



TEXAS MEDICAL INSURANCE COMPANY

## **ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION**

- Applicant must be employed and supervised by a TMLT insured physician.**
- Complete and sign the *Application for Coverage*.
- Complete the *Claim/Suit Information Addendum* if a professional liability claim or suit has **ever** been brought against you.
- Copy of certificate or licensure.
- IMPORTANT! Attach a copy of your *Declarations Page* and all other pages relative to the retroactive or prior acts date of your current insurance.**
- If payment is included make your check payable to *Texas Medical Insurance Company* or *TMIC*.
- Return all applicable forms to:  
**P.O. Box 160140**  
**Austin, TX 78716-0140**  
We encourage the return of multiple applications for one company in the same envelope.
- Include a listing of all applicants by name and profession.

### **Instructions regarding premium payment:**

Quarterly and annual payment options will be billed by invoice and mailed to the *Named Insured*.

If you choose the monthly payment option, you must complete, sign and return the enclosed *Authorization for Direct Bank Debit* along with a voided check on the account to be debited.

If you have any questions, we will be happy to assist you. Call our toll free number listed below and ask for Sales.

### **TEXAS MEDICAL INSURANCE COMPANY**

P.O. Box 160140 • Austin, TX 78716-0140

901 Mopac Expressway South • Barton Oaks Plaza V, Suite 500 • Austin, TX 78746

Toll free: 800-580-8658 • Local: 512-425-5800 • Fax: 512-425-5998

Email: [sales@tmic.biz](mailto:sales@tmic.biz) • [www.tmic.biz](http://www.tmic.biz)

*Receipt by TMIC of application(s) and/or premium payment does not constitute a binder or acceptance of coverage.*



TEXAS MEDICAL INSURANCE COMPANY

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INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

PLEASE TYPE OR PRINT IN BLACK INK. ALL QUESTIONS MUST BE ANSWERED IN DETAIL.

POLICY NUMBER \_\_\_\_\_ (For Office Use Only)

I. GENERAL INFORMATION

First Name of Applicant Middle Name Last Name

Home Address City State Zip Code

Date of Birth # Texas Medical License/Status (please provide copy) # Social Security Number

Office Phone: Area Code Number Home Phone: Area Code Number Fax: Area Code Number

Pager: Area Code Number Cell Phone: Area Code Number Email Address

Name of Policy Owner (Who will own/pay for this policy?)

Principal Office Address Number Street Suite City State Zip Code County

II. PRACTICE DESCRIPTION

A. Are you a (please check one):

- checkbox Dental Hygienist checkbox Nurse Midwife checkbox Pharmacist checkbox Surgical Assistant checkbox Other
checkbox EMT/Paramedic checkbox Nurse Practitioner checkbox Physician Assistant checkbox Technician
checkbox LVN checkbox Optician checkbox Psychologist checkbox Technologist
checkbox Nurse Anesthetist checkbox Optometrist checkbox RN checkbox Therapist

B. Are you a/an (please check one):

- 1. checkbox Employee checkbox Independent Contractor checkbox Practice Owner checkbox Other
2. Name of employer:
3. Name of practice:
4. Name of supervising physician, if applicable:

### III. INSURANCE COVERAGE

**A. Does your employer have professional liability insurance?**

Yes  No

Insurance Company: \_\_\_\_\_

Limits of liability: \_\_\_\_\_

**B. Requested coverage effective date** 12:01 a.m. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year

In no event shall the effective date of the policy, if issued, be earlier than the date TMIC receives this application.

**C. Professional Liability Coverage** Please check type of coverage (**Occurrence or Claims-made**) and the limits of liability desired.  
 (Note: Occurrence coverage is not available to a Physician Assistant, Nurse Anesthetist, Nurse Midwife or EMT/Paramedic)

- Occurrence** (Limits indicated are the only limits available and are for Each Claim and All Claims)  
 \$100,000/\$300,000     \$200,000/\$600,000

**OR**

- Claims-made** (Limits indicated are Each Claim and All Claims)  
 \$100,000/\$300,000     \$200,000/\$600,000     \$500,000/\$1,500,000

**D. Insurance History for Previous Three Years**

I. Insurance Company:

Coverage Form:

Policy Period:

Limits of Liability  
 Per Claim/All Claims:

|  | Current Year   | First Prior Year   | Second Prior Year  |
|--|--|--|--|
| I. Insurance Company:                        |  |  |  |
| Coverage Form:                               | <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 |
| Policy Period:                               |  |  |  |
| Limits of Liability<br>Per Claim/All Claims: |  |  |  |

**If your current insurance is written on a Claims-made form, it is necessary to purchase a Reporting Endorsement (tail coverage) from your present insurer or Prior Acts (nose coverage) from TMIC to reduce the chances of having a gap in coverage.**

2. Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer for all your previous exposures?

Yes  No

If no, are you requesting Prior Acts (nose coverage) from TMIC?

Yes  No



## V. UNDERWRITING AND RATING INFORMATION

### B. Practice Information

1. On average, how many hours per week do you work? \_\_\_\_\_
2. Does your employment/practice require that you ever be in an operating room? Yes  No
3. Does your employment/practice include work in an emergency room? Yes  No
4. Does your employment/practice include prenatal care? Yes  No
5. Does your employment/practice require that you ever be in a labor and delivery room? Yes  No

**Note: If you are employed or practice as a Nurse Midwife performing deliveries, please complete the *Nurse Midwife Supplemental Application*.**

6. Do you: Employ  Supervise  Contract  with any health care professionals? Yes  No

| Name | Profession | Insured By | Limits of Liability |
|------|------------|------------|---------------------|
|------|------------|------------|---------------------|

| Name | Profession | Insured By | Limits of Liability |
|------|------------|------------|---------------------|
|------|------------|------------|---------------------|

7. Briefly describe your general duties:

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8. Describe the extent to which you are supervised and by whom:

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9. Number of years employed in your current profession: \_\_\_\_\_

**Note: If you answer “yes” to questions 10-18, please provide details on page 6.**

## V. UNDERWRITING AND RATING INFORMATION

10. Has your license, certification or permit ever been denied, restricted, revoked, suspended, cancelled or voluntarily surrendered? Yes  No
11. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? Yes  No
12. (a) Has any hospital or clinic ever denied, restricted, suspended, or revoked your privileges? Yes  No   
(b) Are you currently under investigation? Yes  No   
(c) Have you ever resigned from a hospital, clinic, or other facility during or following a medical staff investigation? Yes  No
13. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? Yes  No
14. Have you ever been treated for alcoholism or substance abuse? Yes  No   
If yes, provide details and a recent statement of insurability from your treating physician.
15. Have you now or ever had any chronic illness, mental illness or physical impairment? Yes  No   
If yes, provide details and a recent statement of insurability from your treating physician.
16. Have you ever been indicted, charged or convicted of a crime other than a minor traffic violation? Yes  No
17. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled or non-renewed? Yes  No   
If yes, please explain why, when and name of insurer(s).
18. Are you aware that your present insurer plans to restrict, surcharge, cancel or non-renew your coverage? Yes  No
19. How many professional liability claims have **ever** been brought against you? # \_\_\_\_\_  
This includes notice of intent to sue, written demand from a patient or lawsuit.  
Complete the information for all claims/suits on page 7.

## VI. AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any policy is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding.

All potential claims or lawsuits have been disclosed herein and have been reported to the applicable, prior professional liability insurance carrier. **I understand any policy issued by TMIC will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMIC any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: any licensing agency; any medical association or society; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability. I further authorize TMIC and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

By submission of this application, or by acceptance of coverage from TMIC, I hereby release TMIC and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

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Applicant's Signature

Date Signed

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Policy Owner's Signature

Date Signed

**THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE**  
**Coverage will not be considered until this application is completed, signed and dated.**  
**Failure to provide complete information/attachments as requested will cause delay.**

**ENCLOSE** a copy of your current Professional Liability **Declarations Page** and **license**.

## VII. ADDITIONAL INFORMATION

Please use this area if additional space is needed for answers to any questions.

| PAGE NUMBER | QUESTION NUMBER | ANSWER AND/OR DETAILS |
|-------------|-----------------|-----------------------|
|             |                 |                       |
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**VIII. CLAIM/SUIT INFORMATION ADDENDUM**

**I. CLAIM/SUIT INFORMATION**

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of incident: \_\_\_\_\_  
Month/Day/Year

Insurance company defending your claim: \_\_\_\_\_

Location: City \_\_\_\_\_ State \_\_\_\_\_ Hospital \_\_\_\_\_

Procedures performed: \_\_\_\_\_

**ALLEGATIONS and narrative description of the medical facts and your involvement. Please attach a second sheet of paper if additional space is required:**

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

Co-defendants: \_\_\_\_\_

Claim settled without indemnity payment on your behalf? Yes  No

Claim is pending: Yes  No

Suit filed: Yes  No  If Yes: Month \_\_\_\_\_ Year \_\_\_\_\_

Court Trial: Yes  No  Jury verdict: Yes  No

Settlement out of court: Yes  No  If Yes: Month \_\_\_\_\_ Year \_\_\_\_\_

Total amount paid to claimant on **your** behalf: \$ \_\_\_\_\_

Total amount paid to claimant for **all** defendants: \$ \_\_\_\_\_

**2. CLAIM/SUIT INFORMATION**

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of incident: \_\_\_\_\_  
Month/Day/Year

Insurance company defending your claim: \_\_\_\_\_

Location: City \_\_\_\_\_ State \_\_\_\_\_ Hospital \_\_\_\_\_

Procedures performed: \_\_\_\_\_

**ALLEGATIONS and narrative description of the medical facts and your involvement. Please attach a second sheet of paper if additional space is required:**

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

Co-defendants: \_\_\_\_\_

Claim settled without indemnity payment on your behalf? Yes  No

Claim is pending: Yes  No

Suit filed: Yes  No  If Yes: Month \_\_\_\_\_ Year \_\_\_\_\_

Court Trial: Yes  No  Jury verdict: Yes  No

Settlement out of court: Yes  No  If Yes: Month \_\_\_\_\_ Year \_\_\_\_\_

Total amount paid to claimant on **your** behalf: \$ \_\_\_\_\_

Total amount paid to claimant for **all** defendants: \$ \_\_\_\_\_