



TEXAS MEDICAL INSURANCE COMPANY

ENCLOSED ARE THE FORMS NECESSARY FOR APPLICATION

- 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.
- Loss runs from your current insurance carrier. TMIC reserves the right to request historical loss runs if needed.
- Review and sign the *Business Associate Agreement*.
- Enclose your check for 25% of the annual premium along with your application. Please contact your sales representative for the amount due. Your check must be received and your application approved prior to binding or effecting coverage.**
- Enclose a copy of your current *Curriculum Vitae*, your *Office Letterhead*, and a copy of your current *Professional Liability Declarations Page*.
- Group Coverage:** If you are a member of a multi-member professional association, partnership, or similar group and desire coverage for the entity, **one** *Professional Association/Partnership Application* should be completed and returned. If Prior Acts Coverage is needed for the entity, please complete the *Prior Acts Coverage* section of the application.

Premium may be paid on a monthly, quarterly or annual basis. Quarterly and annual payment options will be billed by invoice. If you choose the monthly payment option, you must complete, sign and return an *Authorization for Direct Bank Debit* along with a voided check on the account to be debited.

MC/Visa payment options are available. Please contact a TMLT/TMIC sales representative for more information.

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



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 COVERAGE

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

POLICY NUMBER _____ (For Office Use Only)

I. GENERAL INFORMATION

A. _____ M.D. D.O.
First Name Middle Name Last Name
Home Address City State Zip Code
Date of Birth # Texas Medical License/Status # 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

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

1. _____
Number Street Suite City State Zip County
2. _____
Number Street Suite City State Zip County

C. Please list all Texas hospitals where you currently practice or intend to practice. List principal location first.

Table with 3 columns: Hospital Name, City, Type of Privileges. Type of Privileges includes Full, Courtesy, *Restricted, *Other checkboxes.

*If Restricted or Other, please provide details on page 10.

D. Preferred Mailing Address: Home Principal Office P.O. Box/State/Zip Code

E. Other counties where you practice and percentage _____

F. Is any of your practice outside of Texas? No Yes Where/Percentage _____

II. PROFESSIONAL LIABILITY COVERAGE

A. 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.

B. Professional Liability Coverage Please check type of coverage (**Occurrence or Claims-made**) and the limits of liability desired.

- 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 \$300,000/\$900,000 \$500,000/\$1,000,000

C. Professional Premise Liability Coverage (This is limited coverage available only for patients at office locations.)

Limits of liability for patient bodily injury and property damage are \$200,000 Each Claim and All Claims.

Do you wish to apply for this coverage? Yes No

D. Insurance History for Previous Three Years

	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 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

III. PRIOR ACTS COVERAGE

If you are not requesting Claims-made coverage, including Prior Acts, from TMIC, skip to page 4, Section IV.

NOTE: The following two questions apply to your *past* Claims-made coverage and need to be answered for the entire time period following your retroactive date.

- A.** Has any portion of your practice been performed outside the state of Texas? Yes No
If yes, please list below the states, dates and the percentage of practice for each year.

- B.** Has your Claims-made policy ever included coverage for any other individual or for an Entity other than a Solo PA? Yes No

If yes, please explain below and attach a copy of any endorsement providing coverage for such other individual (including locum tenens) or Entity. Each is subject to separate underwriting consideration.

- C.** 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

- D.** Have you reported any incidents (which have not yet resulted in a claim or suit) to another insurance carrier? Yes No

- E.** Have you received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, or other legal process or notification? Yes No

If you answered yes to C, D, or E above, you must provide details below. Report all incidents identified under C or E to your current insurance carrier. Doing so does not necessarily eliminate the need for the Reporting Endorsement (tail coverage).

Patient Name	Date of Incident	Date incident report sent to insurance carrier (provide copies)
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

IV. UNDERWRITING AND RATING INFORMATION

A. Medical Practice History

I. Education

	SCHOOL/HOSPITAL	CITY/STATE	FROM / TO	DEGREE/SPECIALTY
Medical School				
Internship				
Residency				
Fellowship				

2. a. Did you complete residency training? Yes No

b. Are you entering practice for the first time immediately following residency training, military service or an academic position? Yes No

3. a. Are you American Board Certified? Yes No

Name of Specialty Board

Date(s) Certified

b. If not certified, are you admissible to a Specialty Board examination? Yes No

Name of Board

Exam Date

c. Have you ever failed to pass a Board exam? Yes No

Name of Specialty Board

Which portion?/Date(s)

d. Are you certified? ACLS ATLS PALS

e. Have you ever been denied a medical license or certification by a Specialty Board? Yes No
If yes, please provide details on page 10.

4. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF MEDICAL SCHOOL, WITH THE EXCEPTION OF YOUR RESIDENCY OR FELLOWSHIP TRAINING. INCLUDE YOUR SPECIALTY AT THAT TIME.

Specialty City State Country From ____/____/____ To ____/____/____
Month Year Month Year

Specialty City State Country From ____/____/____ To ____/____/____
Month Year Month Year

Specialty City State Country From ____/____/____ To ____/____/____
Month Year Month Year

IV. UNDERWRITING AND RATING INFORMATION

B. Medical Practice Structure / Operations

1. I. Practice type:

- Individual/Solo unincorporated
- Solo incorporated (Solo P.A. coverage is automatically provided under individual policy.)
- Employee of _____
- Partner or Shareholder of _____
- Locum Tenens

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

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

Federal Tax ID Number: _____

2. A. Do you **Employ** **Supervise** **Contract**

with any licensed physicians? (Include Interns, Residents or Fellows) Yes No

B. Do you **Employ** **Supervise** **Contract**

with midwives or any individuals who administer anesthesia, other than licensed physicians? Yes No

If yes to 2A or 2B, list below.

Name	Specialty	Insured By	Limits of Liability
_____	_____	_____	_____
_____	_____	_____	_____

3. Indicate number of professional licensed personnel in each category employed or supervised by you personally or by any Entity of which you are a member or shareholder.

	Insured by	Limits of Liability
_____ RNs	_____	_____
_____ LVNs	_____	_____
_____ Lab/Radiology Techs	_____	_____
_____ PAs	_____	_____
_____ Nurse Practitioners	_____	_____
_____ LPTs	_____	_____
_____ Other	_____	_____

4. Average number of patients seen per week: # _____

5. Average number of practice hours per week involved in both direct patient care and related administrative activities: # _____

IV. UNDERWRITING AND RATING INFORMATION

C. Medical Practice Description

1. What is your Medical Specialty? _____

2. Please check any of the following procedures you perform:

<u>Biopsy</u>		Endoscopic Sclerotherapy	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>
Breast	<input type="checkbox"/>	ERCP's	<input type="checkbox"/>	Saline Breast Implants	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	Esophageal Gastro Dilatation	<input type="checkbox"/>	Silicone Breast Implants	<input type="checkbox"/>
Liver	<input type="checkbox"/>	Liposuction	<input type="checkbox"/>	Silicone Injections	<input type="checkbox"/>
Lung	<input type="checkbox"/>	Percutaneous Gastrostomy	<input type="checkbox"/>	Spinal Surgery	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	Percutaneous Transhepatic		Tubal Ligations	<input type="checkbox"/>
Cardiac Catheterization	<input type="checkbox"/>	Cholangiography	<input type="checkbox"/>	Vasectomies	<input type="checkbox"/>

3. Do you perform minor surgery other than the incision of boils, suturing of skin or superficial abscesses? Yes No

(includes most procedures performed under a local anesthetic)

If yes, # per year _____

4. Do you perform major surgery? Yes No

(includes tonsillectomies, adenoidectomies, D&C's, cesarean sections, abortions and open fractures)

If yes, # per year _____

5. Surgeries per year:
Cardiovascular _____% Thoracic _____% Vascular _____%

6. Do you assist in major surgery on your own patients? Yes No

If yes, # per year _____

7. Do you assist in major surgery on patients other than your own? Yes No

If yes, # per year _____

8. Do you perform major surgery in a freestanding facility or your office? Yes No

If yes, please provide details on page 10.

9. Do you perform weight control surgery? Yes No

(Limits restricted on this procedure to a maximum of \$200,000/\$600,000, or limits being requested, if lower.)

If yes, # per year: _____ Type: _____

10. Do you perform pain management procedures in an office? Yes No

If yes, please request a pain management questionnaire for completion.

11. Is laser equipment utilized in your practice(s)? Yes No

If yes, please provide details on page 10.

12. Do you perform plastic surgery? Yes No

Cosmetic: _____% Reconstructive: _____%

IV. UNDERWRITING AND RATING INFORMATION

C. Medical Practice Description (continued)

13. Does your practice include cosmetic/aesthetic procedures? Yes No
If yes, please provide details on page 10.
14. Does your practice include telemedicine? _____% Yes No
If yes, please provide details on page 10.
15. Do you function as a Hospitalist? Yes No
If yes, please provide details on page 10.
16. Do you perform emergency medicine other than for maintaining privileges? Yes No
If yes: Number hours per week _____
Is insurance provided for this exposure? Yes No
If yes, please provide details on page 10.
17. Do you provide patient care in a nursing home or other residential care facility? Yes No
If yes, what percentage of these visits represents your total annual patient visits? _____
18. Are you a medical director of a nursing home or other residential care facility? Yes No
If yes, please provide:
a. the number of nursing homes and/or facilities _____
b. a copy of the professional liability insurance policy, including the Declarations Page, for each nursing home and/or facility, showing that your medical director duties are insured. TMIC's policy provides coverage for direct patient care but does not cover your liability as a medical director.
c. the name(s) of any nursing home(s) or other residential care facility(ies) in which you are an owner, partner, shareholder, stockholder, etc.
19. Do you provide prenatal care? Yes No
If yes, does it include high risk pregnancy? Yes No
a. Do you deliver infants? Yes No
Vaginal deliveries #/year _____ VBAC #/year _____ C-sections #/year _____
b. Do you practice in a freestanding birthing center? Yes No
Medicare certified? Yes No
Vaginal deliveries #/year _____ C-sections #/year _____
20. Do you perform abortions? Yes No
If yes: Office #/year _____ Hospital #/year _____ Other #/year _____
21. Do you spend greater than 50% of your practice time supervising medical students, residents or fellows? Yes No
Is insurance provided for this exposure? Yes No
If yes, please provide details on page 10.
22. Do you advertise? Yes No
If yes, please send samples of your Yellow Page display ads and other media advertisements.
If you use radio or television, please provide details on page 10.

IV. UNDERWRITING AND RATING INFORMATION

C. Medical Practice Description (continued)

If you answer yes to questions 23-35, please provide details on page 10.

23. Do you dispense or prescribe medications or use medical devices which are disapproved by the FDA in the treatment or care of human beings? Yes No
24. 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.
25. Have you now or ever had any chronic illness, mental illness or physical defect? Yes No
If yes, provide details and a recent statement of insurability from your treating physician.
26. Has your medical license or permit to prescribe drugs ever been under investigation or voluntarily surrendered? Yes No
27. Has your medical license or permit to prescribe drugs ever been denied, restricted, revoked, suspended, or cancelled? Yes No
28. (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
29. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? Yes No
30. Have you ever been indicted, charged or convicted of a crime other than a minor traffic violation? Yes No
31. Have any fee complaints or professional relations complaints ever been made against you with your medical association, hospital or licensing authority? Yes No
32. Have Medicare/Medicaid or their authorities ever brought charges against you for alleged fraud or inappropriate fees? Yes No
33. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? Yes No
34. 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).
35. Are you aware that your present insurer plans to restrict, surcharge, cancel or non-renew your coverage? Yes No
36. 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 pages 10-11.

V. 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 hereby authorize all insurance carriers who have previously provided me with professional liability insurance or any licensing agency in this or any other state to supply any information regarding previous claims or lawsuits to TMIC upon its request.

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: Texas State Board of Medical Examiners; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society 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 Medical Professional Liability and/or Premise 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 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.

The medical professional liability coverage provided by your policy is issued through the TMIC Risk Purchasing Group. No claim against a purchasing group or its members shall be entitled to payment from any insurance insolvency guaranty fund or similar mechanism in Texas. The insurer for the TMIC Risk Purchasing Group may not be subject to all the insurance laws and regulations of this state. The insurance insolvency fund may not be available to the purchasing group.

Physician'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 **Curriculum Vitae**, your **Office Letterhead**, and a copy of your current **Professional Liability Declarations Page**.

VII. CLAIM/SUIT INFORMATION ADDENDUM

2. CLAIM/SUIT INFORMATION

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

Insurance company defending your claim: _____

Location: City _____ State _____ Hospital _____

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) 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: \$ _____

3. CLAIM/SUIT INFORMATION

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

Insurance company defending your claim: _____

Location: City _____ State _____ Hospital _____

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) 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: \$ _____