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MEDICAL FACILITIES AND PROVIDERS PHYSICIAN SUPPLEMENTAL APPLICATION

This Supplemental Application is part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):

B. PHYSICIAN INFORMATION

2. Physician Name:

NOTE: THE PHYSICIAN IDENTIFIED IN SECTION B.2. ABOVE MUST ATTACH A COPY OF HIS/HER CV WITH THIS SUPPLEMENTAL APPLICATION.

3. Name of facility where services are provided:

4. Does your employment with the facility identified in Section B.3 above require that you provide services to any other organization? ☐ Yes ☐ No

   If "Yes," please provide details:

5. Do you practice for the facility identified in Section B.3 above? ☐ Full Time ☐ Part Time

   Hours per week: ____________ How many patients do you see per week? ____________

6. Medical School/State: ______________________ Month/Year Graduated: ____________

   Degree: ☐ M.D. ☐ D.O. ☐ Other: ____________ Are you currently a resident, intern or fellow? ☐ Yes ☐ No

   If "Yes," please specify date you will complete training: ____________

7. List all states where you are licensed to practice and the applicable license number:

   State/License Number: ______________________
   State/License Number: ______________________
   State/License Number: ______________________
   State/License Number: ______________________

8. List all hospitals where you have staff privileges (Attach a separate sheet if needed.)

   Hospital Name, City/State: ______________________
   Hospital Name, City/State: ______________________
   Hospital Name, City/State: ______________________
   Hospital Name, City/State: ______________________

C. AREAS OF PRACTICE

9. Indicate percentage of time devoted to the following medical and/or surgical activities (Total must = 100%)

______ % Allergy & Immunology
______ % Anesthesiology
______ % Broncho-Esophagology
______ % Cardiovascular Disease
______ % Colon & Rectal
______ % Dermatology
______ % Diabetes
______ % Emergency Medicine
______ % Endocrinology
______ % Family Practice or General Practice, Excl. OB
______ % Family Practice or General Practice, Incl. OB
______ % Fetal & Maternal Medicine
______ % Foot & Ankle Surgery
______ % Gastroenterology
______ % General Preventative Medicine
______ % Geriatrics
______ % Gynecology
______ % Hand
______ % Head & Neck
______ % Hematology
______ % Infectious Diseases
______ % Intensive Care Medicine
______ % Larynology
______ % Limited General Practice
______ % Legal Medicine
______ % Neoplastic Diseases
______ % Nephrology
______ % Neurology

______ % Nuclear Medicine
______ % Nutrition
______ % Obstetrics/Pre-Natal Care
______ % Oncology
______ % Ophthalmology
______ % Oral-Maxillofacial Surgery
______ % Orthopedics
______ % Otology
______ % Otorhinolaryngology
______ % Pain Management
______ % Pathology
______ % Pharmacology
______ % Physiatry
______ % Physician-NOC
______ % Physical Medicine & Rehabilitation
______ % Psychiatry
______ % Psychoanalysis
______ % Physchsomatic Medicine
______ % Public Health
______ % Pulmonary Diseases
______ % Radiology
______ % Rheumatology
______ % Rhinology
______ % Teleradiology
______ % Thoracic
______ % Urology
______ % Weight Reduction/Control
______ % Other (list) ____________________

SURGERY

______ % Abdominal
______ % Bariatric
______ % Cardiac
______ % Cardiovascular
______ % Colon & Rectal
______ % Dermatology
______ % Endocrinology
______ % Foot & Ankle
______ % Gastroenterology
______ % General
______ % Gynecology
______ % Hand
______ % Head & Neck
______ % Laryngology
______ % Neonatal
______ % Neoplastic
______ % Nephrology
______ % Neurology
______ % Obstetrics
______ % Ophthalmology
______ % Orthopedic Excl Spine
______ % Orthopedic Incl Spine
______ % Otorhinolaryngology
______ % Perinatology
______ % Plastic
______ % Plastic-Otorhinolaryngology
______ % Thoracic
______ % Traumatic
______ % Urological
______ % Vascular
______ % Other (list): ______________
____

10. Do you practice telemedicine? ☐ Yes ☐ No

If "Yes," please provide details:

11. Do you work in correctional institutions? ☐ Yes ☐ No

If "Yes," please provide details:

12. Do you work in research or clinical trials? ☐ Yes ☐ No

If "Yes," please provide details:

D. MEDICAL SPECIALTY

13. Are you certified by an approved specialty board? ☐ Yes ☐ No

If "No," are you Board Eligible? ☐ Yes ☐ No

Name(s) of approved specialty board(s): ______________________________

Cert. #:	Date Issued:	Expiration Date:
Cert. #:	Date Issued:	Expiration Date:

If you are not board certified, please explain: ______________________________

14. Primary Specialty: ____________________ Sub-Specialty: ____________________

Is your practice limited to your sub-specialty? ☐ Yes ☐ No

E. CURRENT AND REQUESTED COVERAGE

15. Current Carrier: ____________ Limits (Each Claim/Aggregate): $ ____________ /$ ____________

Retroactive Date: ____________

16. Are you requesting Prior Acts coverage? ☐ Yes ☐ No

If "Yes," specify retroactive date desired if not provided above: ____________

F. CLAIMS HISTORY

17. Have you ever:

a. Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity or board? ☐ Yes ☐ No

b. Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐ Yes ☐ No

c. Been treated for any alcohol, narcotics or any substance abuse? ☐ Yes ☐ No

d. Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐ Yes ☐ No

e. Had hospital privileges reduced, suspended or revoked? ☐ Yes ☐ No

f. Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐ Yes ☐ No

18. MISSOURI RESIDENTS - DO NOT ANSWER. Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for you? ☐ Yes ☐ No

19. Do you have knowledge of any claim, suit or potential claim in which you are named or may become involved, including, without limitation, knowledge of any actual or alleged injury arising out of the rendering of, or failure to render, professional services which may give rise to a claim? ☐ Yes ☐ No

If "Yes," have these been reported to your current carrier? ☐ Yes ☐ No

Please complete and attach a Claim Information Form (Form HPA-30005-07-12) for EACH such claim, suit or potential claim or provide a current carrier loss run for such claim, suit or potential claim.

G. SIGNATURE AND AUTHORIZATION

The undersigned declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Physician Supplemental Application and any attachments of information submitted with this Physician Supplemental Application are true and complete. The undersigned understands that the information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representation and conditions set forth therein.

NOTICE: 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 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.

Physician Signature		
Print Name		Date

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Application

MEDICAL FACILITIES AND PROVIDERS PHYSICIAN CLAIM INFORMATION FORM

This Physician Claim Information Form is Part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):	

B. CLAIM INFORMATION

INSTRUCTIONS: THIS FORM MUST BE COMPLETED IF ANY PHYSICIAN PROPOSED FOR THIS INSURANCE HAS KNOWLEDGE OF ANY CLAIM, SUIT OR POTENTIAL CLAIM IN WHICH HE/SHE IS NAMED OR MAY BECOME INVOLVED AS INDICATED BY A "YES" ANSWER TO QUESTION E.19. OF THE PHYSICIAN SUPPLEMENTAL APPLICATION. PLEASE COMPLETE ONE CLAIM INFORMATION FORM FOR EACH SUCH CLAIM, SUIT OR POTENTIAL CLAIM. USE SEPARATE SHEETS IF NECESSARY.

2. Physician Name:			
3. Name of Patient or Claimant:		☐ Male ☐ Female	Age:
4. Location of Incident:			
5. Date of Incident:			
6. Physician's relationship to the Patient/Claimant (Attending Physician, Assistant Surgeon, etc.)			
7. Insurance Carrier:			

8. Current Status: ☐ Open ☐ Closed If closed, date closed: ____________________

9. Please provide the following information (as applicable):

a. Open Reserve Amount	$ ____________	b. Closed Loss Amount	$ ____________
c. Settlement Total Amount	$ ____________	d. Judgement Total Amount	$ ____________
Your Portion	$ ____________	Your Portion	$ ____________

10. Name of other physician(s) and hospital(s), if any, involved in claim, suit or potential claim:

11. Allegation(s):

12. Condition and diagnosis of patient at time of treatment:

13. Description of medical treatment rendered to patient:

14. Condition of patient subsequent to treatment:

C. SIGNATURE AND AUTHORIZATION

The undersigned declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Physician Claim Information Form and any attachments of information submitted with this Physician Claim Information Form are true and complete. The undersigned understands that the information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representation and conditions set forth therein.

NOTICE: 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 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.

Physician Signature		
Print Name		Date