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.**

PLICO

VOLUNTEER PHYSICIANS PROFESSIONAL LIABILITY INSURANCE APPLICATION

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

SECTION 1 - GENERAL INFORMATION		
1. Name of Applicant:		2. Degree or Title:
3. Address:		
City:	State:	Zip Code:
4. Billing/Mailing Address (if different):		
City:	State:	Zip Code:
5. Home Address:		
City:	State:	Zip Code:
6. Home Phone:		7. Office Phone :
8. Fax:		9. E-Mail:
10. Web Site:		11. SSN:
12. Date of Birth:	13. Place of Birth:	14. Sex:
15. Contact Person:		

Please provide on a separate sheet of paper any other names by which you have been known, specifying the dates during which the name was used.

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

4. Insurance history

Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current:				
Present Carrier: Please attach a copy of your current policy, including the Declarations Page and all endorsements. If you are presently insured under a Group Policy, attach a copy of your Certificate of Insurance.				
Prior:				
Prior:				
Prior:				
Prior:				
Prior:				

5. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage?	Yes	No
6. Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument?	Yes	No

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING				
School or Facility	**Name and Location of School and/or Hospital**	**Degree and/or Specialty**	**Start Date**	**Completion Date (or Ex-pected)**
Medical School:				
Internship:				
Residency:				
Residency:				
Fellowship:				
How many continuing education credits (CME's) have you completed altogether the past 3 years?				

SECTION 4 - CERTIFICATION / LICENSURE / ASSOCIATION			
1. Are you Board Certified?		Yes	No
2. Name of Specialty Board:			
Date Certified:	Latest Recertification Date:		
3. Name of Specialty Board (if dual or sub-specialty certified):			
Date Certified:	Latest Recertification Date:		
4. Professional Degree:			
5. Medical License No.:			
6. State:	7. Expiration Date:		
8. Medicare No.:	9. Medicaid No.:	10. DEA No.:	
11. Name of Partnership or Professional Corporation:			
12. Has your medical license in any state ever been suspended, revoked, denied, or limited? If "Yes", please explain on a separate sheet.		Yes	No
13. Are you currently under investigation by any state licensing board or agency? If "Yes", please explain on a separate sheet.		Yes	No
14. Are you licensed in other states? Yes_____ No_____ State_____ Lic. #_____			
15. Are you an active member of a state medical association		Yes	No
16. If you are a Doctor of Osteopathy: are you an active member of an osteopathic association? If "Yes", please list association in space provided below:		Yes	No
17. Have any of the following ever been denied, revoked, suspended, reduced, limited, canceled, sanctioned, placed on probation, not renewed, or relinquished for disciplinary reasons?			
a. State narcotics registration		Yes	No
b. Academic appointment		Yes	No
c. Membership on any hospital or healthcare facility medical staff		Yes	No
d. Clinical privileges, prerogatives, or rights on any medical staff		Yes	No
e. Membership in other healthcare organizations or facilities		Yes	No
f. Professional society membership or fellowship		Yes	No
g. Any other type of professional reprimand or sanction		Yes	No

SECTION 4 - CERTIFICATION / LICENSURE / ASSOCIATION (continued)		
h. Educational Commission for Foreign Medical Graduates (ECFMG) certification	Yes	No
i. Participation in the Medicare of Medicaid program or other government health benefits program	Yes	No
Please list Medical Society Affiliations:		

SECTION 5 - HOSPITAL PRIVILEGES AND FREE CLINIC ASSOCIATION		
1. Please indicate the name and location (city and state) of each hospital where you now hold staff privileges:		
2. Has any hospital ever taken action to deny, suspend, revoke, or restrict your medical staff privileges or your application or reapplication for medical staff privileges? If "Yes", identify hospital, date, and reasons on a separate sheet.	Yes	No
3. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? If "Yes", identify hospital, date, and give reasons on a separate sheet.	Yes	No

SECTION 6 - PRIOR PRACTICE		
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. Are you able 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. Most recent physical examination date: _____ Significant Findings: _____		
9. Has your employment at a health care organization ever been terminated?	Yes	No
10. Have you ever been charged of a crime other than a minor traffic offense?	Yes	No

SECTION 6 - PRIOR PRACTICE (continued)		
11. Are there any felony charges pending against you?	Yes	No
12. Have you ever withdrawn your application for appointment, reappointment, and/or clinic privileges or resigned from the medical staff or surrendered your clinical privileges while under investigation or before a recommendation or decision by a hospital's or health care facility's medical executive or governing board was rendered?	Yes	No
13. Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)?	Yes	No
14. Have you ever been terminated, rejected, limited or been excluded or refused membership in a managed care organization (HMO, PPO, PHO, etc.) for a stated reason?	Yes	No
15. Are you employed by the state? If "Yes", indicate percent of time involved in private practice.	Yes	No
16. Are you employed by the United States Military Service?	Yes	No
17. Do you treat prison or jail inmates?	Yes	No

18. Has your practice been reduced because of any of the following? (Check all that apply)	
	Semi-retirement
	Disability
	Majority of practice is conducted in a teaching role which is insured elsewhere
	Majority of practice is insured through another entity such as an employer
	Pregnancy or dependent care
	Maintenance of another practice in bordering state that is insured elsewhere

19. List Clinic(s) and/or Hospital(s) for which coverage is needed. If additional space is needed, please attach separate sheet.
20. Name/Address:
21. Number of hours worked per week at the above location:
22. Specialty practiced at the above location:
23. List all other clinics for which coverage is NOT needed. If additional space is needed, please attach separate sheet.
24. Name/Address:
25. Number of hours worked per week at the above location:
26. Specify practiced at the above location:
27. Insurance carrier providing coverage at the above location:

SECTION 7 - SPECIALTY CLASSIFICATION

1. What is your present Specialty? | 2. Sub-specialty?

3. Please check which ONE of the following best describes your practice:

	Addiction Medicine			Neurology			SURGERY: endocrinology
	Aerospace Medicine			Nuclear Medicine			SURGERY: gastroenterology
	Allergy			Nutrition			SURGERY: general
	Anesthesiology			Occupational Medicine			SURGERY: general practice or family practice-not primarily engaged in major surgery
	Broncho-Esophagology			Oncology			SURGERY: general
	Cardiovascular Disease			Ophthalmology			SURGERY: geriatrics
	Dermatology			Otology			SURGERY: gynecology
	Diabetes			Otorhinolaryngology			SURGERY: hand
	Emergency Medicine			Pain Management			SURGERY: head and neck
	Endocrinology			Pathology			SURGERY: laryngology
	Family Practice (FP)			Pediatrics			SURGERY: neoplastic
	Forensic Medicine			Pharmacology-clinical			SURGERY: nephrology
	Gastroenterology			Physiatry			SURGERY: neurology
	General Practice (GP)			Physical Medicine and Rehabilitation			SURGERY: obstetrics
	General Preventive Medicine			Psychiatry			SURGERY: obstetrics-gynecology
	Geriatrics			Psychoanalysis			SURGERY: ophthalmology
	Gynecology			Psychosomatic Medicine			SURGERY: orthopedic – including back
	Hematology			Public Health			SURGERY: orthopedic - no back
	Hospitalist			Pulmonary Diseases			SURGERY: otology
	Hypnosis			Radiology – Interventional* (list procedures in Section 11)			SURGERY: otorhinolaryngology
	Immunology			Radiology - Diagnostic			
	Infectious Disease			Retired			SURGERY: plastic
	Intensive Care Medicine			Rheumatology			SURGERY: rhinology
	Internal Medicine			Rhinology			SURGERY: thoracic
	Laryngology			SURGERY: abdominal			SURGERY: traumatic
	Legal Medicine			SURGERY: cardiac			SURGERY: urological
	Neoplastic Diseases			SURGERY: cardiovascular			SURGERY: vascular
	Nephrology			SURGERY: colon and rectal			

Other (please identify):

SECTION 8 – 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 11.

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 from your current insurer with a recent valuation date 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 $ _____

What is/was 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 9 - 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 Association's 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.

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 10 - COPIES OF REQUIRED DOCUMENTS

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

Attached	Item
	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
	Current Federal DEA Registration Certificate
	Curriculum Vitae
	Copy of your current policy, including the Declarations page, and all endorsements. If you are insured under a Group policy, include a copy of your current Certificate of Insurance.
	Copy of claims history/loss reports from current and previous carriers for the past ten (10) years.
	Information Packet on the clinics you plan to offer your services.

SECTION 11 - 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 #

PLICO

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