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 • 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

P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmic.biz

INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
PODIATRIST

PLEASE TYPE OR PRINT IN BLACK INK. ALL QUESTIONS MUST BE ANSWERED IN DETAIL.
COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETED AND SIGNED.

I. GENERAL INFORMATION

*Policy Number:*________________________________
(For TMIC Use Only)

A. Contact Information

1. Name of applicant:

____
First *Middle* *Last*

2. Home address:

____
Street *City* *State* *Zip*

3. Preferred mailing address:
❏ Home ❏ Principal Office ❏ P.O. Box # _______ ❏ Other ______________________

4. Telephone numbers:

____
Office Phone: *(Area Code) Number* ***Home Phone:*** *(Area Code) Number* ***Facsimile:*** *(Area Code) Number*

5. Other information:

____
Date of Birth *Country of Birth* *Podiatric License #/Status* *DEA/Status*

B. Practice Locations

1. Please list all office locations where you currently practice or intend to practice.
List principal location first.

Number *Street* *Suite* *City* *State* *Zip* *County*

a. ____
b. ____
c. ____

2. Other counties where you practice:

____

3. Is any of your practice outside of Texas? ❏ yes ❏ no

____
Where *Percentage*

4. Current professional memberships:

____

C. **Enclose** a copy of your current **Curriculum Vitae** and your **Office Letterhead.**
If you currently have professional liability coverage, include a copy of the **Declaration Page.**

II. INSURANCE COVERAGE

A. I request that my insurance commence at 12:01 a.m. on:

____

Month *Day* *Year*

B. Professional Liability Coverage:
Please check limits of liability desired. **(Only one.)**

Claims-made (Limits indicated are Each Claim and All Claims.)

❑ $100,000/$300,000 ❑ $500,000/$1,500,000
❑ $200,000/$600,000 ❑ $1,000,000/$3,000,000

I understand the unique nature of the Claims-made policy and the importance of purchasing a Reporting Endorsement (tail coverage) upon cancellation or non-renewal of this policy, if issued.

C. Insurance History

1. Indicate name, policy number, limits of liability, and expiration date of your present insurance.

____

Name of Insurer *Policy No.* *Limits of Liability* *Expiration Date*

2. On which basis is your present professional liability policy written?
❑ Claims-made ❑ Occurrence ❑ None carried

If my current insurance is written on a Claims-made form, I understand the necessity of purchasing a Reporting Endorsement (tail coverage) from my present insurer or Prior Acts (nose coverage) from TMIC to avoid having a gap in coverage.

If present insurance is written on an Occurrence form, proceed to Section III.

3. Have you purchased or are you planning to purchase a Reporting Endorsement (tail coverage) from your present insurer? ❑ yes ❑ no

4. If "no," are you requesting Prior Acts Coverage from TMIC? ❑ yes ❑ no
If "yes,"
   a. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered) which you have reason to believe may lead to a claim or suit against you? ❑ yes ❑ no

   b. Have you reported any incidents (which have not yet resulted in a claim or suit) to your current carrier? ❑ yes ❑ no

   c. Have you received any oral or written threats of legal action, request for patient records, subpoena, petition, complaint, summons, citation, or other legal process or notification? ❑ yes ❑ no

If you answered "yes" to a, b, or c above, please provide details, including dates, in the *Additional Information* section on page 8 of the application.

   d. What is the retroactive or prior acts date on your current policy?

____

Month *Day* *Year*

Please attach a copy of your current Declarations Page and all other pages relative to the retroactive or prior acts date.

III. UNDERWRITING AND RATING INFORMATION

A. Practice History

1. Education

	Name	*City/State*	*From/To*
Podiatry College	______________________	_____________	_____________
Residency	______________________	_____________	_____________
Preceptorship	______________________	_____________	_____________

2. Did you complete residency training? ❑ yes ❑ no

3. Did you participate in any continuing education programs during the past year? ❑ yes ❑ no
If "yes," total # of hours: ______________ and describe:

____

____

____

4. Did you attend any malpractice loss prevention programs during the past year? ❑ yes ❑ no
If "yes," where? when? and describe:

____

____

5. a. Are you American Board of Podiatric Surgery Certified? ❑ yes ❑ no

b. Are you American Board of Podiatric Surgery qualified or eligible? ❑ yes ❑ no

c. Have you ever failed to pass a board exam? ❑ yes ❑ no
If "yes," date(s):

____
Month *Day* *Year*

6. Where have you practiced your podiatric profession since completion of your formal training? (Include military or any public service organization.) PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF PODIATRIC COLLEGE, WITH THE EXCEPTION OF ANY RESIDENCY OR PRECEPTORSHIP TRAINING.

____ From ____________ To______________
City *State/Country* *Month* *Year* *Month* *Year*

____ From ____________ To______________
City *State/Country* *Month* *Year* *Month* *Year*

____ From ____________ To______________
City *State/Country* *Month* *Year* *Month* *Year*

B. Practice Structure

1. Organization structure
   - ❑ Partnership
   - ❑ Office Share/De Facto Partnership
   - ❑ Solo Professional Association (Solo PA coverage is automatically provided under an individual's policy.)
   - ❑ Professional Association (PA)
   - ❑ Other:

   ____
   Describe

   Do you desire coverage for the above? ❑ yes ❑ no
   *If "yes," please complete the **Professional Association/Partnership Application**.*

2. Type of practice
   - ❑ Individual Practice
   - ❑ Employee
   - ❑ Independent Contractor
   - ❑ Other (Please specify): ______________________________

3. Exact name and address of Solo PA, Professional Association/Partnership, Group, HMO or Employer, etc.:

   ____
   Name

   ____
   Street *City* *State* *Zip*

4. Any other name under which you practice (i.e. DBA)?

   ____

5. Are you an employee of any hospital? ❑ yes ❑ no
   If "yes," name of hospital(s):

   ____

6. Are you on staff at any hospital? ❑ yes ❑ no
   If "yes," name of hospital(s):

   ____

C. Personnel

1. Do you ❑ Employ ❑ Supervise ❑ Contract
   any licensed podiatrists (including Residents and/or Preceptees) or individuals who administer anesthesia? ❑ yes ❑ no

Name	*Title/Degree*	*Insured By*	*Limits of Liability*

2. Indicate number of professional licensed personnel in each category employed, contracted or supervised by you personally or by a partnership or corporation of which you are a member or shareholder.
   - ______ Podiatry Assistants
   - ______ Nurses
   - ______ Preceptees
   - ______ Residents
   - ______ Other:______________________________

3. Do you desire individual coverage for any of the above personnel? ❑ yes ❑ no
   *If "yes," please request and complete the **Health Care Professional application(s).***

D. Patients

1. Average number of patients seen per week in your office is: #________
2. Average number of practice hours per week involved in both direct patient care and related administrative activities is: #________
3. Source of patient services/patient mix
   a. Fee for service ________ %
   b. Pre-paid (HMO-PPO, etc.) ________ %
      • List the number of all current HMO-PPO-IPAs or similar organizations you belong to: #________
      • List the number of contracts under which you receive capitated payments: #________
      • Total number of capitated lives in your practice: #________
   c. Other:____ ________ %
   d. **TOTAL** **100** %

E. Practice Description

1. Surgery
   a. Do you perform surgery in your office? ❑ yes ❑ no
   b. Do you perform surgery in a hospital? ❑ yes ❑ no
   c. Do you perform surgery in any other non-hospital facility? ❑ yes ❑ no

   Name of hospital or other facility and type of surgical privileges:

   ____

   ____

2. Anesthesia
   a. Do you administer local anesthesia? ❑ yes ❑ no
      If "yes," where? ❑ *office* ❑ *hospital*
   b. Do you administer nitrous oxide analgesia? ❑ yes ❑ no
      If "yes," where? ❑ *office* ❑ *hospital*
   c. Do you perform surgery under general anesthesia? ❑ yes ❑ no
      If "yes," where? ❑ *office* ❑ *hospital*
   d. Please list the monitoring equipment you have available:

      ____

      ____

      ____

   e. Please list the resusitative equipment and medications you have available in the office to support any adverse reaction or medical emergency.
      1. Equipment:

         ____

         ____

         ____

      2. Medication:

         ____

         ____

         ____

3. Lasers
   a. Do you use a laser in your treatment of patients? ❑ yes ❑ no
      If "yes," with what type of treatment do you use the laser?

      ____

   b. How many times per week do you use the laser? #__________

   c. What type of training did you receive in the use of the laser? Check all that apply.
      ❑ Seminar ❑ Course ❑ Preceptorship ❑ Hands On ❑ Other
      Please specify name of program(s):

      ____

4. Do you:
   a. perform osseous surgery on metatarsals? ❑ yes ❑ no
   b. perform osseous surgery on digits? ❑ yes ❑ no
   c. perform osseous surgery on tarsals? ❑ yes ❑ no
   d. perform tenotomies? ❑ yes ❑ no
   e. perform nail surgery? ❑ yes ❑ no
   f. incise and drain abscesses? ❑ yes ❑ no
   g. excise verruca, molluscum contagiosum cysts and other benign lesions? ❑ yes ❑ no
   h. provide post-operative care? ❑ yes ❑ no

   Note: If any of the answers to questions 5 through 19 are **"yes,"** details (including dates, if applicable) must be provided in the *Additional Information* section on page 8.

5. Are you entering practice for the first time immediately following podiatric or post graduate training, military service or an academic position? ❑ yes ❑ no

6. Are you a proprietor, superintendent, executive officer or administrative officer of any business enterprise? ❑ yes ❑ no

7. Are you an employee of or do you do any contract work for any federal, state, local or governmental agency? ❑ yes ❑ no
   If "yes," please give details, including whether professional liability insurance is provided for you.

8. Do you advertise? ❑ yes ❑ no
   If "yes," please send samples of your yellow pages display ads and other media advertisements. If you use radio or television, please describe.

9. Have you ever been treated for alcoholism or any substance abuse or mental illness? ❑ yes ❑ no
   If "yes," provide statement of insurability from treating physician.

10. Have you now or ever had any chronic physical defect or emotional impairments? ❑ yes ❑ no
    If "yes," provide statement of insurability from treating physician.

11. Have you ever had your license and/or your permit to prescribe drugs restricted, revoked, suspended, or cancelled? ❑ yes ❑ no

12. (a) Are either your Podiatric license or DEA license under pending investigation? ❑ yes ❑ no

(b) Have you ever voluntarily surrendered your Podiatric license or DEA license during or following an investigation? ❑ yes ❑ no

13. (a) Has any hospital, clinic or other facility 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 following a staff investigation? ❑ yes ❑ no

14. Have you ever been denied a license or certification by a specialty board? ❑ yes ❑ no

15. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? ❑ yes ❑ no

16. Have you ever been convicted of a crime other than a minor traffic violation? ❑ yes ❑ no

17. Have any fee complaints or professional relations complaints been registered against you with any professional association or licensing authority? ❑ yes ❑ no

18. Have you ever been the subject of disciplinary proceedings or been reprimanded by an administrative agency, hospital, professional association or peer review? ❑ yes ❑ no

19. Has your professional liability insurance ever been denied, cancelled or non-renewed or do you have knowledge that your present insurer plans to cancel or non-renew your coverage? ❑ yes ❑ no
If "yes," please explain why, when and name of insurer(s).

F. Claim Information

1. Has any professional liability claim or suit ever been brought against you? ❑ yes ❑ no
If "yes," please provide the total number of claims and complete the information for all claims/suits in Section VI, ***Claim/Suit Information Addendum*** *on page 8* #____________

(Failure to provide complete information as requested will cause delay in processing your application.)

IV. AUTHORIZATION AND REPRESENTATION STATEMENT

I certify that the foregoing information is true and correct and agree that if any policy is issued, such policy will be issued in reliance upon the representations made herein.

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 county or state professional society, association or organization; 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 Professional Liability Coverage. 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 insurance coverage from TMIC, I hereby release TMIC and its representatives from liability for any acts or omissions in connection with any communications, investigation or decision regarding insurance underwriting investigation.

____

Applicant's Signature *Date*

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

V. ADDITIONAL INFORMATION

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

Page Number	*Question Number*	*Answer and/or Details*

VI. CLAIM/SUIT INFORMATION ADDENDUM

If additional space is required, please photocopy this form as needed. Please type or print in black ink.
Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.

1. Claim/Suit Information Name of applicant: ___________________________________

Patient's Name: __________________________Age: ______Sex: ______Date of incident: ___________________
(month/day/year)

Insurance company defending your claim: _____________________________Policy # ______________________

Location: City___________________________________State __________Hospital ______________________

Procedures performed: ____

ALLEGATIONS and narrative description of the treatment and your involvement:

____

____

____

____

Co-defendants:____

Suit filed?	❏ yes	❏ no	If "yes," month______________ year_______________
Court trial?	❏ yes	❏ no	If "yes," month______________ year_______________
Jury verdict?	❏ yes	❏ no	If "yes," month______________ year_______________
Settlement out of court?	❏ yes	❏ no	If "yes," month______________ year_______________

❏ Claim settled without indemnity payment on your behalf
❏ Claim is pending:
Amount in reserve by insurance company: $________________________
Total amount paid to claimant on your behalf: $________________________
Total amount paid to claimant for all defendants: $________________________

2. Claim/Suit Information Name of applicant: ___________________________________

Patient's Name: __________________________Age: ______Sex: ______Date of incident: ___________________
(month/day/year)

Insurance company defending your claim: _____________________________Policy # ______________________

Location: City___________________________________State __________Hospital ______________________

Procedures performed: ____

ALLEGATIONS and narrative description of the treatment and your involvement:

____

____

____

____

Co-defendants:____

Suit filed?	❏ yes	❏ no	If "yes," month______________ year_______________
Court trial?	❏ yes	❏ no	If "yes," month______________ year_______________
Jury verdict?	❏ yes	❏ no	If "yes," month______________ year_______________
Settlement out of court?	❏ yes	❏ no	If "yes," month______________ year_______________

❏ Claim settled without indemnity payment on your behalf
❏ Claim is pending:
Amount in reserve by insurance company: $________________________
Total amount paid to claimant on your behalf: $________________________
Total amount paid to claimant for all defendants: $________________________

3. Claim/Suit Information   Name of applicant: ______________________

Patient's Name: ______________________ Age: ______ Sex: ______ Date of incident: ____________________
(month/day/year)

Insurance company defending your claim: ______________________ Policy # ____________________

Location: City ______________________ State __________ Hospital ____________________

Procedures performed: ____
ALLEGATIONS and narrative description of the treatment and your involvement:

____

____

____

____

Co-defendants: ____

Suit filed?	❏ yes	❏ no	If "yes," month__________ year__________
Court trial?	❏ yes	❏ no	If "yes," month__________ year__________
Jury verdict?	❏ yes	❏ no	If "yes," month__________ year__________
Settlement out of court?	❏ yes	❏ no	If "yes," month__________ year__________

❏ Claim settled without indemnity payment on your behalf
❏ Claim is pending:
Amount in reserve by insurance company: $____________________
Total amount paid to claimant on your behalf: $____________________
Total amount paid to claimant for all defendants: $____________________

4. Claim/Suit Information   Name of applicant: ______________________

Patient's Name: ______________________ Age: ______ Sex: ______ Date of incident: ____________________
(month/day/year)

Insurance company defending your claim: ______________________ Policy # ____________________

Location: City ______________________ State __________ Hospital ____________________

Procedures performed: ____
ALLEGATIONS and narrative description of the treatment and your involvement:

____

____

____

____

Co-defendants: ____

Suit filed?	❏ yes	❏ no	If "yes," month__________ year__________
Court trial?	❏ yes	❏ no	If "yes," month__________ year__________
Jury verdict?	❏ yes	❏ no	If "yes," month__________ year__________
Settlement out of court?	❏ yes	❏ no	If "yes," month__________ year__________

❏ Claim settled without indemnity payment on your behalf
❏ Claim is pending:
Amount in reserve by insurance company: $____________________
Total amount paid to claimant on your behalf: $____________________
Total amount paid to claimant for all defendants: $____________________