



**Application for Physicians & Surgeons  
Professional Liability Insurance  
(Claims Made Basis)**

Applicant's Instructions:

1. Answer all questions. If the answer requires detail, please attach a separate sheet. If a question is not applicable, state NOT APPLICABLE.
2. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

**I. GENERAL INFORMATION**

- a. Full Name of Applicant (Include professional degree) \_\_\_\_\_
- b. Home address: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- c. Principal business address: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- d. Additional business address(s): \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- e. Please attach list of any additional locations.
- f. Phone: Business: \_\_\_\_\_ Fax \_\_\_\_\_ Home: \_\_\_\_\_
- g. Email: \_\_\_\_\_ Web address: \_\_\_\_\_
- h. Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_
- i. Medical License # \_\_\_\_\_ Exp: \_\_\_\_\_ DEA License # \_\_\_\_\_ Exp: \_\_\_\_\_
- j. Are you a US Citizen?  Yes  No  
 If no, please indicate your status and the date of entry into the US.

**2. APPLICANT PRACTICE INFORMATION**

- a. Practice is:
 

<input type="radio"/> Solo Practitioner	<input type="radio"/> Professional Corporation
<input type="radio"/> Employee	<input type="radio"/> Professional Association
<input type="radio"/> Partnership	<input type="radio"/> Other: _____
- b. If you are employed by an entity outside your primary practice, give name and address of employer, and provide copy of employment contract:  
 \_\_\_\_\_
- c. If you are a member of a professional entity, give the formal corporation, association, partnership or business name:  
 \_\_\_\_\_
- d. Are all members of the professional entity covered by professional liability insurance?  Yes  No  
 If yes, by what company? \_\_\_\_\_
- e. Do you wish to have coverage for the professional entity?  Yes  No  
 If yes, please complete the attached Professional Entity Application Addendum.
- f. Is your office compliant with the HIPAA rules?  Yes  No

g. Is any portion of your practice outside your primary practice state? ○ Yes ○ No

State	License #	License Exp. Date	Avg Hours / Week

h. What is your medical or surgical specialty? \_\_\_\_\_

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

j. Do you have a sub-specialty? ○ Yes ○ No  
If yes, please attach a detailed explanation.

k. Are you “chief of” or “head” of any hospital department? ○ Yes ○ No  
If yes, are these duties covered under a hospital insurance policy? ○ Yes ○ No

l. Do you perform one of or more of the following procedures? Please check all that apply and provide a detailed explanation for all items checked including the name and location of the offices, hospitals, or centers where the procedures are performed.

- |  |   |
|--|---|
| <input type="checkbox"/> Endoscopic procedures (other than Sigmoidoscopy or proctoscopy)<br><input type="checkbox"/> Catheterization (other than swan-ganz, umbilical cord, urethral catheterization, or arterial line in a peripheral vessel)<br><input type="checkbox"/> Dilation and Curettage<br><input type="checkbox"/> Needle biopsies<br><input type="checkbox"/> Electroshock therapy or hypnosis<br><br><input type="checkbox"/> Arteriography<br><input type="checkbox"/> Lymphangiography<br><input type="checkbox"/> Myelography<br><input type="checkbox"/> Pneumoencephalography<br><input type="checkbox"/> Interventional radiology<br><input type="checkbox"/> Percutaneous transluminal angioplasty or embolization<br><input type="checkbox"/> Radiation therapy (including radium transplants)<br><br><input type="checkbox"/> Cosmetic plastic surgery (cosmetic body contouring implants, injections and/or blepharopigmentation)<br><input type="checkbox"/> Open reduction of fractures<br><input type="checkbox"/> Hysterectomies<br><br><input type="checkbox"/> Laparoscopic hysterectomies<br><br><input type="checkbox"/> Tonsillectomies<br><input type="checkbox"/> Adenoidectomies<br><input type="checkbox"/> Weight reduction surgery<br><input type="checkbox"/> Experimental research, surgical research, or experimental therapy in human patients<br><input type="checkbox"/> Sex change operations | <input type="checkbox"/> Chemabrasion<br><br><input type="checkbox"/> Dermabrasion<br><br><input type="checkbox"/> Hair transplants or suturing of hairpieces<br><input type="checkbox"/> Mohr micrographic surgery<br><input type="checkbox"/> Acupuncture (for analgesia) or acupuncture anesthesia<br><input type="checkbox"/> Prenatal care and normal deliveries<br><input type="checkbox"/> Home deliveries<br><input type="checkbox"/> Supervise midwives<br><input type="checkbox"/> Radial keratotomy<br><input type="checkbox"/> Hexagonal keratotomy<br><input type="checkbox"/> Any minimal incision surgery<br><br><input type="checkbox"/> Surgery (other than incision of boils and superficial abscess or suturing skin and superficial fascia)<br><input type="checkbox"/> Non-spontaneous abortions (1st or 2nd trimester)<br><br><input type="checkbox"/> Sterilization procedures<br><input type="checkbox"/> Spinal surgery (including chemonucleolysis and/or percutaneous lumbar discectomy)<br><input type="checkbox"/> Administer Anesthesia (general spinal or caudal block)<br><input type="checkbox"/> Cholecystectomies<br><input type="checkbox"/> Laparoscopic cholecystectomies<br><input type="checkbox"/> Caesarian sections<br><input type="checkbox"/> Organ transplantations<br><br><input type="checkbox"/> Other surgery |
|--|---|

- m. Do you perform surgery in your office?  Yes  No  
If yes, please attach a description of the surgical procedure(s).
- n. Do you perform surgery in non-hospital facilities?  Yes  No  
If yes, please indicate the facility and describe the surgical procedure(s).
- o. Is general anesthesia administered for any of the surgeries performed in Questions 2(l) and 2(m)?  Yes  No  
If yes, please indicate who administers the anesthesia \_\_\_\_\_
- p. Do you assist in surgery (either your own patients or others' patients)?  Yes  No
- q. Do you perform any hospital emergency room care?  Yes  No  
If yes, please provide a detailed explanation, specifically indicating the approximate hours per month spent in emergency room care, whether it is a requirement for staff privileges, and whether this care is for only your own patients.
- r. Does your practice include plastic surgery?  Yes  No  
If yes: percentage of practice devoted to traumatic surgery \_\_\_\_\_  
percentage of practice devoted to cosmetic surgery \_\_\_\_\_
- s. Does your practice include weight reduction or control (other than by diet/exercise)?  Yes  No  
If yes, please provide a detailed explanation including the percentage of patients that are specifically weight control patients, whether you dispense any drugs and the names of the drugs, and whether you use injections for weight control and a list of the drugs injected.
- t. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hour walk-in clinic or birthing center?  Yes  No  
If yes, please provide a detailed explanation, including the location of the center.
- u. What is the approximate gross annual income from your practice? (check one)
- less than \$50,000                       \$150,000 to \$199,999
- \$50,000 to \$99,999                       \$200,000 or more (Please estimate) \$ \_\_\_\_\_
- \$100,000 to \$149,999                       Other: \_\_\_\_\_
- v. Do you anticipate any changes in your practice within the next year?  Yes  No  
If yes, please explain on a separate sheet.
- w. Has your practice (specialty, procedure) changed in the last five years?  Yes  No  
If yes, please explain on a separate sheet.
- x. Do you anticipate your practice (specialty, procedure) changing within the next year?  Yes  No  
If yes, please explain on a separate sheet.

y. Volume of Practice:

	Per Week
Avg. # of patients seen by you in office (including house calls)	
Avg. # of surgeries performed in hospital(s) or outpatient center(s)	
Avg. # of patients seen by you in nursing home(s) or assisted living facility(ies)	
Avg. # of hours worked	

z. Hospitals / Outpatient Centers where you have privileges:

Hospital /Surgical Center Name & City/State	Type & Extent of Privileges / Procedures Performed	Avg Hrs/Week

aa. Please list prior professional liability insurance for the past 3 years. If None, state none

Carrier	Policy #	Liability Levels	Premium	Coverage Dates	Claims Made Form?	Retro Date
					<input type="radio"/> Y <input type="radio"/> N	
					<input type="radio"/> Y <input type="radio"/> N	
					<input type="radio"/> Y <input type="radio"/> N	

### 3. POLICY FORM INFORMATION

a. Proposed Effective Date: \_\_\_\_\_ Retroactive Date Requested: \_\_\_\_\_

b. Coverage limits requested:

- \$100K/\$300K       \$250K/\$750K       \$500K/\$1.5M       \$1M/\$3M       \$2M/\$4M

c. Do you practice part-time?  Yes  No

If yes, list average hours worked per week: \_\_\_\_\_

d. Do you intend to purchase a reporting endorsement (aka tail coverage) from your current insurer (if currently Claims Made Form)?  Yes  No

If No, do you wish to obtain Prior Acts Coverage from us?  Yes  No

If Yes, please complete the following:

Applicant  is /  is not as of this date aware of any claims against him/her that have not been reported to his/her present or prior insurer(s).

Applicant  is /  is not as of this date aware of any conduct, circumstances or incidents which occurred during the periods of coverage listed above which could reasonable be expected to result in a claim, and has not been reporting to his/her present or prior insurer(s).

**NOTE: IF YOU DO NOT OBTAIN PRIOR ACTS COVERAGE, YOU WILL HAVE NO COVERAGE THROUGH US FOR ANY CLAIM OR SUIT BASED UPON THE RENDERING OF OR FAILURE TO RENDER PROFESSIONAL SERVICES PRIOR TO THE EFFECTIVE DATE OF THIS POLICY.**

### 4. APPLICANT EDUCATION

Undergraduate Degree:

Degree Obtained:	Institution:
Dates Attended:	Location (City/State):

Medical Degree:

Degree Obtained:	Institution:
Dates Attended:	Location (City/State):

If foreign medical school, are you certified by the Educational Council for Medical School Graduates?  Yes  No

If yes, state year of certification \_\_\_\_\_

Residency Training:

Type:	Institution:
Inclusive Dates:	Location (City/State):
Type:	Institution:
Inclusive Dates:	Location (City/State):

- a. Have you received any additional medical training?  Yes  No  
If yes, please provide an explanation on a separate sheet specifically detailing the type of training, where received, and the time period in which it was obtained.

**5. APPLICANT CERTIFICATIONS AND AFFILIATIONS**

- a. Are you American Board Certified?  Yes  No  
If yes, Medical Specialty: \_\_\_\_\_  
Orig. Certification Date: \_\_\_\_\_ Recertification Date: \_\_\_\_\_
- b. Are you a member of any professional societies?  Yes  No  
If yes, please provide information regarding your membership(s):  
\_\_\_\_\_  
\_\_\_\_\_
- c. List or attach any Risk Management related Continuing Education Programs and credit hours received within the last 12 months. **Course description and proof of participation required in order to receive credit.**  
\_\_\_\_\_  
\_\_\_\_\_
- d. Have you met your state's Continuing Medical Education requirements to maintain your medical license?  Yes  No  N/A  
If yes, please attach copy of certificates.

**6. CLAIMS**

(Attach a detailed explanation for any "yes" answers.)

- a. Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association?  Yes  No  
Attach a copy of the Complaint and Consent Order, if applicable.
- b. Have you ever been convicted for an act committed in violation of any law or ordinance?  Yes  No
- c. Have you 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 that you be evaluated for any alleged mental condition and/or alcohol or drug addiction?  Yes  No
- d. Have you 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. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?  Yes  No
- f. Have you ever failed any medical licensing or specialty organization examination?  Yes  No
- g. Do you have any chronic physical illness or defect?  Yes  No
- h. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?  Yes  No
- i. Has any claim or suit for alleged malpractice been brought against you?  Yes  No  
If yes, provide a loss run from each carrier for the past ten (10) years.
- j. Are you aware of any medical incidents, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?  Yes  No  
If yes, have they been reported to your prior insurance carrier?

**7. MANDATORY ATTACHMENTS**

- a. Curriculum Vitae (C.V)
- b. Copy of Current License
- c. Copy of Board Certification Certificates
- d. Proof of Risk Management Credits
- e. Declarations Page from Current Professional Liability Policy
- f. 5 Years of Loss Runs from Prior Carriers

**By my signature below:**

1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.

2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.

3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify Campmed in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.

4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and Campmed Casualty & Indemnity Company, Inc. of Maryland and my broker, agent or peer review.

**CAMPMED FRAUD STATEMENT**

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 and denial of insurance benefits.

**Please see the attached specific Fraud Warnings required by some states.**

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

**PLEASE MAIL / FAX / EMAIL COMPLETED APPLICATION TO:**

Campania  
 111 Berry Street SE, Vienna, VA 22180  
 Fax (703) 242-3815  
 msackie@thecampaniagroup.com

Thank you for choosing Campania for your insurance needs.

## FRAUD WARNINGS

**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 applicant.

**Notice to Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of 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 or concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Louisiana And West Virginia 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 Maryland Applicants:** Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

**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 York 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 or 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 North Carolina Applicants:** Any person who knowingly presents false information in an application for insurance is guilty of a felony and may be subject to fines and imprisonment.

**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 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 Tennessee and 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.