

PODIATRIC PHYSICIANS PROFESSIONAL LIABILITY APPLICATION



Rockwood Programs, Inc.

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NOTICE: THIS IS A CLAIMS-MADE FORM: EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD.

All questions must be answered completely. If the answer to any question is NONE or NOT APPLICABLE, so state.

PLEASE ATTACH THE FOLLOWING INFORMATION

Continuing Education Course Certifications Declaration Page From Your Current Policy (If Prior Acts Coverage Requested)

1. Name of Podiatric Physician _____
2. Name of Professional Corporation, Partnership, Association (Attach a copy of the letterhead) _____

3. Primary Office Address _____
City _____ State _____ Zip _____
Mailing Address _____
City _____ State _____ Zip _____
4. List offices where you are practicing _____

5. Business Phone (_____) _____
6. FAX No. (_____) _____
7. E-mail Address _____
8. Tax I.D. No. _____
9. Date of Birth _____
10. Are you a member of a professional association? Yes No If "Yes", please specify _____

11. Are you currently in active, full time practice? Yes No If "No", please complete the Part-Time Practice Supplement.

I COVERAGE QUESTIONS

1. Proposed Effective Date ____/____/____
2. Requested Limits of Liability: \$ _____
3. Retroactive Date* ____/____/____
** Attach a copy of your Declarations Page from your current or prior insurance company showing the retroactive date.*
4. Type of policy requested: Surgical Non-Surgical Non-Surgical/Prior Surgeries

SURGICAL AND NON-SURGICAL POLICY DEFINITION

Coverage is provided for all procedures authorized by state statute and/or regulation in each state a license is held.

Surgery shall include any procedure requiring an anesthetic or intravenous or gaseous sedation including post-operative treatment. Exceptions to this definition include diagnostic and therapeutic injections, surgical procedures involving the nail, excision of skin lesions, incision and drainage of abscesses and the treatment of ulcers.

Post-operative treatment will be covered under a non-surgical policy if and only if the podiatric physician performing the surgery maintains a surgical policy through the insurance carrier.

5. Administrative Hearing Coverage is included with a limit of \$25,000 unless you are a resident or new practitioner. If resident or new practitioner, coverage may be purchased for an additional premium. Do you wish to purchase this coverage..... Yes No

6. Have you ever been involved in any administrative hearings? Yes No
If "Yes", please provide complete detail(s). Attach a separate sheet of paper if necessary.

7. Have you ever practiced without malpractice insurance or had it declined, canceled or issued on a restricted basis? Yes No
NOTE: MISSOURI APPLICANTS DO NOT RESPOND. If "Yes", please explain: _____

8. Professional liability insurance history (all years to present):

<u>Insurance Company</u>	<u>Policy Limits</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Retroactive Date</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. Are you a:
 Sole Practitioner Independent contractor
 Preceptee Employed podiatric physician without ownership interest in employer
 Resident Podiatric physician with ownership interest in legal Corporation, Partnership or Professional Association
Full Corporate, Partnership or Association name: _____

List other podiatric physicians with ownership interest in this entity: _____

10. If you have ownership interest in a legal Corporation, Partnership or Professional Association, choose one option below.
Note: All podiatric physicians in the group must carry the same limits of liability and agree to the same option.
 Do not add this entity to my policy. Add this entity, with a **single** set of limits of liability.
 Add this entity, with a **SEPARATE** set of limits of liability.

11. Are you a first-year practicing podiatric physician? Yes No Medical School: _____ Year Graduated ___/___/___

12. Have you had any Residency/ Preceptor training? Yes No If "Yes", complete the following:

<u>Director or Program Name</u>	<u>Start Date</u>	<u>Completion Date</u>	<u>Number of Years</u>
_____	_____	_____	_____
_____	_____	_____	_____

13. Are you Board Certified? Yes No If "Yes", name of Specialty Board: _____

II UNDERWRITING PROFILE

1. Has your professional liability insurance ever been canceled, declined, non-renewed, or accepted only on special terms?
NOTE: MISSOURI APPLICANTS DO NOT RESPOND Yes No If "Yes", provide details.

2. Has your podiatric license ever been suspended, revoked, voluntarily surrendered, or subject to probation in any state?
 Yes No If "Yes", provide details. _____

3. Do you consult, teach or train outside your practice? Yes No If "Yes", provide details. _____

How many hours do you teach per month: _____

4. Have you ever been accused or engaged in behavior defined as sexual misconduct with any of your current or former patients or any current or former patients' spouse or any person with a direct relationship to the patient or former patient (for example a guardian, a blood relative of the patient or spouse or any person sharing the patient's domicile)? Yes No

If "Yes", provide details. _____

5. Have you ever had any licensing board or professional ethics bodies ever require you to surrender your license or found you guilty of violations of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

Yes No If "Yes", provide details. _____

6. Current podiatric physician's license information (all licenses) *Please attach a copy of all State Licenses:*

State and Country	License Number	Date Licensed	Expiration Date	Practice Time (hours per week)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. a. Your narcotics license number: _____ *Please attach a copy of License.* b. Your D.E.A. license number: _____ *Please attach a copy of License.*

c. Has your narcotics or D.E.A. license ever been subject to probation, revoked, or suspended? Yes No
If "Yes", please attach an explanation and a copy of your current license.

8. Have you ever:

- a. Been convicted for violation of any law or ordinance other than minor traffic offenses? Yes No
 b. Been treated for alcoholism or drug addiction? Yes No
 c. Had any chronic illness or physical defect that affected your ability to practice podiatry? Yes No
 d. Had any hospital privileges suspended or revoked? Yes No
 e. Had practicing privileges with an HMO, PPO, or other managed care facility suspended or revoked? Yes No

If you answered "Yes" to any of the above questions, please explain on a separate sheet.

III PRACTICE PROFILE

1. What percentage of your practice involves (**MUST total 100%**):

Sports medicine _____ % Diabetic patients _____ % Children _____ % Routine Podiatric Care _____ %
 Other (list): _____ %

2. Are you involved in the practice of medicine in any other capacity? Yes No If "Yes", please provide details:

	Office	+	Hospital	+	Other Facility*	=	Total
a. Estimate amount of time (%) spent practicing in the following locations	_____ %	+	_____ %	+	_____ %	=	100%

*Please describe other facility: _____

b. List the annual Percentage of procedures you perform: Non-surgical _____ % Soft tissue Surgery _____ % Osseous Surgery _____ %

4. Non-Surgical Policyholders: If you provide post-operative care other than for nails—See "Definition of Surgery" following Question 4, Section I., provide name of Surgeon and malpractice insurance carrier: _____

5. List hospitals where you have privileges (list by name of hospital, city and state): _____ Accredited?
 _____ Yes No
 _____ Yes No
 _____ Yes No

6. List any HMO or PPO memberships: _____

7. Please list any other podiatric physicians you assist, practice in conjunction with, or are in any other way associated with, and explain your relationship:

Name	Relationship
_____	_____
_____	_____
_____	_____

8. List the annual percentage of time you spend performing the following procedures (*total of all categories must equal 100%*):

Nail-related procedures _____ % Osseous surgery on metatarsal _____ % Surgery on Achilles _____ %
 Abscess incision and draining .. _____ % Ankle/Joint/Lower Leg Surgery _____ % Osseous surgery on tarsals.... _____ %
 Tendon/Tendon Transfer Surgery _____ % Excision of molluscum contagiosum, cysts and other benign lesions _____ %
 Minimal incision foot surgery* _____ % Other (List): _____ ... _____ %

*If you do **any** minimal incision foot surgery, complete the following:

Average **number** of monthly procedures on: Digits _____ Metatarsals _____ Tarsals _____
 Do you provide post-operative care? Yes No

9. Indicate the number of support personnel employed or contracted by you or your group:

Podiatric Assistants _____ Other Licensed Podiatric Physicians _____ CRNA** _____ Other** _____

****NOTE: Coverage is not provided for CRNA or other licensed podiatric physicians.**

IV CLAIMS HISTORY

- Are you now or have you in the past 10 years been involved directly or indirectly in a claim or incident? Yes No
 If "Yes", please provide details on the claim supplement form attached. Use separate form for each claim.
- Are there any circumstances of which you are aware that may result in any professional liability claim or suit being made against you, your predecessors in business or against any past or present partner(s)?..... Yes No
 If "Yes", please provide details on a separate sheet. Please use one sheet for each incident.
- Have any professional liability claims or suits been made or brought against any of your employees or any member, stockholder or partner of your professional association, professional corporation or partnership? Yes No
 If "Yes", please provide details: _____

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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.”

NOTICE TO LOUISIANA APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.”

NOTICE TO MAINE APPLICANTS: “IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.”

NOTICE TO NEW JERSEY APPLICANTS: “ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.”

NOTICE TO NEW MEXICO APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.”

NOTICE TO NEW YORK APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.”

NOTICE TO OHIO APPLICANTS: “ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.”

NOTICE TO OKLAHOMA APPLICANTS: “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” (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.”

NOTICE TO VIRGINIA APPLICANTS: “IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.”

Principal's Signature: _____

Title: _____

Date: _____

Name of Agent: _____

Submitted by: _____

Date: _____

Address: _____

Telephone Number: _____

Florida License #: _____