Physician and Surgeon
Professional Liability Application for
Claims Made Coverage

LONGEVITY PHYSICIANS
Insurance Company

I. – PRODUCER INFORMATION

Producer Name	Address	Telephone:
		Email Address:

II. – GENERAL APPLICANT INFORMATION

Name of Applicant:	Social Security Number	Date of Birth
Residence Address City State Zip	Office Phone:	
	Residence Phone:	
Preferred Mailing Address: ☐ Residence ☐ Primary Office	Email Address:	

III. – EDUCATION - Copy of C.V. is required

Medical School of Graduation (city, state, country)		Degree	Graduation Date
Name & Location of Internship		Name & Location of Residency	
If foreign medical school graduate, are you certified by the educational council for foreign medical graduates?	☐ Yes ☐ No	Month/Year residency or fellowship completed _____/_____	
Are you certified by an approved specialty board?	☐ Yes ☐ No	If so, list specialty and attach a copy of the certificate.	
Have you participated in any continuing medical education within the last three years?	☐ Yes ☐ No	If yes, how many category one credit hours? ______ Please attach a description or a copy of a certificate of completion.	

IV. – LIMITS OF LIABILITY - Indicate Limits Desired

Each Claim: $	Annual Aggregate: $

V. – COVERAGE INFORMATION

Requested Coverage Effective Date: Effective Date: ___________ Expiration Date: ___________

Claims Made Coverage Desired (please choose one of the below options)

☐ Claims Made with Prior Acts	Retroactive Date Desired: ____________ The retroactive date is the date first continuously insured under a Claims Made policy.	A copy of your current *Declarations Page* illustrating your *Retroactive Date* is required to exercise this option.
☐ Claims Made without Prior Acts	Status of Prior Acts exposure: ☐ Current coverage provided on an Occurrence basis. *LPIC does not offer Occurrence coverage.* ☐ An extended reporting endorsement (tail coverage) has been purchased. Please attach a copy of this document. ☐ An extended reporting endorsement (tail coverage) has not and will not be purchased. This option requires the completion of the below warranty.	Please contact your agent should you have any questions pertaining to the differences between Claims Made and Occurrence coverage, Prior Acts exposures or the additional expense associated with an "extended reporting endorsement" or "tail coverage".

I will not purchase an extended reporting endorsement (tail coverage) from my current carrier where I am insured under a claims made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I purchase from LPIC will not provide prior acts coverage.

Initial here: ☐

VI. – CURRENT PRACTICE STRUCTURE

☐ Individual ☐ Resident/Fellow ☐ Partnership/LLC ☐ Professional Corporation	☐ Solo Corporation ☐ Solo Corporation with employed or contracted physicians	Is corporate coverage desired?	☐ Yes ☐ No
		Corporate limits structure desired?	☐ Shared ☐ Separate
		Name of Solo Corporation/Corporation or Partnership:	
Completion of the Corporation & Partnership Application is required for all Professional Corporations and Partnerships.		Name of partner(s) or other members:	

Please list any Physicians, Surgeons, or Certified Nurse Midwives you employ. *Be sure to identify all Physicians, Surgeons or CNM's in your employ who are not applying for primary coverage with LPIC. Unless Vicarious Coverage for each employee is added to the policy, coverage from exposure arising from these employees against the named insured or associated entity(ies) will not be covered by LPIC. A charge may be applied for vicarious coverage.* ***Non completion of this option will be underwritten as a selection of None.***

Name	Specialty	Surgery Performed			Vicarious Coverage Desired	
		None	Minor	Major	Yes	No
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

Please list any of the following healthcare extenders which you employ.
Physician Assistant, Nurse Practitioner, Advance Practice Registered Nurse or Certified Registered Nurse Anesthetist. *Be sure to identify all ancillary employees in your employ who are not applying for primary coverage with LPIC. Unless Vicarious Coverage for each employee is added to the policy, coverage from exposure arising from these employees against the named insured or associated entity(ies) will not be covered by LPIC. A charge may be applied for vicarious coverage.* ***Non completion of this option will be underwritten as a selection of None.***

Name	Job Title/Specialty	Limit Structure Desired		
		Shared	Separate	Vicarious
		☐	☐	☐
		☐	☐	☐

**If coverage is desired for the above employees the completion of an LPIC Employed Healthcare Extender Application is required.*

Does any one physician supervise more than two Certified Nurse Midwives, Physician Assistant, Nurse Practitioner, Advance Practice Registered Nurse or Certified Registered Nurse Anesthetist? If yes, please submit a letter outlining practice guidelines	☐ Yes ☐ No

VII. – PRACTICE LOCATION(S)

Office Locations (List Primary Location First)

Address	City & State	Zip Code	County	% of Practice
Address	City & State	Zip Code	County	% of Practice
Address	City & State	Zip Code	County	% of Practice
Address	City & State	Zip Code	County	% of Practice

Healthcare Facilities where you have medical staff or courtesy privileges (List Primary Location First)

Hospital	City & State	County	% of Practice	JCAHO Accredited?
Hospital	City & State	County	% of Practice	JCAHO Accredited? ☐ Yes ☐ No
Hospital	City & State	County	% of Practice	JCAHO Accredited? ☐ Yes ☐ No
Hospital	City & State	County	% of Practice	JCAHO Accredited? ☐ Yes ☐ No

VII. – PRACTICE LOCATION(S) (continued)

Previous Locations Of Practice (List most recent location first)				
Address	City & State	County	From Month/Year	To Month/Year
Address	City & State	County	From Month/Year	To Month/Year

VIII. – MEDICAL LICENSING

Please list states in which you hold a license to practice medicine

State	License Number	% of Activities	Active	Inactive	Restricted	Revoked/Suspended
State	License Number	% of Activities	☐	☐	☐	☐
State	License Number	% of Activities	☐	☐	☐	☐
State	License Number	% of Activities	☐	☐	☐	☐

Question	Response
Have you ever been denied a medical license?	☐ Yes ☐ No
Has your medical license ever been restricted, suspended, voluntarily surrendered or revoked in any state?	☐ Yes ☐ No
Has your DEA certificate ever been restricted, suspended, voluntarily surrendered or revoked in any state?	☐ Yes ☐ No
Has a hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges, or probation?	☐ Yes ☐ No
Have you ever been involved in or are you aware of any future involvement in an investigation by a regulatory or peer review board?	☐ Yes ☐ No
Have you ever had a complaint or claim brought against you for sexual misconduct?	☐ Yes ☐ No
Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree?	☐ Yes ☐ No
Have you ever been indicted and/or convicted of a crime other than a minor traffic violation?	☐ Yes ☐ No
Have you ever been suspended, restricted or put on probation by any governmental health program (e.g., Medicare or Medicaid)?	☐ Yes ☐ No
Do you know or have you ever had a drug or alcohol addiction or dependency or sought treatment for such?	☐ Yes ☐ No

If the response to any questions above is Yes, the completion of an LPIC Narrative Addendum is required.

IX. – PRACTICE ACTIVITIES

Please state your medical specialty:		Percentage of your practice:
If applicable please state your sub-specialty:		Percentage of your practice:

Select one of the following as applicable:

☐ No Surgery	Includes incision of boils and superficial abscess, or suturing of skin or superficial fascia. Does not include obstetrical procedures, prenatal care or the assisting in surgery.
☐ Minor Surgery	Includes any superficial surgical procedure involving little hazard to the life of the patient and does not involve anesthesia or respiratory assistance.
☐ Major Surgery	Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard of life.
☐ Assisting in Major Surgery	Includes the additional surgical assistance on the patients of others. If assisting, indicate the percentage of total practice spent assisting: _________% (Do not include if you occasionally assist on an emergency basis.)

IX. – PRACTICE ACTIVITIES (continued)

Please complete each section as applicable:

General Procedures

☐ Alternative/Holistic	☐ IV Therapy
☐ Allergy	☐ Neutral Therapy
☐ Anti-Aging	☐ Nutritional Therapy
☐ Arthritis Treatment	☐ Laser Therapy
☐ Auriculotherapy	☐ Pain Management
☐ Bio-Identical Hormonal Therapy	☐ Prolotherapy
☐ Biopsies	☐ Rheumatology
☐ Bio-Oxidative Therapies	☐ Thermography
☐ Cardiac Catheterization	☐ Ultraviolet Light Blood Irradiation
☐ Chelation Therapy	☐ Weight Management
☐ Candidiasis	☐ Non-FDA Approved Drugs, Pharmaceuticals, or Medical Devices
☐ Colon Hydrotherapy	☐ Acupressure
☐ Hypothyroidism	☐ Bariatrics

Dermatology, Plastic & Cosmetic

☐ Abdominoplasty	☐ Dermabrasion
☐ Blepharoplasty	☐ Hair Transplant
☐ Botox Injection	☐ Liposuction
☐ Breast Augmentation	☐ Phalloplasty
☐ Breast Reduction	☐ Rhinoplasty
☐ Chemical Peels	☐ Silicone Injections
☐ Collagen Injections	☐ Varicose Vein Treatment

Surgeons, please provide breakdown of surgical activities

%	Activity
_______%	Abdominal
_______%	Bariatric
_______%	Assisting in Bariatric
_______%	Cardiac
_______%	Colon/Rectal
_______%	General
_______%	Gynecology
_______%	Hand
_______%	Head/Neck
_______%	Laparoscopic Surgery
_______%	Laser Surgery
_______%	OB/GYN
_______%	Ophthalmology
_______%	Organ Transplants
_______%	Orthopedic (incl. spinal surgery)
_______%	Orthopedic (no spinal surgery)
_______%	Otorhinolaryngology
_______%	Otorhinolaryngology w/Plastic
_______%	Plastic
_______%	Sex Change Surgery
_______%	Thoracic
_______%	Traumatic
_______%	Urological
_______%	Vascular

Anesthesia & Pain Management

☐ Spinal	☐ Acupuncture
☐ Caudal	☐ Facet Blocks
☐ General	☐ Nerve Blocks
☐ Local	☐ Nerve Block (spinal)
☐ Conscious Sedation	☐ Medication Only
☐ Implantation/Removal of Drug Infused Pumps	
☐ Other: ___________________________________	

Radiology

☐ Diagnostic Only	Includes the interpretation of images to aid in the diagnosis or prognosis of disease.
☐ Interventional Radiology	Includes minimally invasive procedures performed using image guidance such as an *angiogram* and also includes procedures done for treatment purposes such as an *angioplasty*.
☐ Mammography	Examination of the human breast.

IX. – PRACTICE ACTIVITIES (continued)

Please complete the following:

Average weekly patient load: __________ Number of direct patient care hours per week: __________

Average weekly walk-in patients: __________ Number of surgical procedures per week: __________

Do you practice less than 21 hours in direct patient care services? ☐ Yes ☐ No
If yes, how many consecutive years have you been practicing under 21 hours: ________

Do you perform surgery in your office? ☐ Yes ☐ No
If yes, please attach a list of these procedures.

Do you treat or review the treatment of prison inmates? ☐ Yes ☐ No
If yes, please provide percentage of practice: _________%

Do you treat or review the treatment of professional athletes? ☐ Yes ☐ No
If yes, please provide percentage of practice: _________%

Do you treat patients in any nursing home, skilled nursing facility or assisted living center? ☐ Yes ☐ No
If yes, please provide percentage of practice: _________%

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ☐ Yes ☐ No
If yes, please attach a description of these activities and provide copies of any protocols and informed consent documents.

Do you or have you ever participated in any weight control treatment including but not limited to the prescribing of anorectic drugs? ☐ Yes ☐ No
If yes, please attach a description of all current and prior weight control activities.

Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary office locations, including but not limited to telemedicine, internet medicine or the interpretation of films, slides or specimens? ☐ Yes ☐ No
If yes, please attach a description of activities, percentage of activity and state licensure.

Do you have or have you ever had any Medical Director responsibilities? ☐ Yes ☐ No

If yes, does the facility provide you with coverage for your administrative responsibilities? ☐ Yes ☐ No

Please be advised that LPIC does not provide coverage for any liability assumed solely as your role as medical director of any facility.

Are you employed full time or part time by the federal, state, or local government, or are you on active military duty? ☐ Yes ☐ No
If yes, please attach an explanation of your employment.

Do you serve in a hospital emergency room for which you require coverage? ☐ Yes ☐ No
If yes, please provide the number of hours per month: __________

Do you perform any activities not routinely performed by other physicians practicing in your specialty or sub-specialty? ☐ Yes ☐ No
If yes, please explain:____

Have there been any changes in your specialty or practice activities including but not limited to a material change in number of hours per week, changes or additions of an entity name, the addition or deletion of procedures within the last 5 years. ☐ Yes ☐ No
If yes, please attach a description of these changes.

Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No
If yes, please complete the following:

Practice Name: ________________________

Practice Activities: ________________________ Name of Carrier: ______________

X. – COVERAGE HISTORY

Please provide Practice/Claims & Insurance history for a minimum of the last 10 years starting with most recent.

☐ I do not currently carry professional liability coverage.

Dates of Coverage	Insurer	Coverage Type	Tail Coverage Purchased	# of Pending Claims	# of Closed Claims	Total Claims	Premium
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				
		☐ Occurrence ☐ Claims Made	☐ Yes ☐ No				

If your coverage is currently Claims Made please indicate the coverage trigger associated with your most recent policy. ☐ Incident ☐ Written Demand

Contact your agent should you have any questions pertaining to the differences between an Incident or Written Demand claims made trigger.

Have you ever experienced any gaps in your professional liability coverage? ☐ Yes ☐ No
If yes, please attach a narrative outlining any gaps in coverage.

Please attach a copy of your most recent declarations page and policy.

Has an insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? ☐ Yes ☐ No
If yes, please list below company, date and reason for this action.

Company	Date	Reason
Company	Date	Reason

XI. – CLAIMS INFORMATION

Please note that the use of **claim** or **suit** in this application is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any professional corporation.

Are you now or have you ever been involved in a malpractice **claim** or **suit**, either directly or indirectly? ☐ Yes ☐ No
If yes, please indicate the total number of **claims** and **suits**:________

Have all **claims** and **suits** been reported to your current or prior professional liability insurer? ☐ Yes ☐ No
If no, please attach an explanation

Please note that the use of **potential claim** in this application is defined as any circumstance which may have been brought to your attention by a patient or representative of a patient, in such a manner as to reasonably indicate the possibility of legal action against you or any professional corporation including but not limited to a patient requesting medical records, a letter from an attorney or an intent to pursue a claim or file a suit, or the apparent dissatisfaction of a patient or family member with the outcome of a procedure, treatment or diagnosis.

Do you have knowledge of any **potential claim** in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a **claim** or **suit** even if you believe the **claim** or **suit** would be without merit? ☐ Yes ☐ No
If yes, please indicate the total number of **potential claims**: ________

Have all **potential claims** been reported to your current or prior professional liability insurer? ☐ Yes ☐ No
If no, please attach an explanation

XI. – CLAIMS INFORMATION (continued)

Have you ever had an adverse outcome that has or may have resulted in the following:

The death of a patient.	☐ Yes ☐ No
The neurological, sensory, or systemic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing.	☐ Yes ☐ No
The permanent damage related to an injury during delivery of a child or administration of anesthesia.	☐ Yes ☐ No
The limitation on a patient's daily living activities including but not limited to the loss of a limb.	☐ Yes ☐ No
The failure to diagnosis cancer.	☐ Yes ☐ No

If you have answered "Yes" to any of the questions in Section XI. – CLAIMS INFORMATION, the completion of an LPIC Narrative Addendum is required.

XII. – PLEASE ATTACH A COPY OF THE FOLLWING TO THIS APPLICATION

☐ Copy of current Declaration Page

☐ Curriculum Vitae (C.V.) for each physician

☐ Loss Runs from all carriers for the prior 10 years.

☐ A narrative of all past claims using the LPIC Claim narrative Addendum.

☐ Copies of each physician's license to practice and board certification

☐ Completed LPIC Corporation & Partnership application, if applicable

☐ Completed LPIC Employed Healthcare Extender application, if applicable

XIII. – PAYMENT OPTIONS

☐ I would like the zero interest, 10-payment installment plan option.

☐ I will pay my premium in full.

XIII. – PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company.

I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm, or professional association.

I UNDERSTAND AND AGREE THAT THE COMPLETION OF THIS APPLICATION TOGETHER WITH ANY PREMIUM OR FINANCING DOES NOT BIND THE COMPANY TO ISSUE NOR ME TO PURCHASE, A CONTRACT OF INSURANCE, PROVIDED HOWEVER, IF I AM ISSUED INSURANCE BY THE COMPANY AND I PURCHASE SUCH CONTRACT OF INSURANCE, I UNDERSTAND AND AGREE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION BY ME IN THIS APPLICATION MAY ACT TO VOID SUCH CONTRACT OF INSURANCE AND GIVE THE COMPANY A RIGHT TO RESCIND SUCH CONTRACT.

I understand that the Company may wish to contact persons, hospitals, schools, employers, and other entities listed in this application to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I understand that the offering by the RRG is always subject to the Underwriting Committee's review and approval.

Date Signed:	Signature:

This Policy is issued by your risk retention group. Your risk retention group may not be subject to all insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your risk retention group.