MIEC

6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

Employed, Subcontracting or Volunteer Physician Application for Professional Liability Insurance Additional Insured Basis

Please type or print. Answer all questions. Please note that this application is for coverage limited to services rendered while employed by, or practicing as a sub-contractor or volunteer of the individual(s) or entity listed in Question 3. Please sign as indicated on pages 10, 12 and 13.

PERSONAL INFORMATION / LICENSE / CERTIFICATE INFORMATION — ANSWER 1- 4

1. PERSONAL INFORMATION

First Name | M.I. | Last Name | Date of Birth (mm/dd/yyyy) | Place of Birth | Country | Male/Female

2. NAME OF GROUP YOU WILL WORK FOR

Name of Group

3. HOSPITAL LOCATIONS WHERE YOU WILL WORK

Name | Address | City | State | Zip Code

Name | Address | City | State | Zip Code

4. ACTIVE LICENSES/CERTIFICATES

State | License Number | Date Licensed | Expiration Date

State | License Number | Date Licensed | Expiration Date

State | License Number | Date Licensed | Expiration Date

Narcotics License | Date Licensed | Expiration Date

MEDICAL EDUCATION AND TRAINING — ANSWER 5-12

5. MEDICAL SCHOOL

Name _____ City _____ State _____ Country _____

From _____ (mm/yyyy) To _____ (mm/yyyy) Degree _____

6. INTERNSHIP

Hospital _____ City _____ State _____ Country _____

From _____ (mm/yyyy) To _____ (mm/yyyy)

7. RESIDENCY

Hospital _____ City _____ State _____ Country _____

Medical Specialty _____ From _____ (mm/yyyy) To _____ (mm/yyyy) Residency complete? ☐ Yes ☐ No

8. ADDITIONAL RESIDENCY

Hospital _____ City _____ State _____ Country _____

Medical Specialty _____ From _____ (mm/yyyy) To _____ (mm/yyyy) Residency complete? ☐ Yes ☐ No

9. FELLOWSHIPS AND ADDITIONAL MEDICAL TRAINING

Hospital or Facility _____ City _____ State _____ Country _____

Type of Training _____ From _____ (mm/yyyy) To _____ (mm/yyyy)

Hospital or Facility _____ City _____ State _____ Country _____

Type of Training _____ From _____ (mm/yyyy) To _____ (mm/yyyy)

10. BOARD CERTIFICATION

Are you certified by one or more of the boards of the American Board of Specialties? ☐ Yes ☐ No

Name of Board _____ Year Certified _____

Name of Board _____ Year Certified _____

If not currently certified, are you Board prepared? ☐ Yes ☐ No

Do you intend to take the Board examination? ☐ Yes ☐ No When? _____ Date

MEDICAL EDUCATION AND TRAINING, cont'd. ANSWER 5-12

10. BOARD CERTIFICATION, cont'd.

If you are no longer Board eligible, state reason:_____

_____

If eligible, have you taken the written examination? ☐ Yes ☐ No Result_____

Oral examination? ☐ Yes ☐ No Result_____

11. CONTINUING MEDICAL EDUCATION

How many hours of Category 1 CME have you taken in each of the last two years?_____Last Year _____2 years prior

12. SPECIALTY

A. What is your medical or surgical specialty?_____

B. Do you limit your practice to the above specialty? ☐ Yes ☐ No

C. Do you have a subspecialty? If yes, please describe:_____

D. Do you limit your practice to the above subspecialty? ☐ Yes ☐ No

SCOPE OF PRACTICE ANSWER 13-25

13. PRACTICE ACTIVITY

A. How many hours per week do you render professional services as an employed or contract physician of the entity under which you are applying for professional liability coverage?_____

B. How many patients per week do you see on behalf of the facility?_____

C. Do you have a separate private practice? ☐ Yes ☐ No

If yes, do you carry individual professional liability insurance for this private practice? ☐ Yes ☐ No

Name of Carrier_____

Limits of Liability_____ Expiration Date of Policy_____

14. HOSPITALS AND AMBULATORY SURGERY CENTERS

List ALL hospitals and ambulatory surgery centers where you currently have privileges or have applied for privileges. Indicate type of privileges and restrictions, if any. Also, if you wish evidence of coverage sent to any of these hospitals, please indicate.

Name of Hospital	Type of Privileges	Restrictions
Name of Hospital	Type of Privileges	Restrictions
Name of Hospital	Type of Privileges	Restrictions

PROCEDURES	ANSWER 15-25

15. OFFICE SURGERY

A. Do you perform surgical procedures, other than minor surgery such as the removal of skin lesions, suture of lacerations, etc., at the facility? ☐ Yes No ☐

If yes, describe the procedures._____

B. What type(s) of anesthesia are used for these procedures, and who administers?

Type of Anesthesia	Administered By
Type of Anesthesia	Administered By

16. X-RAYS

Do you take and interpret X-rays? ☐ Yes No ☐

If yes, describe type of X-rays taken and interpreted._____

17. SURGERY

A. Do you perform surgery at a hospital not accredited by the Joint Commission on Accreditation of Healthcare Organizations? ☐ Yes ☐ No

If yes, provide name of facility(ies) and list procedures performed._____

B. Do you perform surgery at a non-hospital outpatient facility? ☐ Yes ☐ No

If yes, provide name of facility(ies) and list procedures performed._____

18. ANESTHESIA

A. Do you administer regional or general anesthesia in a non-hospital facility? ☐ Yes ☐ No

Describe fully._____

B. Do you supervise nurse anesthetists (CRNA)? ☐ Yes ☐ No

If yes, how many?_____ What facility(ies)?_____

19. DELIVERIES

A. Do you participate in any program of planned non-hospital births? ☐ Yes ☐ No

Describe fully._____

B. Do you perform home deliveries? ☐ Yes ☐ No

C. Do you sponsor, supervise, direct or participate in nurse midwife deliveries? ☐ Yes ☐ No

Describe fully._____

20. PROCEDURES

☐ *Check here if none.* Please check ALL procedures that you perform, and provide estimates of how many you perform per year.

☐ Abortions	#_____	☐ Hair transplants	#_____
☐ Acupuncture	#_____	☐ Intraocular lens implants	#_____
☐ Angiography	#_____	☐ IVPs	#_____
☐ Angioplasty	#_____	☐ Laparoscopic cholecystectomy	#_____
☐ Aortography	#_____	☐ Other laparoscopic procedures	#_____
☐ Cardiac catheterization	#_____	☐ Myelography	#_____
☐ Contrast media in CNS	#_____	☐ Pacemaker insertions, temporary	#_____
☐ Coronary angiography	#_____	☐ Pacemaker Insertions, permanent	#_____
☐ Cosmetic plastic surgery (non-specialist)	#_____	☐ Periocular tattooing	#_____
☐ Administration of drug shock therapy*	#_____	☐ Therapeutic use of X-rays	#_____
☐ Administration of electroshock therapy*	#_____	☐ Posterior lumbar fusion*	#_____
☐ Use of chymopapain*	#_____	☐ Other spinal surgery*	#_____
☐ Intragastric balloon placement*	#_____	☐ Total joint replacements	#_____
☐ Delivery of Infants in locations other than state licensed acute-care facilities*	#_____	☐ Surgical suction lipectomy	#_____
☐ Use of Laetrile**	#_____	☐ Radial keratotomy*	#_____
☐ Surgery intended for weight reduction**	#_____	☐ Refractive keratoplasty	#_____
☐ Use of chelation therapy in treatment of cardiovascular disease**	#_____	☐ None	#_____

*Coverage for these procedures is excluded under MIEC's policy. If you want to be insured for any of these procedures, MIEC will require additional information be submitted and committee approval be obtained before coverage can be extended. Please call MIEC.

**MIEC does not provide coverage for these procedures.

21. SURGICAL PROCEDURES

☐ *Check here if none.* Check which surgical procedures you perform and percentage of your total medical practice (with regard to your employment by the group in Question 2) each represents. (Do not include assisting at surgery.)

	# Performed Per Year / Percent		# Performed Per Year / Percent
☐ Abortions_____ Type/Trimester	_____/_____%	☐ Neurosurgery	_____/_____%
☐ Anesthesiology*	_____/_____%	☐ Obstetrics**	_____/_____%
☐ Cardiovascular surgery	_____/_____%	☐ Ophthalmic surgery	_____/_____%
☐ Colon and rectal surgery	_____/_____%	☐ Orthopedic surgery (include closed reductions)	_____/_____%
☐ General surgery	_____/_____%	☐ Plastic surgery – cosmetic**	_____/_____%

PROCEDURES, cont'd. ANSWER 13-25

22. SURGICAL PROCEDURES, cont'd.

	# Performed Per Year / Percent		# Performed Per Year / Percent
☐ Gynecologic surgery (other than abortions)	_____/_____%	☐ Plastic surgery - other	_____/_____%
☐ Hand surgery	_____/_____%	☐ Thoracic surgery (other than Cardiovascular)	_____/_____%
☐ Head and neck surgery	_____/_____%	☐ Urologic surgery	_____/_____%
Describe_____		☐ Vascular surgery	_____/_____%

*Important: Please sign and attach an "Anesthesia Restrictive Endorsement."

**Important: Please sign and attach a "Supplement to Application for Obstetrical Practice." If not enclosed, please call MIEC.

***If you are not a Board certified or Board eligible plastic surgeon, please attach a description of cosmetic procedures that you perform.

NOTE: If your surgical practice will change significantly in the coming year, attach a narrative description of the changes to this application.

23. WEIGHT CONTROL

Do you specialize in weight control practice? ☐ Yes ☐ No

If yes, please describe._____

24. SEX THERAPY

Do you specialize in, or does a significant portion of your practice include therapy, counseling, or surgery for sexual dysfunction? ☐ Yes ☐ No

If yes, explain methodology._____

_____

25. EXPERIMENTAL AND INVESTIGATIVE PROCEDURES

Do you use experimental procedures, drugs or therapy in treatment or surgery? ☐ Yes ☐ No

If yes, please describe._____

Do you follow FDA approved protocol? ☐ Yes ☐ No

Describe fully._____

PROFESSIONAL AND INSURANCE HISTORY ANSWER 26-33

26. MEMBERSHIPS AND ACTIVITIES

Medical Specialty Societies, Professional Associations and Hospital Committees

_____ _____
Organization/Society/Committee Name Title or Position Held

_____ _____
Organization/Society/Committee Name Title or Position Held

_____ _____
Organization/Society/Committee Name Title or Position Held

27. PAST PRACTICE LOCATIONS

List ALL locations you have practiced since completing your formal training. (Include military, private and group organizations.)

Name/Type of Practice | City | State | From (mm/yyyy) | To (mm/yyyy)

Reason for leaving.

Name/Type of Practice | City | State | From (mm/yyyy) | To (mm/yyyy)

Reason for leaving.

Name/Type of Practice | City | State | From (mm/yyyy) | To (mm/yyyy)

Reason for leaving.

Name/Type of Practice | City | State | From (mm/yyyy) | To (mm/yyyy)

Reason for leaving.

Name/Type of Practice | City | State | From (mm/yyyy) | To (mm/yyyy)

Reason for leaving.

28. PAST HOSPITAL STAFF PRIVILEGE LOCATIONS

If you have relocated your practice within the past five years, list names and addresses of hospitals where you previously had staff privileges.

Name of Hospital | Address | City | State | Zip Code

Name of Hospital | Address | City | State | Zip Code

Name of Hospital | Address | City | State | Zip Code

Name of Hospital | Address | City | State | Zip Code

Name of Hospital | Address | City | State | Zip Code

29. PRIOR INSURANCE

List ALL professional liability carriers who have insured you.

Name of Carrier | Address | City | State | Zip Code

Coverage Dates | Policy No. ☐ Claims-Made ☐ Occurrence

29. PRIOR INSURANCE, cont'd.

Name of Carrier | Address | City | State | Zip Code

Coverage Dates | Policy No. ☐ Claims-Made ☐ Occurrence

Name of Carrier | Address | City | State | Zip Code

Coverage Dates | Policy No. ☐ Claims-Made ☐ Occurrence

If current policy is claims-made, do you intend to purchase tail coverage? ☐ Yes ☐ No

Complete an "Authorization to Release Information" for each carrier listed (see page 13).

30. INSURANCE

Has any insurance ever declined, canceled, refused to renew, restricted, or rated up your professional liability insurance? ☐ Yes ☐ No

If yes, give details._____

31. GOVERNMENTAL ACTION

A. Have you ever been investigated as the subject of, charged with or convicted of a misdemeanor or felony in this state or any other state or country? ☐ Yes ☐ No

B. Have you ever entered a "no contest" plea to a crime, other than a traffic violation? ☐ Yes ☐ No

If you answered "yes" to Question 33A or B, please furnish full details on your letterhead, including the following information.

1. The nature of the investigation, the charge made or entered against you and the date and jurisdiction in which it was made or entered.
2. The substance of the investigation or allegations made or entered in the charge.
3. The manner in which the investigation or charge was resolved (i.e., dismissal, conviction, etc.).
4. Any additional information concerning the investigation or charge as you may deem appropriate.

C. Have you ever been investigated by any state or federal regulatory body? ☐ Yes ☐ No

D. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your medical license or your narcotics license? ☐ Yes ☐ No

If you answered "yes," to questions 32C or D, please furnish full details, included the following information.

1. The reasons for the suspension, restriction, termination, curtailment, revocation, or nonrenewal of your license, and/or the disciplinary action.
2. The substance of both the allegations and findings in any such action, proceeding, hearing, or procedure involving the suspension, restriction, termination, curtailment, revocation, or non-renewal of your license and/or disciplinary action.
3. The date of suspension, restriction, termination, curtailment, revocation, or non-renewal of your license, and/or the disciplinary action; the full name of the licensing agency and its full address.
4. Any additional information concerning such action, proceedings, hearing, or procedure as you may deem appropriate.

32. STAFF PRIVILEGES

Have you ever had any hospital or surgical outpatient privileges denied, suspended, revoked, restricted, reduced, proctored or modified in any way? ☐ Yes ☐ No

If yes, furnish details, including name, dates, allegations, circumstances, and outcome on your letterhead.

PROFESSIONAL AND INSURANCE HISTORY, cont'd. ANSWER 26-33

33. HEALTH

A. Have you ever received treatment or consultation for drug or alcohol abuse? ☐ Yes ☐ No

B. Are you being treated for any medical condition, disease or illness that affects your ability to practice medicine? ☐ Yes ☐ No

If you answered "yes" to any of the above, please furnish details, which must include:

1. The nature of the condition for which you sought treatment or consultation; the hospital or other institution at which you treated or were consulted and its full address; the hospital or other institution with which you were affiliated at the time and its full address; the name of the individual with whom you treated or consulted; the date(s) of treatment or consultation.
2. The name of the treatment or consultation and the recommended course of continuing treatment or consultation.
3. The manner in which the condition for which you were treated or consulted currently affects your day-to-day activities.
4. Any additional information concerning the treatment or consultation as you may deem appropriate.

CLAIMS HISTORY ANSWER 34

34. CLAIMS

Have you ever been involved in a malpractice claim, suit or arbitration proceeding, or reported any incidents which resulted in a claim to a former carrier? ☐ Yes ☐ No

If yes, please complete a Claim Information Form for each claim or suit on page 11.

COVERAGE REQUEST ANSWER 35

35. REQUESTED COVERAGE DATE

_____
Date (mm/dd/yyyy)

I request that this insurance commence at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

NOTE: Approval for coverage and actual effective date are subject to the decision of MIEC's Underwriting Department.

ADDITIONAL COMMENTS

CLAIM INFORMATION FORM

☐ Attachment contains this information ☐ None [Please be sure to check here if no claims]

Name of Patient/Claimant _____ Gender _____ Age _____

1. Condition and diagnosis of patient prior to treatment and/or surgery:

2. Date(s) and type of treatment and/or surgery rendered by you:

3. Condition of patient subsequent to treatment and/or surgery by you:

4. Nature of allegation:

5. Was a suit ever filed against you? ☐ Yes ☐ No

   If yes, was it served? ☐ Yes ☐ No

   When? _____

6. Names of other doctors and hospital, if any, involved:

7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

Name of insurance carrier defending you

Name of attorney defending you

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

LIMITED PRACTICE WARRANTIES

PLEASE READ AND SIGN THE APPROPRIATE WARRANTY, IF APPLICABLE.

Non-surgical specialists and family/general practitioners who do not perform surgery

I limit my practice to non-surgical and non-obstetrical cases, and do not assist in any element of surgery as defined.

Signature _____ Date _____

Non-surgical specialists and family/general practitioners who do not perform surgery but occasionally assist

I limit my practice to non-surgical and non-obstetrical cases. On request of my patients, I perform a maximum of 50 surgical assists per year.

Signature _____ Date _____

Family/general practitioners - Limited performance of surgery, unlimited surgery assists, excluding obstetrics

I estimate that during the next 12 months less than 5% of my medical practice will be surgery. I do not include obstetrics, orthopedics (other than closed reductions), plastic surgery, neurosurgery, thoracic surgery, or the administration of regional or general anesthesia in my practice.

Signature _____ Date _____

Psychiatrists

I limit my practice to psychiatry and do not engage in the practice of electroshock or drug-shock therapy.

Signature _____ Date _____

Note: Procedures such as suturing and the removal of skin lesions are not considered surgical procedures by MIEC.

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to Medical Insurance Exchange of California, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that all statements and answers in this application are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned understands that this application for professional liability coverage, if accepted, will apply only to professional services rendered while acting within the scope of undersigned's duties as an employee of, subcontractor of, or volunteer for the entity shown under Question 2 of the attached application.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature and Title _____ Print Name _____ Date _____

WARRANTY

I understand that the insurance coverage is limited to my practice while working within the scope of my duties as an employed, subcontracting or volunteer dentist of the individual or entity and while at the location(s) listed on page one and shall not apply to any separate private practice, or to services rendered at any other facility. I further understand that the coverage applicable to me is governed by the terms, conditions and exclusions, of the policy or policies issued by MIEC to the individual(s) or entity shown under Question 2 of this application.

Signature and Title _____ Print Name _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION FOR HOSPITALS/MEDICAL STAFFS / AMBULATORY FACILITIES

As an applicant for initial or continued professional liability insurance coverage from MEDICAL INSURANCE EXCHANGE OF CALIFORNIA (MIEC), I hereby give my consent to MIEC, its agents and representatives, to make inquiries to hospitals, medical staffs or ambulatory facilities where I have exercised or applied for clinical privileges.

I grant permission to hospitals and medical staffs and their representatives and agents to provide information to MIEC which pertains to those privileges I have exercised and to my fitness and qualifications to exercise such privileges. This includes but is not limited to information relating to the scope of privileges granted, any special limitations imposed on such privileges and any information regarding my disciplinary action taken with respect to such privileges.

I further agree that the organization releasing the information, its representatives, agents, servants and employees shall not incur any liability as a result of furnishing or releasing information pursuant to this authorization, even if such information is incomplete or incorrect.

Signature and Title _____ Print Name _____ Date _____

Facility Name and Address _____ City _____ State _____ Zip _____

AUTHORIZATION TO RELEASE INFORMATION FOR PRIOR CARRIERS / MEDICAL ASSOCIATIONS

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society.

I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

Signature and Title	Print Name	Date

Facility Name and Address	City	State	Zip

You can send in your application by:

1. Mail- {Print PRE-PAID Mailing Label]
2. Fax- (510) 654-4634
3. E-mail- Underwriting@MIEC.com

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 739 OAKLAND, CA

POSTAGE WILL BE PAID BY ADDRESSEE

Medical Insurance Exchange of California
Attn: UNDERWRITING
6250 Claremont Avenue
Oakland, CA 94618-9983

PRE PAID MAILING LABEL – PLEASE FIRMLY ATTACH TO YOUR ENVELOPE