PLICO, Inc.
Application Guideline

Thank you for your consideration of PLICO for your professional liability insurance needs. Since 1979, PLICO has been the leading choice by Oklahoma physicians for protecting themselves and their practices. PLICO is wholly owned by the Oklahoma State Medical Association and directed by a board of peer physicians.

Please note the following instructions for the included application. If you have any questions, please do not hesitate to call PLICO Underwriting at 405.815.4800.

- All questions must be answered. If a question does not apply, enter "N/A" for that question.
- Section 2 – Coverage Information (page 1): Previous Insurance Company information for the preceding 5 years must be provided. Proof of insurance from each carrier should accompany the application. If there are previous exclusions of specific procedures or restrictions on the professional liability insurance, please explain on the Additional Information Section, or on a separate sheet of paper.
- *Entity coverage* - for associations, partnerships, corporations, or companies, on shared or separate limits basis, please provide the following documents/information:

    1. Copy of the W-9 and 1099 (IRS) forms for the entity,

    2. Copy of the Employers Quarterly Contribution Report with a notation of employee's position for the entity,

    3. Copy of the Articles of Incorporation or Formation for the entity,

    4. Provide a current Certificate of Insurance for each employed or contracted physicians not insured by PLICO.

- *License restrictions or investigations*– explain any restrictions or investigation in the Additional Information Section, or on a separate sheet of paper.
- *Physicians' Section 9 and Ancillaries' Section 5* – Explain any "Yes" answers in the Additional Information Section, or on a separate sheet of paper.
- *Medical and Surgical Procedures* (Physicians' Section 8) - indicate the procedures that you will perform under this policy/coverage.
- ***CLAIMS HISTORY* – issued by all previous insurance carriers must be submitted with every application if you have had past claims. If no past claims, please complete the attached No Known Loss Affidavit.**

ANCILLARY MEDICAL PERSONNEL PROFESSIONAL LIABILITY INSURANCE APPLICATION

THIS FORM PROVIDES CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

Add to Policy #: ___________ ***Name of Physician or Group*** ________________________

SECTION 1 – GENERAL INFORMATION

1. Name of Applicant:			2. SSN:
3. Indicate other names by which you have been known. Specify the dates during which the name was used:			
4. Degree or Title:	5. Sex:	6. Place of Birth:	7. Date of Birth:
8. Office Address:			
City:	State:	Zip Code:	
9. Contact Person:			
10. Home Phone:	11. Office Phone:	12. Fax:	
13. E-mail:	14. Web Site:		
15. Home Address:			
City:	State:	Zip Code:	
16. Name of employer/Supervising Physician and her/his medical specialty:			

SECTION 2 - COVERAGE INFORMATION

1. Requested Effective Date: ___________________ 2. Requested Retroactive Date: ____________

3. Requested Limits of Liability:

☐ $100,000 / $300,000 ☐ $200,000 / $600,000 ☐ $500,000 / $1 million
☐ $1 million / $1 million ☐ $1 million / $3 million ☐ $2 million / $2 million
☐ $2 million / $4 million

Note: the selected limits of liability must not exceed the lowest limits of liability of any physician in the policy.

4. Insurance history

Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current:				
Prior:				
Prior:				
Prior:				
Prior:				
Prior:				

5. Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 9. Yes☐ No☐

6. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? If "Yes", provide details on Section 9. Yes☐ No☐

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING			
NAME AND LOCATION OF SCHOOL AND/OR HOSPITAL	DEGREE OR SPECIALTY	START DATE	COMPLETION DATE (OR EXPECTED)
Indicate how many continuing education credits have you completed during the past 3 years?			

SECTION 4 – LICENSURE – CERTIFICATION - ASSOCIATION		
1. State License #:		2. Expiration Date:
3. Are you licensed in other states? Yes☐ No☐	State: _______ State: _______	License #:__________________ License #:__________________
4. Has your license in any state ever been suspended, revoked, denied, or limited? If "Yes", provide details on Section 9.		Yes☐ No☐
5. Are you currently under investigation by any state licensing board or agency? If "Yes", please explain on a separate sheet.		Yes☐ No☐
6. Please list any Professional Society Affiliations:		

SECTION 5 - CURRENT PRACTICE PROVIDE DETAILS FOR ANY "YES" ANSWER(S) ON SECTION 9	
1. Do you currently have any medical and/or psychiatric problem including alcohol and/or drug dependence?	Yes☐ No☐
2. Have you ever been treated for psychiatric, drug or alcohol-related problem?	Yes☐ No☐
3. Have you ever been institutionalized during the past five years?	Yes☐ No☐
4. Do you have any continuing health problems requiring current therapy?	Yes☐ No☐
5. Do you currently have any condition or circumstance that may prevent or impair you to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?	Yes☐ No☐
6. Are you currently engaged in the illegal use of drugs? (If you are making application to a government entity, you have the right to elect not to answer this question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution.)	Yes☐ No☐
7. Is your physical or mental health such that it may impair your ability to practice within the scope of the privileges for which you have applied?	Yes☐ No☐
8. Has your employment at a health care organization ever been terminated?	Yes☐ No☐
9. Have you ever been charged of a crime other than a minor traffic offense?	Yes☐ No☐
10. Are there any felony charges pending against you?	Yes☐ No☐
11. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges, or have you resigned from the medical staff, or surrendered your clinical privileges while under investigation or before a recommendation or decision by a hospital's or healthcare facility's medical executive or governing board was rendered?	Yes☐ No☐

SECTION 5 - CURRENT PRACTICE (continued)

REFER TO SECTION 9 FOR ADDITIONAL SPACE

12. Are you involved in the treatment of prisoners or jail inmates? Yes☐ No☐
If yes, indicate location of practice

13. List of locations of employment for which coverage is being requested:

Name/Address:	**Hours per week worked at this location**:	**Nature of your practice:**
1.		
2.		

14. List all other locations of employment for which coverage is NOT being requested.

Name/Address:	**Hours per week worked at this location**:	**Nature of your practice:**
1.		
2.		

	Yes	No	# in past year	Changes?
15. Do you practice at an Emergency Department of a Hospital or Health care Facility? If yes, indicate name of the hospital or medical facility				
16. Are you employed in an Urgi Center or Emergi-care Center? If yes, indicate name of the healthcare facility.				
17. Do you perform office based surgery in your professional office?				
18. Are you using anesthesia including conscious sedation in your office?				

SECTION - 6 – CLAIMS HISTORY/ REPORT

1. Have you been involved in a professional liability claim/suit in the past ten (10) years? Yes☐ No☐

2. Have all claims/suits/incidents been reported to your current/prior professional liability carrier? Yes☐ No☐
If "No", please explain on Section 9

3. Complete the following questionnaire for all claims or incidents in which you have been directly or indirectly involved. We require ten (10) year claim or incident history/report, with a recent valuation date from your current insurer if you have had any claims/suits.

Claim #	Patient's Initials	Insurance Company	Date of Loss	Date Reported	Date Closed	*Award's Amount

*Attributed to your involvement: $____________________ *Paid by All Parties $ ________________________

Indicate your status in the case: ☐ Primary Defendant ☐ Co-defendant ☐ Other (explain)________________

If the claim or suit is pending, when was the last contact with the Plaintiff's attorney? ________________________

What is/was the alleged harm to the patient? ____

____

What were the allegations made against you? ____

____

Describe the patient's illness and related effects of the alleged harm ______________________________________

____

Describe any other details you believe are pertinent to the case ____

____

Name of other parties named in the suit: ____

____

SECTION 7 - WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted.

I UNDERSTAND that the statements and answers herein will be relied upon by PLICO and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE any professional societies, prior, or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to **PLICO** or to the Oklahoma State Medical Association (Association) upon the request of either. I authorize the use of a copy of this authorization in place of the original.

In order to facilitate the risk management program, I authorize **PLICO** to provide the Association with any records and information concerning claims arising under any policy or insurance issued in connection with this application.

I declare that to the best of my knowledge and belief I have:

1. Reported all known claims, suits, and incidents that could result in a medical negligence claim or suit to my previous or current carrier(s) or risk transfer entity (self-insured program),
2. No knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit that has not been reported to my current or previous insurance carrier or risk transfer entity, and
3. No knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last 10 years, that have not been reported to the applicable insurance company or risk transfer entity.

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by **PLICO** in reliance upon such information.

Signature____ Date_________________________

APPLICABLE IN ARKANSAS

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

APPLICABLE IN OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

SECTION - 8 - COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following documents with this application.

Attached	Item
	Copy of Licensure, Certification, Registration or Association membership required for you to practice
	Copy of Job Description
	Copy of expiring insurance policy or certificate of insurance

SECTION - 9 – ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please, make as many copies of this page as it may be required to fully answer all questions. As appropriate, note Section number and question number being addressed:

**Section/
Question #**

AFFIDAVIT

NO KNOWN INCIDENTS, CLAIMS, OR SUITS

I, ________________________, declare that to the best of my knowledge and belief, I have:

1. No knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit, and

2. No knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last ten (10) years.

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

___________________________ ___________________________
Applicant's Signature Date

___________________________ ___________________________
Witness' Signature Date

P.O. Box 1838 Oklahoma City, OK 73101-1838 • Accounting (405) 815-4824 • Claims (405) 815-4802 • Marketing (405) 815-4880
Risk Mgt. (405) 815-4803 • Underwriting (405) 815-4801 • Toll Free (866) 867-4566 • Fax (405) 815-4900