



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 st trimester (Not exceeding 14 weeks gestation) _____ 2 nd 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