospital and all other hospitals and facilities you designate

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I authorize the Hospitals Insurance Company, Inc. (HIC) to issue Statement(s) of Insurance to the following:  
(Print clearly, include full address)

NAME

---

ADDRESS

---

CITY

STATE

ZIP CODE

---

NAME

---

ADDRESS

---

CITY

STATE

ZIP CODE

---

NAME

---

ADDRESS

---

CITY

STATE

ZIP CODE

---

NAME

---

ADDRESS

---

CITY

STATE

ZIP CODE

---

NAME

---

ADDRESS

---

CITY

STATE

ZIP CODE

---

**Please sign, date and return to:** Hospitals Insurance Company, Inc.  
50 Main Street, Suite 1220  
White Plains, NY 10606

SIGNATURE OF APPLICANT

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DATE

---

PRINT NAME

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## Release and Authorization

I hereby authorize HIC to obtain full information from any insurer or from any person, health care facility, organization or governmental agency with respect to any claim, suit or incident pertaining to professional acts or omissions asserted against me. I recognize that I may be required to furnish as part of my application a copy of my National Practitioner Data Bank report. I expressly release and discharge any insurers, persons, organizations or agencies, including but not limited to HIC, from liability for providing or receiving such information. I further authorize that a photocopy of this release may be accepted with the same authority as the original.

I appoint HIC (and/or such attorneys or representatives as it may appoint) to act in my behalf as attorney in fact in exercising any or all of my rights arising under or in relation to the policies of insurance, which are, have been, or will be in force for my benefit, including but not limited to the following: notification of claims; presentation of information and documentation; demand, receipt and remittance of payments and any other monies representing the liabilities of insurers under policies covering me, making of financial arrangements to facilitate the payment of claims and any other actions that HIC may deem necessary or useful. This appointment shall apply in respect of all insurance policies arranged for me by HIC whether they be past, present or future.

I hereby attest that the statements made in this application are true, complete and accurate and may be relied upon by HIC for the purpose of issuing coverage.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
FULL NAME (PLEASE PRINT)

\_\_\_\_\_  
DATE OF SIGNATURE

**NOTE:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 WILL INVALIDATE YOUR INSURANCE COVERAGE.

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# Application for Excess (Section 18) Professional Liability Insurance

First Layer Excess (Section 18) professional liability insurance is available to you **at no charge**, only if you meet certain eligibility requirements. In addition, you must have: a) a valid New York State license to practice medicine; b) an individual primary professional liability policy of **\$1.3 million/\$3.9 million**; c) an affiliation with a New York State general hospital and d) completion of a qualified risk management program.

## GENERAL INFORMATION

New York State professional license number \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Federal DEA number \_\_\_\_\_ Specialty class code (see page 12) \_\_\_\_\_  
 Phone number \_\_\_\_\_ E-mail address \_\_\_\_\_  
 Medical/Dental school attended \_\_\_\_\_ Date graduated \_\_\_\_\_

## TO APPLY FOR THIS COVERAGE, THE FOLLOWING MUST BE COMPLETED:

1. Name \_\_\_\_\_  

LAST
FIRST
MI
2. Mailing address \_\_\_\_\_  

STREET
CITY
STATE
ZIP
3. Name of **primary** hospital affiliation \_\_\_\_\_
4. Additional hospital affiliation(s) \_\_\_\_\_
5. Primary coverage insurance company \_\_\_\_\_ Policy number \_\_\_\_\_
6. Risk management program completed?  Yes  No Provider \_\_\_\_\_ Date completed \_\_\_\_\_
7. Boards certification(s) \_\_\_\_\_
8. Licensing board disciplinary proceedings
  - (a) License to practice ever revoked/suspended in any state  Yes  No If yes, date \_\_\_\_\_
  - (b) Probation ever invoked in any state?  Yes  No If yes, date \_\_\_\_\_
9. Hospital disciplinary proceedings
  - (a) Privileges ever revoked in any hospital?  Yes  No If yes, date \_\_\_\_\_
  - (b) Privileges ever restricted or suspended in any hospital?  Yes  No If yes, date \_\_\_\_\_
10. Claim history?  None  Yes (If yes, attach additional page(s) to list claimant's name, date of incident and settlement, and amounts paid.)
11. Do you own or operate a hospital, medical clinic or laboratory?  Yes  No  
 If yes, provide name and address \_\_\_\_\_
12. Is your practice limited to 20 hours or less per week (excluding teaching time)?  Yes  No
13. Do you, as an individual or a professional corporation, employ any other licensed physician, dentist, podiatrist, osteopath, certified nurse midwife, laboratory technician, licensed X-ray therapy technician, nurse, licensed dental hygienist, pharmacist, optician, licensed X-ray therapist, nurse anesthetist or physiotherapist?  Yes  No

## IMPORTANT: THIS APPLICATION AND RELEASE MUST BE SIGNED BY THE APPLICANT.

I authorize the release and exchange of information, involving but not limited to claim matters, between my professional society or association, previous insurance carrier, hospital or clinic and Hospitals Insurance Company, Inc. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
FULL NAME (PLEASE PRINT)

\_\_\_\_\_  
DATE OF SIGNATURE

**NOTE:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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 WILL INVALIDATE YOUR INSURANCE COVERAGE.

**THIS COVERAGE WILL NOT BE EFFECTIVE UNTIL YOUR APPLICATION IS ACCEPTED  
AND YOU RECEIVE WRITTEN NOTIFICATION FROM HOSPITALS INSURANCE COMPANY, INC.**

