

# PMIS

## Individual Physician Quote

Name: \_\_\_\_\_ date of birth: \_\_\_\_\_ social security #: \_\_\_\_\_

Primary office address: \_\_\_\_\_ phone: \_\_\_\_\_

Secondary office address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ email address: \_\_\_\_\_

Address where correspondence should be sent:

Indicate limits requested: (some may not be available in all states)

\_\_\_\_\_ \$100,000/\$300,000    \_\_\_\_\_ \$200,000/600,000    \_\_\_\_\_ \$250,000/750,000    \_\_\_\_\_ \$300,000/900,000  
\_\_\_\_\_ \$500,000/1,500,000    \_\_\_\_\_ \$1,000,000/3,000,000    \_\_\_\_\_ \$2,000,000/4,000,000

Policy form requested:    \_\_\_ claims made    \_\_\_ occurrence (may not be available from all carriers)

Requested effective date: \_\_\_\_\_ Retroactive date: \_\_\_\_\_

(effective dates and retroactive dates are found on the declarations page, or face sheet, of your current policy, the dec. page also includes your name, address, limits, premium, etc. PLEASE ENCLOSE A COPY WITH THIS FORM).

What month and year did you begin practice?

DEA registration number:

List states in which you are or have been licensed:

State: \_\_\_\_\_ Date license obtained: \_\_\_\_\_ License # \_\_\_\_\_ \*Temporary

Education	Institution	City, State	Degree/Type	Year
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Undergrad.

**Medical School**

**Internship**

**Residency**

**Fellowship**

**List the Medical Societies or Specialty Societies to which you belong:**

**Have you participated in any CME in the last three years? yes no**  
**Attach an explanation.**

**Have you completed any risk management courses for CME? yes no**

**Please provide copy of completion certificate.**

**If a foreign medical graduate, are you certified by the ECFMG? yes no**

**You are presently participating in an internship, residency or fellowship program? yes no**

**Is yes, indicate program and location:**

**Do you plan to take additional residencies or change specialties? yes no**

**If yes, explain:**

**Do you have any teaching responsibilities or supervisory responsibility with residents, interns or students?**  
**yes no**

**If yes, explain:**

**Where**

**What % time involved**

**Full time teaching faculty member:**

**Part time teaching faculty member:**

**Is institutional coverage provided for the activity?**

**PRACTICE AND SPECIALTY:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Allergy and immunology | <input type="checkbox"/> Gynecology                | <input type="checkbox"/> Orthopedic surgery        |
| <input type="checkbox"/> Anesthesiology         | <input type="checkbox"/> Hand surgery              | <input type="checkbox"/> Osteopathic medicine      |
| <input type="checkbox"/> Cardiology             | <input type="checkbox"/> Hematology                | <input type="checkbox"/> Otorhinolaryngology       |
| <input type="checkbox"/> Cardiovascular Surgery | <input type="checkbox"/> Internal Medicine         | <input type="checkbox"/> Otorhinolaryngology and   |
| <input type="checkbox"/> Child Neurology        | <input type="checkbox"/> Neonatology               | <input type="checkbox"/> Orofacial plastic surgery |
| <input type="checkbox"/> Child Psychiatry       | <input type="checkbox"/> Nephrology                | <input type="checkbox"/> Otolaryngology            |
| <input type="checkbox"/> Dermatology            | <input type="checkbox"/> Neurological surgery      | <input type="checkbox"/> Pathology                 |
| <input type="checkbox"/> Diagnostic Radiology   | <input type="checkbox"/> Neurology                 | <input type="checkbox"/> Pediatrics                |
| <input type="checkbox"/> Emergency Medicine     | <input type="checkbox"/> Neurology and Psychiatry  | <input type="checkbox"/> Physiatry                 |
| <input type="checkbox"/> Endocrinology          | <input type="checkbox"/> Nuclear medicine          | <input type="checkbox"/> Plastic and Recon.        |
| <input type="checkbox"/> Family Medicine        | <input type="checkbox"/> Obstetrics and Gynecology | <input type="checkbox"/> surgery                   |
| <input type="checkbox"/> General Practice       | <input type="checkbox"/> Occupational Medicine     | <input type="checkbox"/> Proctology                |

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> General surgery  | <input type="checkbox"/> Ophthalmology                    | <input type="checkbox"/> Psychiatry            |
| <input type="checkbox"/> Geriatrics       | <input type="checkbox"/> Oromaxillofacial Plastic surgery | <input type="checkbox"/> Psychometric medicine |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Orthopedics                      | <input type="checkbox"/> Public health         |
- 
- 
- Pulmonary medicine
- 
- 
- Radiology
- 
- 
- Rehabilitation medicine
- 
- 
- Rheumatology
- 
- 
- Rhinology
- 
- 
- Sports medicine
- 
- 
- Therapeutic Radiology
- 
- 
- Thoracic surgery
- 
- 
- Urological surgery
- 
- 
- Urology
- 
- 
- Vascular surgery
- 
- 
- other \_\_\_\_\_

Are you Board certified in your specialty? yes no

Are you Board Eligible? yes no

If yes, give specialty dates of certification:

Do you take and/or interpret your own x-rays? yes no If yes, # per year:

Do you use radiology back up? yes no

Does a non-radiologist review all of your films? yes no

If yes, name and specialty of physician:

Do you provide office-based lab services? yes no

If yes, is it "Waivered test?  Level 1?  Level 11?

Has the U.S. Department of Health and Human Services certified your laboratory? yes no

List hospitals where you currently practice?

Name:

Location:

Type privileges:

**PROCEDURES:** Do you perform any of the following?

Minor surgery, other than superficial suturing of boils and abscesses, or suturing of skin? yes no

Assist in major surgery on own patients? yes no

Assist in major surgery on patients of others? yes no

Major surgery (attach a list)? yes no

Normal OB, not considered major surgery? yes no

Nonsurgical deliveries each year \_\_\_\_\_

Home deliveries each year \_\_\_\_\_

OB which are considered major surgery: \_\_\_\_\_

Number each year: \_\_\_\_\_

Reconstructive Plastic surgery yes no

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Cosmetic Plastic Surgery \_\_\_yes \_\_\_no  
Acupuncture other than acupuncture anesthesia \_\_\_yes \_\_\_no (provide training certificate)  
Arteriography or angiography \_\_\_yes \_\_\_no  
Do you perform the following:  
Swan ganz procedures \_\_\_yes \_\_\_no  
Cardiac Catheterization \_\_\_yes \_\_\_no  
Coronary Angioplasty (PTCA) \_\_\_yes \_\_\_no  
Pace maker insertions: Temporary \_\_\_yes \_\_\_no  
Permanent \_\_\_yes \_\_\_no

Any others?

Arthroscopic procedures (provide training if non-surgical specialty) \_\_\_yes \_\_\_no  
Chemabrasion or dermabrasion \_\_\_yes \_\_\_no  
Chemonucleolysis \_\_\_yes \_\_\_no (provide training details)  
Chelation therapy \_\_\_yes \_\_\_no (provide training details)  
Colonoscopy and/or sigmoidoscopy \_\_\_yes \_\_\_no  
Cryosurgery used in treatment of \_\_\_\_\_  
Discograms \_\_\_yes \_\_\_no  
Endoscopic retrograde cholangiopancreatography (ERCP) \_\_\_yes \_\_\_no  
Laparoscopy (peritoneoscopy) \_\_\_yes \_\_\_no  
Lasers used in therapy \_\_\_yes \_\_\_no  
Lymphangiography \_\_\_yes \_\_\_no  
Myelography \_\_\_yes \_\_\_no  
Phlebography \_\_\_yes \_\_\_no  
Pneumatic or mechanical esophageal dilation ( not with bougie or olive) \_\_\_yes \_\_\_no  
Pneumoencephalography \_\_\_yes \_\_\_no  
Electro-Convulsive Therapy (ECT) \_\_\_yes \_\_\_no  
Mammoplasty/Breast augmentation or reduction \_\_\_yes \_\_\_no  
Implantation or injection of silicone or other materials for cosmetic reasons \_\_\_yes \_\_\_no  
Legal abortions \_\_\_yes \_\_\_no # per year \_\_\_\_\_ # therapeutic \_\_\_\_\_ #elective \_\_\_\_\_ #after first trimester  
Lumbar punctures \_\_\_yes \_\_\_no  
Needle biopsy-including lung, liver kidney or prostate \_\_\_yes \_\_\_no  
Closed reductions \_\_\_yes \_\_\_no  
Laminectomies, or other spinal surgery \_\_\_yes \_\_\_no  
Hair transplants \_\_\_yes \_\_\_no (provide details and types of procedures)

Weight reduction methods used: \_\_\_\_\_

Weight control surgery used: \_\_\_\_\_

Zyderm injections? \_\_\_yes \_\_\_no

Other:

Please provide additional training details for the above as necessary:

If you are an Ophthalmologist, please complete the following:

Do you assist in surgery? \_\_\_yes \_\_\_no Do you assist on the following?  
Corneal transplants \_\_\_yes \_\_\_no  
Radial keratotomy \_\_\_yes \_\_\_no  
Refractive keratoplasty \_\_\_yes \_\_\_no  
Epikeratophakia \_\_\_yes \_\_\_no  
Keratomileusis \_\_\_yes \_\_\_no

Do you perform major surgery? \_\_\_yes \_\_\_no Do you perform the following?  
Retinal detachment surgery \_\_\_yes \_\_\_no  
Par plana vitrectomy \_\_\_yes \_\_\_no  
Corneal transplants \_\_\_yes \_\_\_no  
RK \_\_\_yes \_\_\_no  
Refractive keratoplasty \_\_\_yes \_\_\_no  
Ophthalmic plastic surgery – cosmetic \_\_\_yes \_\_\_no  
Retrobulbar masses \_\_\_yes \_\_\_no

If you are a General surgeon, please complete the following:

Do you perform:  
Thoracic surgery \_\_\_yes \_\_\_no  
Cardiovascular surgery \_\_\_yes \_\_\_no  
Vascular surgery \_\_\_yes \_\_\_no  
Trauma surgery \_\_\_yes \_\_\_no

What % of surgical procedures do you perform: in your office \_\_\_\_\_ in a hospital \_\_\_\_\_  
Other \_\_\_\_\_ Please explain other:

Do you maintain overnight recovery beds in your office? \_\_\_yes \_\_\_no  
If yes, please provide details:

Indicate level of anesthesia you use during office procedures:

Type of Anesthesia  
None \_\_\_\_\_ You \_\_\_ CRNA \_\_\_ Anesthesiologist \_\_\_  
Local \_\_\_\_\_ You \_\_\_ CRNA \_\_\_  
Regional \_\_\_\_\_ You \_\_\_ CRNA \_\_\_  
Twilight \_\_\_\_\_ You \_\_\_ CRNA \_\_\_  
General \_\_\_\_\_ You \_\_\_ CRNA \_\_\_

If a CRNA or Anesthesiologist administers anesthesia in your office, you have a copy of his/her certificate of insurance? \_\_\_yes \_\_\_no

Time spend in active practice: \_\_\_\_\_ hours per week \_\_\_\_\_ weeks per year  
What changes do you anticipate in the scope and volume of your practice in the next year?

What is the average number of minutes that you spend with each of the following?

- A new patient in the hospital \_\_\_\_\_
- A new patient in a nursing home of other similar situation \_\_\_\_\_
- A new patient in the office \_\_\_\_\_
- A patient seen on a follow-up visit \_\_\_\_\_

Do you use a collection agency? yes no If yes, state the name of the firm and the # of accounts referred annually:

- Do you work in:
- |   |                              |                             |
|---|------------------------------|-----------------------------|
|   | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| An Emergency Department                       | _____                        | _____                       |
| An Intensive Care Unit                        | _____                        | _____                       |
| A free-standing, urgent care, ambulatory care |                              |                             |
| Or similar outpatient facility                | _____                        | _____                       |
| Industrial clinic                             | _____                        | _____                       |

If yes, explain whether this is to maintain staff privileges, supplemental moonlighting and hours per week:

Is professional liability insurance provided for any of the above? yes no Name carrier and provide certificate of insurance:

Are you requesting coverage for any of the above?

- Are you:
- Self employed? yes no
  - An employee of another physician? yes no if , yes, explain:

An employee of an organization, other than a hospital, engaged in the delivery of medical services? yes no

An independent contractor to an organization, other than a hospital, engaged in the delivery of medical services? yes no

Are you a partner, stockholder or employee in a medical partnership, professional association, or professional service corporation? yes no  
If yes, explain:

Name of entity: \_\_\_\_\_ type of entity: \_\_\_\_\_

List stockholders, partners and associates:

- Are you requesting that the legal entity be named on your policy? yes no
- Are you requesting separate limits of the legal entity? yes no

Employees, associates under your supervision or direction:

Number/Specialty      Hours per week      Insurance provided      Limits

Other doctors:

Nurses:

Physicians assistants:

Other:

Are you a proprietor, owner, director, partner, superintendent, executive officer, administrator of any of the following? If you have answered "yes" to any of the below, list the names of the facilities and your affiliation with them in the space provided:

Hospital \_\_\_yes \_\_\_no

Nursing home \_\_\_yes \_\_\_no

Sanitarium \_\_\_yes \_\_\_no

Surgicenter \_\_\_yes \_\_\_no

Clinic with bed and board \_\_\_yes \_\_\_no

Blood bank \_\_\_yes \_\_\_no

Lab \_\_\_yes \_\_\_no

other medical facility \_\_\_yes \_\_\_no

Prepaid health plan or HMO \_\_\_yes \_\_\_no

Do you practice medicine at these institutions? \_\_\_yes \_\_\_no

If yes, please explain:

Provide detailed explanations on all yes answers:

Have you ever been treated for alcoholism, narcotics addition or mental illness? \_\_\_yes \_\_\_no

Have you now or ever had a professional liability insurance policy declined, canceled, issued on special terms or renewal refused? \_\_\_yes \_\_\_no

Has your license to practice medicine or your permit to prescribe drugs ever been declined, canceled, issued on special terms or renewal refused? \_\_\_yes \_\_\_no

Has your membership in any professional society ever been refused, censured, suspended or revoked? \_\_\_yes \_\_\_no

Has any hospital ever restricted or revoked your privileges or invoked probation for any cause? \_\_\_yes \_\_\_no

Have you ever been indicted or convicted of a crime other than a minor traffic violation? \_\_\_yes \_\_\_no

Have you signed contractual agreement where you agreed to hold others harmless? \_\_\_yes \_\_\_no

Have you signed a contract to supervise any department in a hospital? \_\_\_yes \_\_\_no

Have you ever been denied a medical license or been denied certification by a specialty board? \_\_\_yes \_\_\_no

Do you direct the field operations of paramedics or EMT's? \_\_\_yes \_\_\_no

Has your practice changed in the last 10 years? \_\_\_yes \_\_\_no

Please explain "yes" answers fully:

Has any claim or suit for alleged malpractice been brought against you? \_\_\_yes \_\_\_no

If so, give details including patient's name or description, allegations, carrier handling, outcome including payment and amount: (use separate sheet if necessary)

Record of previous carriers in last five years:

Name?	Indemnity period?	Limits?	Claims made?/Occurrence?	Retrodate?
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**YOU MIGHT ATTACH A COPY OF YOUR MOST RECENT DECLARATIONS PAGE (THE FACE SHEET OF YOUR CURRENT POLICY THAT SHOWS YOUR NAME, RETRODATE, LIMITS, PREMIUM, ADDRESS, ETC.) SO THAT WE MIGHT ATTEMPT TO MATCH COVERAGES CORRECTLY.**

**Other comments or explanations:**

I understand that completion of this application does not constitute acceptance of this application or obligate the Company to provide the insurance for which I have applied. However, facts and answers to questions set forth in this application will be relied upon by the Company as the basis of the contract should a policy be issued.

I understand and agreed that this application will be made a part of any policy issued, and any such policy will be issued in reliance upon the representations made herein. I further understand and agree that failure to provide a true and accurate response to any of the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this application and /or denial of claims asserted against me under any policy issued.

I will notify the Company within (30) thirty days of any change in the nature of my practice, including but not limited to any change in location, specialty, licensing and status.

**RELEASE OF INFORMATION**

I hereby authorize the insurer to obtain full information from any insurance company or from any person with respect to any claims or suit or incident pertaining to professional acts or omissions asserted against me. I expressly release and discharge from liability any insurance company or person providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

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<b>Date signed</b>	<b>Personal signature</b>	<b>Printed or Typed Name</b>
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Any person who knowingly and with intent to defraud any insurance company or other person, or files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any cat material thereto, commits a fraudulent insurance act.

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<b>Date signed</b>	<b>Personal Signature</b>	<b>Printed or Typed Name</b>
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