Voluntary Attending Physicians (VAP) Application for Professional Liability Insurance

Hospitals Insurance Company, Inc.

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

3. The desired effective date of coverage is: _____

4. Residence: _____ (STREET) _____ (APT) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

_____ (PHONE NUMBER) _____ (FAX) _____ (EMAIL ADDRESS)

Date of Birth: _____ (MM DD YYYY) Sex: ☐ Male ☐ Female

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

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

   Insurer_____ Policy Number_____ From __/__/__ to /___/___

   Address _____

   _____

   Insurer_____ Policy Number_____ From __/__/__ to /___/___

   Address _____

   _____

   Insurer_____ Policy Number_____ From __/__/__ to /___/___

   Address _____

   _____

   Insurer_____ Policy Number_____ From __/__/__ to /___/___

   Address _____

   _____

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

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.

   _____

   _____

Business Entities

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					
TOTAL					

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

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

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*

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 60th 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

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	☐	☐
By suction curettage up to 12 _____	☐	☐
Other _____	☐	☐
Where is it performed (circle one)? Office Hospital Clinic		
Acupuncture (If yes, enclose certificate)	☐	☐
Alternative medicine	☐	☐
Describe _____		
_____		
Anesthesia	☐	☐
If yes, specify where administered _____		
Distance to nearest hospital _____		
Equipment available in the event of emergency _____		
Written transfer agreement with nearby hospital?	☐	☐
Angiography	☐	☐
Botox, Restylane, Juvederm	☐	☐
Cardiac catheterization	☐	☐
Colon and rectal surgery	☐	☐
Limited to colon, rectum, anus _____	☐	☐
Abdominal approach _____	☐	☐
Describe _____		
_____		
Dermabrasion	☐	☐
Dermatopathology	☐	☐

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	☐	☐
Diagnostic dilatation and curettage _____	☐	☐
_____		
Other _____	☐	☐
Electric shock therapy	☐	☐
Endoscopy	☐	☐
Type _____		
If you perform endoscopic retrograde cholangiopancreatography, where is it performed (circle one)? Office Hospital Clinic		
Facial peels	☐	☐
Hair transplants	☐	☐
Laparoscopy	☐	☐
Procedures _____		
Laser therapy	☐	☐
Laser type(s): _____		
Eye	☐	☐
Hair removal	☐	☐
Skin	☐	☐
Other _____	☐	☐
Liposuction	☐	☐
Lithotripsy	☐	☐
Mohs microsurgery	☐	☐
Myelography	☐	☐
Obstetrical/Gynecological care	☐	☐
Limited to gynecological surgery	☐	☐
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	☐	☐
If yes, provide full details _____		
Prenatal	☐	☐
Deliveries	☐	☐
Home deliveries	☐	☐
VBACs	☐	☐
Organ transplants (excluding corneal)	☐	☐
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	☐	☐
Pain management _____		
Invasive	☐	☐
Non-invasive	☐	☐
Describe procedures performed _____		
_____		
Pain management training: provide preceptor/training details and number of years of experience: _____		
_____		
_____		
Plastic/cosmetic surgery	☐	☐
Surgery limited to hand and upper extremities	☐	☐
Radiological studies	☐	☐
Interventional radiology	☐	☐
Surgery	☐	☐
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	☐	☐
If yes, specify location of telemedicine patient population _____		
Thoracic surgery	☐	☐
Vascular surgery	☐	☐
Weight control therapy	☐	☐
Medications prescribed _____	☐	☐
Weight control surgery	☐	☐
Procedures _____		
_____		
X-ray therapy	☐	☐
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.)**

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	☐	☐	_____
Hemorrhoidectomies	☐	☐	_____
Pilonidal cysts (I&D only)	☐	☐	_____
Open reduction of fractures	☐	☐	_____
Closed reduction of fractures	☐	☐	_____
Excision of superficial growths	☐	☐	_____
Diagnostic dilatation and curettage	☐	☐	_____
Herniorrhaphies	☐	☐	_____
Tonsillectomy and adenoidectomy	☐	☐	_____
Abortions (suction curettage through 12 weeks)	☐	☐	_____
Vasectomies	☐	☐	_____
Varicose vein surgery	☐	☐	_____
Assistance at major surgery	☐	☐	_____
Prenatal care	☐	☐	_____
Other major/minor procedures (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

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

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**

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 DATE

PRINT NAME

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 Date 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

Hospitals Insurance Company, Inc.

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.

50 Main Street, Suite 1220, White Plains, NY 10606 T. 800.982.7101 F. 914.328.3716 www.hicgroup.com