

THE MEDICAL PROTECTIVE COMPANY

Physicist Professional Liability Insurance Application

GENERAL INFORMATION

A. _____
 Last Name First Name Middle Name Degree

B. WHAT IS YOUR PRESENT SPECIALTY? _____ SUB-SPECIALTY? _____

What percentage of your practice is devoted to your specialty? _____ Subspecialty? _____

Are you permanently retired from the practice of clinical medicine? Yes No

C. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:

- | | | |
|--|---|---|
| <input type="checkbox"/> ABORTIONS
<input type="checkbox"/> ACUPUNCTURE
<input type="checkbox"/> THERAPEUTIC/LOCAL ANESTHETIC
<input type="checkbox"/> GENERAL ANESTHETIC
<input type="checkbox"/> ANGIOGRAPHY
<input type="checkbox"/> ANGIOPLASTY
<input type="checkbox"/> ARTHROSCOPY
<input type="checkbox"/> ARTERIOGRAPHY
<input type="checkbox"/> ASSISTING IN MAJOR SURGERY
<input type="checkbox"/> OWN PATIENTS ONLY
<input type="checkbox"/> OWN & OTHER THAN OWN PATIENTS
<input type="checkbox"/> BLEPHAROPIGMENTATION
<input type="checkbox"/> BLEPHAROPLASTY - BROW LIFTS
COSMETIC _____% OF PRACTICE
RECONSTRUCTION _____% OF PRACTICE
<input type="checkbox"/> BREAST IMPLANTS
COSMETIC _____% OF PRACTICE
RECONSTRUCTION _____% OF PRACTICE
<input type="checkbox"/> BRONCHOSCOPY
<input type="checkbox"/> CATARACT SURGERY
<input type="checkbox"/> CRYOSURGERY (OTHER THAN EXTERNAL LESIONS)
<input type="checkbox"/> ERCP
<input type="checkbox"/> D & C
<input type="checkbox"/> PHENOL FACIAL PEELS
<input type="checkbox"/> DIAGNOSTIC EMBOLIZATION
<input type="checkbox"/> GENERAL/SPINAL/CAUDAL ANESTHESIA
<input type="checkbox"/> PULSE OXIMETRY
<input type="checkbox"/> END TIDAL CO ² ANALYZER
<input type="checkbox"/> HAIR TRANSPLANTS
<input type="checkbox"/> SCALP EXCISION/TRANSPLANTATIONS
<input type="checkbox"/> PLUG TECHNIQUE/MINIGRAPH | <input type="checkbox"/> LAPAROSCOPIC CHOLECYSTECTOMY
<input type="checkbox"/> LAPAROSCOPY
<input type="checkbox"/> LASER SURGERY
<input type="checkbox"/> LIPOSUCTION
<input type="checkbox"/> LYMPHANGIOGRAPHY
<input type="checkbox"/> LITHOTRIPSY
<input type="checkbox"/> MAJOR GYNECOLOGICAL SURGERY
<input type="checkbox"/> MYELOGRAPHY
<input type="checkbox"/> NEEDLE BIOPSY
<input type="checkbox"/> NERVEBLOCKS
<input type="checkbox"/> LUMBAR EPIDURAL STEROID
<input type="checkbox"/> PARASPINAL
<input type="checkbox"/> SCIATIC
<input type="checkbox"/> FACET
<input type="checkbox"/> PARAVERTEBRAL
<input type="checkbox"/> PERIPHERAL
<input type="checkbox"/> MYOFASCIAL
<input type="checkbox"/> OCCIPITAL
<input type="checkbox"/> TRIGGERPOINT INJECTION
<input type="checkbox"/> PHLEBOGRAPHY
<input type="checkbox"/> PNEUMOENCEPHALOGRAPHY
<input type="checkbox"/> RADIAL/LASER KERATOTOMY
<input type="checkbox"/> RADIATION/X-RAY THERAPY
<input type="checkbox"/> RADIOPAQUE DYE
<input type="checkbox"/> NON-IONIC ONLY
<input type="checkbox"/> SHOCK THERAPY
<input type="checkbox"/> SIGMOIDOSCOPY
<input type="checkbox"/> LESS THAN 60 CM
<input type="checkbox"/> GREATER THAN 60 CM
<input type="checkbox"/> COLONOSCOPY
<input type="checkbox"/> POLYPECTOMY
<input type="checkbox"/> GASTROINTESTINAL ENDOSCOPY | <input type="checkbox"/> BIOPSY (ENDOSCOPIC)
<input type="checkbox"/> PERITONEOSCOPY
<input type="checkbox"/> LASER THERAPY (ENDOSCOPIC)
<input type="checkbox"/> PACEMAKERS UNDER GENERAL ANESTHESIA
<input type="checkbox"/> SILICONE INJECTIONS
<input type="checkbox"/> SKIN FLAP/GRAFTS
COSMETIC _____% OF PRACTICE
RECONSTRUCTION _____% OF PRACTICE
<input type="checkbox"/> SWAN-GANZ CATHETERIZATION
<input type="checkbox"/> RIGHT HEART CATHETERIZATION (OTHER THAN CVP LINES)
<input type="checkbox"/> LEFT HEART CATHETERIZATION
<input type="checkbox"/> TUBAL LIGATIONS
<input type="checkbox"/> VASECTOMIES
<input type="checkbox"/> ON OWN PATIENTS
<input type="checkbox"/> ON OTHER THAN OWN PATIENTS
<input type="checkbox"/> WEIGHT CONTROL THERAPY/SURGERY _____% PRACTICE
<input type="checkbox"/> MEDICATION-WEIGHT CONTROL
<input type="checkbox"/> GASTRIC BUBBLE
<input type="checkbox"/> GASTRIC STAPLING
<input type="checkbox"/> OTHER WEIGHT CONTROL PROCEDURES
<input type="checkbox"/> PRENATAL PRACTICE
<input type="checkbox"/> SEE PATIENTS DURING THE FIRST & SECOND TRIMESTER
<input type="checkbox"/> SEE PATIENTS TO TERM BUT DO NOT PERFORM DELIVERY
<input type="checkbox"/> SEE PATIENTS TO TERM AND PERFORM DELIVERY
<input type="checkbox"/> NORMAL OBSTETRICAL DELIVERIES
HOW MANY PER YEAR? _____
<input type="checkbox"/> CESAREAN SECTIONS
HOW MANY PER YEAR? _____
<input type="checkbox"/> OTHER MEDICAL TECHNIQUES
LIST PROCEDURES _____

_____ |
|--|---|---|

D. INDICATE THE PERCENTAGE OF YOUR SURGICAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:

- | | | |
|---|--------------------|---|
| _____ % PLASTIC (RECONSTRUCTION ONLY) | _____ % THORACIC | _____ % ORTHOPEDIC (INCLUDING BACK) |
| _____ % PLASTIC (COSMETIC ENHANCEMENT ONLY) | _____ % CARDIAC | _____ % ORTHOPEDIC (NOT INCLUDING BACK) |
| _____ % HAND | _____ % VASCULAR | _____ % OTHER (DESCRIBE) _____ |
| _____ % TRAUMATIC | _____ % OBSTETRICS | |

E. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures? Yes No
 If Yes, list procedures and date discontinued _____
2. Have you performed weight control surgery or prescribed weight control medication? Yes No
3. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?
 <1% 1%-10% 11%-50% >50%
4. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?
 <1% 1%-10% 11%-50% >50%
5. Do you have ownership interests in a weight control clinic? Yes No
6. If yes, what is the name of the weight control clinic with which you are affiliated: _____

ADDITIONAL PROFESSIONAL INFORMATION

A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER:

1. Do you treat or review treatment of Federal prison inmates? Yes No
2. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Yes No
If yes, please indicate the date(s): _____
3. Have you had any professional liability insurance refused, canceled or non-renewed? Yes No
4. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.) Yes No

If Yes, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type	Duration	Treating Physician (Name & Address)

STATE STATUTORY REQUIREMENT

NOTE: All applicants must read and initial the following:

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS I WILL HAVE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Date Signed: _____ Signature: _____

Printed Name: _____

