

I. General Information (continued)

D. Practice Locations: (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Office Hospital Other If other please explain: _____
% of practice

Practice/Hospital Name
Number & Street
Suite City State Zip Code -
County Start Date: MM / YYYY

2. Office Hospital Other If other please explain: _____
% of practice

Practice/Hospital Name
Number & Street
Suite City State Zip Code -
County Start Date: MM / YYYY

3. Office Hospital Other If other please explain: _____
% of practice

Practice/Hospital Name
Number & Street
Suite City State Zip Code -
County Start Date: MM / YYYY

E. Do you admit patients to any of the above hospital locations?

Yes No

If no, please explain your protocol to admit patients to a hospital if the circumstance would arise. _____

F. Billing and Correspondence Address:

Location # (from Question D above): Residence Other (Please enter below)
Number & Street Suite
City State Zip Code -

II. Educational Background

A. Medical School:

Name of School Degree
City State Completed from: MM / YYYY To: MM / YYYY
Country

II. Educational Background (continued)

If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program? Yes No

If no, please explain: _____

B. Residency: List all Residency training programs.

Please enter each specific specialty.

1. _____
Name of Hospital/Facility/Program

City State Country

Specialty Type
Completed? Yes No Still in training From: ____ / ____ To: ____ / ____
MM YYYY MM YYYY

2. _____
Name of Hospital/Facility/Program

City State Country

Specialty Type
Completed? Yes No Still in training From: ____ / ____ To: ____ / ____
MM YYYY MM YYYY

C. Have you participated in any additional training? (i.e. Fellowship, etc.)

Yes No

1. _____
Name of Hospital/Facility/Program

City State Country

Specialty Type
Completed? Yes No Still in training From: ____ / ____ To: ____ / ____
MM YYYY MM YYYY

2. _____
Name of Hospital/Facility/Program

City State Country

Specialty Type
Completed? Yes No Still in training From: ____ / ____ To: ____ / ____
MM YYYY MM YYYY

D. Are you entering private practice for the first time?

Yes No

E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 credit hours.

F. Have you completed a risk management education course within the last twelve (12) months?

Yes No

III. Practice Information

A. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, Telemedicine or Internet Medicine?

Yes No

(If this is covered by another professional liability insurance policy, complete Section IV., Question H.)

If yes, which state(s): _____

B. States in which you hold a license to practice medicine:

Please check the appropriate box to indicate the status of your license.

(Exclude state abbreviation from license number.)

	Active	Inactive	Temporary	Pending
1. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. State _____ License # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Practice Information (continued)

C. Do you have previous practice location(s)? If yes, list all location(s) within the past 10 years. If your requested retroactive date is greater than 10 years, provide locations back to the retroactive date. Please list most recent location first. Yes No

1. _____
 Name of Practice _____
 City _____ State _____ Country _____
 Specialty _____ From: MM / YYYY To: MM / YYYY

2. _____
 Name of Practice _____
 City _____ State _____ Country _____
 Specialty _____ From: MM / YYYY To: MM / YYYY

D. Please explain the following gaps if they occurred in the last 10 years:

- Gaps greater than 1 year between your medical school, residency, other training or first time in practice. _____
- Gaps greater than 6 months between practice locations. _____

E. To which Medical Societies or Associations do you belong? _____

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.

****Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.****

F. What is your present specialty? _____ % of total practice
What is your sub-specialty? _____ % of total practice

G. Are you permanently retired from the practice of clinical medicine? Yes No

H. American Board Certified? Yes No _____
 Specialty Board Date most recently certified _____

 Specialty Board Date most recently certified _____

If not American Board Certified, are you board eligible? Yes No If yes, when do you plan on taking your boards? _____
 MM / YYYY

If not American Board Certified, have you ever taken a specialty board examination and failed to pass? Yes No

If yes, how many times?
 If yes, please explain: _____

I. Indicate the estimated average weekly numbers, under each of the following categories, for which you require PLICO coverage.

Hours per week Patients seen per week None Unscheduled walk-in patients per week None

J. Please check any of the following procedures you will perform:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominoplasty - Tummy Tuck | <input type="checkbox"/> D & C | <input type="checkbox"/> Pacemakers - Epicardial |
| <input type="checkbox"/> Abortions- Elective _____% of total practice | <input type="checkbox"/> Discectomy | <input type="checkbox"/> Pacemakers - Endocardial |
| <input type="checkbox"/> Abortions- Therapeutic _____% of total practice | <input type="checkbox"/> Open | <input type="checkbox"/> Pacemakers - Temporary |
| <input type="checkbox"/> Acupuncture - Therapeutic/Local Anesthetic | <input type="checkbox"/> Other Than Open | <input type="checkbox"/> Peritoneoscopy |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal | <input type="checkbox"/> Electromagnetic Therapy | <input type="checkbox"/> Phlebography |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Electroconvulsive/Shock Therapy | <input type="checkbox"/> Pneumoencephalography |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Embolization | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> ERCP | Prenatal /Gynecological Practice |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Face Lifts | <input type="checkbox"/> Prenatal Practice - 1st & 2nd Trimester |
| <input type="checkbox"/> Assisting in major surgery - own patients only | <input type="checkbox"/> Face Lifts Mini (done with laser)___% of total practice | <input type="checkbox"/> Prenatal Practice - to term, no delivery |
| <input type="checkbox"/> Assisting in major surgery - own & other than own patients | <input type="checkbox"/> Gastrointestinal Endoscopy | <input type="checkbox"/> Prenatal Practice - to term, and delivery |
| <input type="checkbox"/> Bariatric Surgery - Laparoscopic | <input type="checkbox"/> Gynecology - Major Surgery | <input type="checkbox"/> Normal Deliveries - total per year _____ |
| <input type="checkbox"/> Bariatric Surgery - Non-Laparoscopic | <input type="checkbox"/> Hair Transplants - Follicular Unit Transplantations | <input type="checkbox"/> Cesarean Deliveries - total per year _____ |
| <input type="checkbox"/> Biopsy - Endoscopic | <input type="checkbox"/> Hair Transplants - Other | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Blepharopigmentation - _____ % of total practice | <input type="checkbox"/> HVLA on the cervical spine on patients younger than 18 years of age | <input type="checkbox"/> Radial/Laser Keratotomy |

III. Practice Information (continued)

- | | | |
|---|---|--|
| <input type="checkbox"/> Blepharoplasty - Cosmetic _____ % of total practice | <input type="checkbox"/> Intrathecal Pumps | <input type="checkbox"/> Radiation/X-Ray Therapy |
| <input type="checkbox"/> Blepharoplasty - Reconstruction ____ % of total practice | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Rectal Ozone Therapy |
| <input type="checkbox"/> Botox _____ % of total practice | <input type="checkbox"/> Laparoscopic Cholecystectomy | <input type="checkbox"/> Rhinoplasty _____% of total practice |
| <input type="checkbox"/> Brachioplasty | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Sigmoidoscopy - 60 cm or less |
| <input type="checkbox"/> Breast Implants - Cosmetic _____ % of total practice | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Sigmoidoscopy - greater than 60 cm |
| <input type="checkbox"/> Breast Implants - Reconstruction ____ % of total practice | <input type="checkbox"/> Laser Therapy (Endoscopic) | <input type="checkbox"/> Silicone Injections__ % of total practice |
| <input type="checkbox"/> Breast Reduction - Cosmetic | <input type="checkbox"/> Laser Therapy (Non-Endoscopic) | Skin Flaps/Grafts |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Lipoinjection _____% of total practice | <input type="checkbox"/> Cosmetic _____% of total practice |
| <input type="checkbox"/> Bronco-esophagology | Liposuction | <input type="checkbox"/> Reconstruction __% of total practice |
| <input type="checkbox"/> Buttock Implants | <input type="checkbox"/> Other Than Tumescent Technique | <input type="checkbox"/> Spinal Cord Stimulators |
| <input type="checkbox"/> Calf Implants | <input type="checkbox"/> Tumescent Technique Only___% of total practice | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Tubal Ligations |
| <input type="checkbox"/> Catheterization - Left Heart | <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Upper GI Endoscopy |
| <input type="checkbox"/> Catheterization - Right Heart (other than CVP lines)/
Swan Ganz | <input type="checkbox"/> Mammograms | <input type="checkbox"/> Vasectomies - own patients |
| <input type="checkbox"/> Cheek/Chin/Lip Implants | <input type="checkbox"/> Myelography | <input type="checkbox"/> Vasectomies - own & other than your
own patients |
| <input type="checkbox"/> Chelation Therapy | Nerve Blocks | <input type="checkbox"/> Weight Control Medication
____ % of total practice |
| <input type="checkbox"/> Chemical Peels - Superficial / Medium | <input type="checkbox"/> Facet | <input type="checkbox"/> Other Medical Techniques |
| <input type="checkbox"/> Chemical Peels - Deep _____% of total practice | <input type="checkbox"/> Lumbar Epidural Steroid | List Procedures (do not restate your specialty) |
| <input type="checkbox"/> Cleft Lip Surgery - Reconstructive | <input type="checkbox"/> Myofascial | _____ |
| <input type="checkbox"/> Cleft Palate Surgery - Reconstructive | <input type="checkbox"/> Occipital | _____ |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Paraspinal/Paravertebral | _____ |
| <input type="checkbox"/> Cryosurgery (Cervical) | <input type="checkbox"/> Peripheral | |
| <input type="checkbox"/> Cryosurgery (non-external lesions) | <input type="checkbox"/> Sciatic | |
| | <input type="checkbox"/> Triggerpoint Injection | |
| | <input type="checkbox"/> Oxidation Therapy | |

K. Please indicate the percentage of your total practice performing the following surgical activities:

- | | | |
|--------------------------------------|--|---|
| <input type="text"/> % Cardiac | <input type="text"/> % Orthopedic (including back) | <input type="text"/> % Thoracic |
| <input type="text"/> % Gynecology | <input type="text"/> % Orthopedic (not including back) | <input type="text"/> % Traumatic |
| <input type="text"/> % Hand | <input type="text"/> % Otolaryngology | <input type="text"/> % Urology |
| <input type="text"/> % Neurosurgery | <input type="text"/> % Plastic (cosmetic enhancement only) | <input type="text"/> % Vascular |
| <input type="text"/> % Obstetrics | <input type="text"/> % Plastic (reconstruction only) | <input type="text"/> % Other (Describe) _____ |
| <input type="text"/> % Ophthalmology | | |

L. In the last 10 years,

1. Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity? Yes No
 If yes, list procedures/activities, reason for discontinuing, and date discontinued. Date: / /

2. Have you performed weight control surgery or prescribed weight control medication? Yes No
 a. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?
 <1% 1% - 10% 11%-50% >50% Never prescribed weight control medication
 b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?
 <1% 1% - 10% 11%-50% >50% Never performed weight control surgery

M. Do you have ownership or financial interests in a weight control clinic?

If yes, what is the name of the weight control clinic with which you are affiliated? _____ Yes No

N. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.)

- Yes No
1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.) hrs
2. On average how many of the above hours are you working in order to fulfill staff privilege requirements? hrs
 (If you have emergency room activities which are covered by another professional liability insurance policy, please complete Section IV, Question H.)

O. Please use the space below for any comments you feel will help PLICO better understand any special circumstances concerning your practice.

IV. Additional Professional Information

Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the question.

(For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)

A. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates. hrs None

B. Indicate the average hours per week devoted to treating non-federal prison inmates. hrs None

C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes. % None

D. Indicate the percentage of your practice devoted to working in a nursing home facility. % None

E. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No
If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

F. Do you practice as a medical director? Yes No
Type and name of facility: _____

If yes, what percentage of your practice is devoted to this activity? %

Briefly describe your responsibilities: _____

G. Do you devise or review plant/employer safety standards? Yes No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

H. Will you be performing activities which will be covered by another professional liability policy? Yes No

If yes, are you a(n): Employee Independent Contractor Resident/Fellow Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

I. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Yes No

If yes, please indicate the date(s) and explain: Date: /
MM YYYY _____

J. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy? Yes No

If yes, please indicate the date(s) and explain: Date: /
MM YYYY _____

K. Have you ever been accused of sexual misconduct of any kind? Yes No

If yes, please indicate the date(s) and explain: Date: /
MM YYYY _____

L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? Yes No
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: _____

Date(s) of treatment(s): From: / To: /
MM YYYY MM YYYY Currently in treatment

Name of treating physician(s): _____

Address(es): _____

VI. Practice Organization Information (continued)

I. Indicate the number of each of the following who provide services in your office (please exclude yourself):

Physicians	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Nurse Midwives	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Physician Assistants	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Dentists	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Nurse Midwife Assistants	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Physician Surgical Assistants	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Aestheticians	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Nurse Practitioners	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Podiatrists	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Case Managers	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Nurse Surgical Assistants	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Psychologists	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
CRNAs/RNAs	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Occupational Therapists	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Respiratory Therapists	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Chiropractors	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Perfusionists	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

J. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services? Yes No

If no, do you plan to do so within 12 months of your requested effective date? Yes No

If yes, please provide an explanation: _____

VII. Coverage Information

Note: Requested limits and/or policy types may not be available in all states.

A. Requested Coverage Period (12:01 am):

Annual policy term will begin and end on the same month and day.

From: / / **To:** / /
MM DD YYYY MM DD YYYY

B. The retroactive date shown on your current Claims-Made policy is:

(This date is required for Occurrence with Prior Acts or Claims-Made with Prior Acts.)

/ /
MM DD YYYY

C. Desired Limits: Per Occurrence/Per Claim Filed , , Annual Aggregate , ,

D. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer: _____

Occurrence Claims-Made From: / / To: / /
MM DD YYYY MM DD YYYY

2. Previous Insurer: _____

Occurrence Claims-Made From: / / To: / /
MM DD YYYY MM DD YYYY

3. Previous Insurer: _____

Occurrence Claims-Made From: / / To: / /
MM DD YYYY MM DD YYYY

E. Please explain any gaps in coverage within the past 10 years. If your requested retroactive date is greater than 10 years, please explain any gaps back to your requested retroactive date.

Assignment of Right to Cancel Coverage Supplement

Applicant's Name: _____

A. Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? Yes No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to (405) 815-4901 or sending written notice to PLICO, Inc., P.O. Box 1838, Oklahoma City, Oklahoma 73101-1838.

Initial Here

Name: _____

Street: _____ Suite: _____

City: _____

State: _____ Zip Code: _____ Phone Number: _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

PLICO, Inc.

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at PLICO's discretion.

A. Is the matter related to: **A** **B** **C** **from the Loss Information section? (Check only one)**

- A. Current or prior claim.
- B. Complication, incident, or adverse outcome.
- C. Written request for records.

B. Patient/Claimant Information:

Last Name

First Name

Age

C. Date of treatment and/or surgery which led, or could lead, to allegations against you.

 /
MM YYYY

D. Date of notice received, if applicable.

 /
MM YYYY

E. Has this matter been reported to your current or former insurer?

Yes No

If yes, date reported to your current or former insurer:

 /
MM YYYY

Current or former insurer name: _____

If no, please explain: _____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

G. Current status: Open Closed

If open, indicate dollar value established by insurer: \$ _____

If closed:

1. Date of closing:

 /
MM YYYY

2. Was a payment made?

Yes No

a. If yes, did you consent to the settlement?

Yes No

b. Total amount of settlement or award: \$ _____

c. Total amount of settlement or award paid on your behalf: \$ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

Practice Organization Information Supplement

A. Type of Legal Entity: (Check only one box)

- Input boxes for Solo Unincorporated/Sole Proprietor, Multi-Shareholder Corporation, Partnership, Limited Liability Company, Solo Incorporated, and Other-please explain.

B. Employment status:

- Input boxes for Employee, Shareholder/Partner, Independent Contractor, Other, and Date joined (MM/DD/YYYY).

C. Type of Organization:

- Input boxes for Standard Medical Practice, Hospital, State Licensed Medical Surgery Center, For use by other physicians, Your patients only, and Other-please explain.

D. Entity Name: (As stated in the Articles of Incorporation and all formal entity/clinic names.)

Grid for entering the entity name.

E. If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.)

Grid for entering additional entity/clinic names.

F. Is this entity or employer currently insured with PLICO?

Yes No

If yes, please provide PLICO corporation or partnership policy or group number, if known.

Input boxes for Policy #, Group #, and Sub-group #.

G. Do you desire coverage for this entity?

Yes No

If yes, please select the type of entity coverage desired:

- Input boxes for Shared Policy Limits and Separate Policy Limits.

(To request Separate Limit Entity coverage, please contact your agent or PLICO Service Representative to complete an application for consideration.)

H. If the purpose of the entity noted above is other than a medical office practice, please explain:

Horizontal lines for explaining the purpose of the entity.

I. Indicate the number of each of the following who provide services in your office (please exclude yourself):

Table with 3 columns listing professions (Physicians, Dentists, etc.) and 3-digit input boxes for the number of each.

J. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services?

Yes No

If no, do you plan to do so within 12 months of your requested effective date?

Yes No

Input box for explanation and horizontal lines for further details.