



# Application for: Non-Standard Physicians & Surgeons Professional Liability Insurance

Please mail or fax this completed application to:  
**Rockwood Programs, Inc.**, 4001 Miller Road, Wilmington, DE 19802-1999  
Toll-Free: (800) 558-8808 • Fax: (302) 765-6039

## Applicant's Instructions:

1. If you have a Curriculum Vitae (C.V.), please attach to application and check here:
2. Please do not complete application earlier than 45 days before proposed effective date of coverage.

**(PLEASE TYPE OR PRINT IN INK)**

1. A. Name of Applicant \_\_\_\_\_ Degree \_\_\_\_\_

B. Social Security No. \_\_\_\_\_

C. Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

D. Are you a U.S. Citizen?  Yes  No If No, please indicate your status and date of entry into USA.

\_\_\_\_\_

\_\_\_\_\_

2. A. Principal Office: \_\_\_\_\_  
No. Street City State Zip Country

Phone: (\_\_\_\_) \_\_\_\_\_

B. Are there other locations?  Yes  No If Yes, please attach a list with all addresses.

3. I practice as:  Solo Practitioner (unincorporated)  Solo Practitioner (incorporated)  
 Professional Association  Partnership  
 Professional Corporation  Employee of \_\_\_\_\_  
(give name)

4. If you practice other than as an employee OR an unincorporated solo practitioner:

A. List the names of ALL your partners, your employees, or members of your professional association or corporation who practice medicine: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. Give the formal corporate, association, partnership, or business name: \_\_\_\_\_

\_\_\_\_\_

C. Attach a copy of your letterhead.

5. List states and license numbers where you practice: \_\_\_\_\_ State \_\_\_\_\_ License Number \_\_\_\_\_

6. A. List hospitals at which you are currently a staff member and show percentages of work at each hospital:

- 1. \_\_\_\_\_ %
- 2. \_\_\_\_\_ %
- 3. \_\_\_\_\_ %

B. Briefly describe type and extent of your hospital privileges: \_\_\_\_\_  
\_\_\_\_\_

C. Are you Chief or Head of a hospital department?  Yes  No

7. Do you or the firm listed in Question 6. A. above own (wholly or in part), operate, or administer any hospital, nursing home, or other institution where medical services are customarily rendered?  Yes  No

If Yes, on a separate sheet give details including name, location, size and number of beds.

CURRENT PRACTICE

8. A. What is your medical or surgical specialty? \_\_\_\_\_  
\_\_\_\_\_

B. Do you limit your practice to the above specialty?  Yes  No

C. Do you have a sub-specialty?  Yes  No

If Yes, describe: \_\_\_\_\_

9. Do you perform one or more of the following ?

	YES	NO	Percentage of Practice:
A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)? If Yes, describe below. _____ _____	A. <input type="checkbox"/>	<input type="checkbox"/>	_____
B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? Describe: _____ _____	B. <input type="checkbox"/>	<input type="checkbox"/>	_____
C. Arteriography/lymphangiography/myelography/phenmoencephalography?	C. <input type="checkbox"/>	<input type="checkbox"/>	_____
D. Interventional radiology - percutaneous transluminal angioplasty or embolization?	D. <input type="checkbox"/>	<input type="checkbox"/>	_____
E. Radiation therapy - deep (includes radium implants)?	E. <input type="checkbox"/>	<input type="checkbox"/>	_____
F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces?	F. <input type="checkbox"/>	<input type="checkbox"/>	_____
G. Mohs micrographic surgery? Describe: _____ _____	G. <input type="checkbox"/>	<input type="checkbox"/>	_____
H. Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____ _____	H. <input type="checkbox"/>	<input type="checkbox"/>	_____
I. Prenatal care and normal deliveries? If Yes, Do you perform home deliveries? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you only perform prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you supervise nurse midwives? <input type="checkbox"/> Yes <input type="checkbox"/> No	I. <input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	Percentage of Practice
J. Dilation and curettage?	J. <input type="checkbox"/>	<input type="checkbox"/>	_____
K. Needle biopsies? Describe: _____ _____	K. <input type="checkbox"/>	<input type="checkbox"/>	_____
OL. Electroshock therapy or hypnosis? Describe: _____ _____	L. <input type="checkbox"/>	<input type="checkbox"/>	_____
M. Radial keratotomy? Indicate where performed: <input type="checkbox"/> Hospital <input type="checkbox"/> Office <input type="checkbox"/> Surgicenter	M. <input type="checkbox"/>	<input type="checkbox"/>	_____
N. Hexagonal keratotomy? Indicate where performed: <input type="checkbox"/> Hospital <input type="checkbox"/> Office <input type="checkbox"/> Surgicenter	N. <input type="checkbox"/>	<input type="checkbox"/>	_____
10. Do you perform any one or more of the following?			
A. Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia?	A. <input type="checkbox"/>	<input type="checkbox"/>	_____
B. Non-spontaneous, induced abortions? _____ 1 <sup>st</sup> trimester (Not exceeding 14 weeks gestation) _____ 2 <sup>nd</sup> trimester (Indicate where performed: <input type="checkbox"/> Hospital <input type="checkbox"/> Office <input type="checkbox"/> Surgicenter)	B. <input type="checkbox"/>	<input type="checkbox"/>	_____
C. Sterilization procedures? Describe: _____ _____	C. <input type="checkbox"/>	<input type="checkbox"/>	_____
D. Cosmetic plastic surgery, cosmetic body contouring (suction lipectomy), implantations, injections and/or blepharopigmentation? Describe: _____	D. <input type="checkbox"/>	<input type="checkbox"/>	_____
E. Spinal surgery? If you also perform chemonucleolysis, check here <input type="checkbox"/>	E. <input type="checkbox"/>	<input type="checkbox"/>	_____
F. Open reduction of fractures? Describe: _____ _____	F. <input type="checkbox"/>	<input type="checkbox"/>	_____
G. Administration of general, spinal or caudal block anesthesia?	G. <input type="checkbox"/>	<input type="checkbox"/>	_____
H. Hysterectomies?	H. <input type="checkbox"/>	<input type="checkbox"/>	_____
I. Cholecystectomies? Do you perform laparoscopic cholecystectomies? Indicate number of laparoscopic cholecystectomies performed to date. _____	I. <input type="checkbox"/>	<input type="checkbox"/>	_____
J. Tonsillectomies and/or Adenoidectomies?	J. <input type="checkbox"/>	<input type="checkbox"/>	_____
K. Caesarian sections?	K. <input type="checkbox"/>	<input type="checkbox"/>	_____
L. Organ transplantations? Describe: _____ _____	L. <input type="checkbox"/>	<input type="checkbox"/>	_____
M. Weight reduction surgery?	M. <input type="checkbox"/>	<input type="checkbox"/>	_____
N. Sex change operation? Describe: _____ _____	N. <input type="checkbox"/>	<input type="checkbox"/>	_____
O. Experimental research or surgical research or experimental therapy in human patients? Describe: _____ _____	O. <input type="checkbox"/>	<input type="checkbox"/>	_____
P. Other surgery? Describe: _____ _____	P. <input type="checkbox"/>	<input type="checkbox"/>	_____

11. A. Do you perform surgery in your office?  Yes  No  
 If Yes, list surgical procedures: \_\_\_\_\_  
 \_\_\_\_\_
- B. Do you perform surgery in other non-hospital facilities?  Yes  No  
 If Yes, list facilities and surgical procedures: \_\_\_\_\_  
 \_\_\_\_\_
12. A. Indicate number of hours per month devoted to hospital emergency room care: \_\_\_\_\_ hours per month
- B. Is this emergency room care:  Yes  No
1. On your own patients only?  Yes  No
2. Required for staff privileges?  Yes  No
3. Other \_\_\_\_\_  Yes  No
13. Do you assist in surgery:  Yes  No
- On your own patients?  Yes  No
- Patients of other?  Yes  No
14. If your practice includes plastic surgery, specify percent of practice devoted to:  
 traumatic surgery \_\_\_\_\_% cosmetic surgery \_\_\_\_\_%
15. A. Do you practice weight reduction or control (other than by diet-exercise)?  Yes  No  
 If Yes, percent of patients exclusively weight control \_\_\_\_\_%
- B. Do you dispense (as opposed to prescribe) any weight control drugs?  Yes  No  
 If Yes, list drugs dispensed. \_\_\_\_\_
- C. Do you use injections for weight control?  Yes  No  
 If Yes, list drugs injected: \_\_\_\_\_
16. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc.,  
 whereby professional advice is offered to the public?  Yes  No  
 If Yes, please attach detailed explanation of this activity.
17. A. List number and type of professional employees: IF NONE, STATE NONE. \_\_\_\_\_  
 \_\_\_\_\_ Physicians (other than yourself) \_\_\_\_\_ Surgeon's Assistants\*  
 \_\_\_\_\_ Nurse Practitioners\*/Physician's Assistants\* \_\_\_\_\_ Nurse Anesthetists  
 \_\_\_\_\_ Other (describe) \_\_\_\_\_  
 \* Describe duties in detail, including extent supervised, on separate sheet.
- B. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  
 If No, attach explanation.  Yes  No
18. Have you or any of the above employees: (Attach detailed explanation for any Yes answers)
- A. Ever been the subject of investigative or disciplinary proceedings or reprimanded  
 by a governmental or administrative agency, hospital or professional association?  
 (Attach copy of Complaint and Consent Order documents, if applicable.)  Yes  No
- B. Ever been convicted for an act committed in violation of any law or ordinance other  
 than traffic offenses?  Yes  No
- C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric  
 treatment or has any administrative agency, hospital or professional association  
 requested or required you be evaluated for an alleged mental condition and/or alcohol  
 or drug addiction?  Yes  No
- D. Ever had any state professional license or license to prescribe or dispense narcotics  
 refused, suspended, revoked, renewal refused or accepted only on special terms or  
 ever voluntarily surrendered same?  Yes  No
- E. Ever had any professional liability insurance cancelled, declined, refused to renew  
 or accepted only on special terms?  Yes  No

F. Ever failed any medical licensing or specialty organization examination?  Yes  No

G. Do you have any chronic illness or defect?  Yes  No

19. Do you supervise any individuals other than your own employees?  Yes  No

If Yes, provide detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-Ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

20. Are you in the employ of any individual, firm or corporation other than your own?  Yes  No

If Yes, attach explanation, including details of any responsibilities.

21. Are you under contract to any individual, firm or corporation other than your own?  Yes  No

If Yes, attach explanation including details of your responsibilities.

If this contract contains a hold-harmless agreement, a copy of contract must be attached to application.

22. Are you in the employ of or under contract to any government entity?  Yes  No

If Yes, attach explanation, including details of your responsibilities.

23. Do you advertise your professional services in any manner  Yes  No

(other than a simple listing in a telephone directory)?

24. Are you associated with any agency or organization that engages in any kind of advertising  Yes  No

for, or solicitation of, patients?

If Yes, submit copy of all the advertisements.

25. A. From what medical school did you graduate? \_\_\_\_\_

Degree: \_\_\_\_\_ Year: \_\_\_\_\_

Location of medical school: \_\_\_\_\_

(City) (State) (Country)

B. If a foreign medical student graduate, are you certified by the Educational Council  Yes  No

for Medical School Graduates?

If Yes, state year and describe: \_\_\_\_\_

C. Residency?  Yes  No

If Yes, complete the following for each residency served:

Location \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Type \_\_\_\_\_

Complete?  Yes  No

Location \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Type \_\_\_\_\_

D. Additional Medical Training?  Yes  No

If Yes, complete the following:

Location \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Type \_\_\_\_\_

26. Are you American Board certified?  Yes  No

Medical Specialty \_\_\_\_\_ Date Certified \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertified \_\_\_\_/\_\_\_\_/\_\_\_\_

27. Where have you practiced your profession since completion of training?

In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

28. Indicate membership in professional societies: \_\_\_\_\_

29. Have you participated in any continuing medical educational program within the past five years?  Yes  No  
If Yes, describe separately.

30. Do you or the firm named in Question 6B above own or operate or provide professional services for  Yes  No  
or at any health care facility or business enterprise not already clearly described in this application?  
If Yes, attach detailed explanation.

31. A. Has any claim or suit for alleged malpractice been brought against you?  Yes  No  
If Yes, complete Supplemental Claim Information form, PSD/Claim (4/03) for each claim or suit.

B. Has any claim or suit for alleged malpractice been brought against you that has NOT  Yes  No  
been reported to a prior insurer?  
If Yes, complete Supplemental Claim Information form, PSD/Claim (4/03) for each claim or suit.

C. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice  Yes  No  
claim, or suit being made or brought against you?  
If Yes, complete Supplemental Claim Information Information form, PSD/Claim (4/03).

32. Do you practice in a surgicenter, abortion clinic, drug control clinic, extended hr. walk-in clinic,  Yes  No  
birthing center, blood bank, emergency treatment facility, convalescent home, psychiatric hospital,  
industrial medical care facility, laboratory, nursing home, sanitorium, urgent care clinic, and x-ray or imaging facility?  
If Yes, state location and describe:

33. A. Average patient load: \_\_\_\_\_ Patients Weekly \_\_\_\_\_ Total Patients Annually  
B. Average number of hours practice time: \_\_\_\_\_ Hours weekly

34. Do you anticipate changes in your practice in the next 12 months?  Yes  No  
If Yes, explain: \_\_\_\_\_

35. Approximate your gross annual income from the practice (check one):  
 Less than \$50,000       \$100,000 - \$149,999       \$200,000 or more (please estimate below)  
 \$50,000 - \$99,999       \$150,000 - \$199,999      \$ \_\_\_\_\_

36. List prior professional liability insurance carried to each of the past five years. If NONE, check here .

Insurance Company	Limits of Liability	Premium	Inception Mo/Day/Yr	Expiration Mo/Day/Yr	Retroactive Mo/Day/Yr	Was this a Claims Made policy form?	
						YES	NO
1. _____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

B. ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

37. Coverage desired:

Liability Limit \$ \_\_\_\_\_ Each Claim

Liability Limit \$ \_\_\_\_\_ Aggregate

Deductible Amount \$ \_\_\_\_\_

Desired Effective Date (12:01 a.m.) \_\_\_\_\_

## Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Underwriters, in conjunction with this application, will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Underwriters to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the Underwriters of such changes, and the Underwriters may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Applicant

\_\_\_\_\_

Title