



Application

FOR

PODIATRISTS

Professional Liability Insurance



Home Office: 1 11 East Shore Road, P.O. Box 4300
Manhasset, New York, 11030-2902
Telephone: (718) 895-6033 (516) 365-6690
(212) 936-3050 (800) 632-6040
Fax: (516) 365-6343

Rochester Office: 1200C Scottsville Road, Suite 252
Rochester, New York, 14624
Telephone: (716) 328-8860 (800) 329-8860
Fax: (716) 328-8686

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any applicable endorsements, has been issued to the named insured.

Help us expedite the processing of your application:

- Please print your responses in ink or type.
- Answer every question or mark it "not applicable" (N/A).
- Use the "Remarks" section to amplify your answers, where requested (see #45)
- If you have had claims or suits filed against you, please make certain you have completed a claims information form for each claim or suit in the past ten years. (See page 12).
- Incomplete answers and/or missing attachments **will** delay our processing of the application.

FOR ASSISTANCE, PODIATRISTS MAY CALL EITHER OF OUR OFFICES
AT ANY ONE OF THE NUMBERS LISTED ABOVE

A. GENERAL INFORMATION (Please type or print clearly in ink)

If my application is approved, make coverage effective on _____,
Month Date Year,
if possible, otherwise on any other date set by PRI.

1. Applicant's Full Name: _____ Date of Birth: _____

2. New York State Podiatric License Number: _____

3. List any non-New York State Podiatric Licenses held:

Table with 3 columns: License Number, Issuing State, Date Issued. Two rows of blank lines for entry.

4. Social Security Number _____ I.R.S. Tax I.D. Number _____

5. Home Address: _____ Phone: () _____
Number Street

City County State Zip

6. I wish to have all correspondence mailed to:

_____ Home _____ Principal Office _____ Other (specify) _____

B. PRACTICE LOCATIONS

List all locations, other than hospitals and ambulatory surgery centers, at which you currently render professional services. Include all office locations, urgent care clinics, and other non-hospital locations. Attach additional pages as needed.

7. Primary Address for which coverage is desired:

Number Street () Telephone
City County State Zip () Fax

This address is a (check one): [] Private Office [] Hospital [] Clinic
[] Other _____

Number of hours per week you are at this location: _____

Number of patients you see per week at this location: _____

8. Other Address for this Policy (if any):

_____ () _____
 Number Street Telephone
 _____ () _____
 City County State Zip Fax

This address is a (*check one*): Private Office Hospital Clinic
 Other _____

Number of hours per week: _____ Number of patients per week: _____
 If this policy is for more than two locations, indicate other location(s) in Remarks, #45.

9. Are you on the staff of any hospital? Yes No

If yes, name of hospital _____

Position you hold at the hospital _____

Do you practice at the hospital clinic? Yes No

If no, what is procedure if patient must be hospitalized? _____

10. Are you a consultant to a nursing home, skilled nursing facility, extended care facility or adult home?

Yes No

If yes, please indicate the name of the facility _____

Number of beds at the facility _____ Number of hours worked (weekly) at the facility _____

Is coverage being provided by another carrier for your work at the facility? Yes No

If yes, name of carrier _____

11. Do you make house calls? Yes No

If yes, how many hours per week do you spend making house calls? _____

C. TRAINING**12. Podiatry College Attended _____ Year Graduated _____**

(a) Have you served a Residency? Yes No

Dates _____

Name and address of Residency Program _____

(b) Have you served a Preceptorship? Yes No

Dates _____

Name and address of Preceptor _____

Telephone Number () _____

Did your Preceptor have hospital privileges? Yes No

If yes, where? _____

13. (a) Are you American Board of Podiatric Surgery (ABPS) certified? Yes No

If yes, what year did you become certified? _____.

(b) Are you American Board of Podiatric Surgery (ABPS) qualified? Yes No

(c) Are you American Board Podiatric Orthopedics and Primary Medicine Certified? Yes No

If yes, what year did you become certified? _____.

(d) Please list other Board(s) certifications or eligibility

D. PROFESSIONAL & INSURANCE HISTORY

14. Practice Locations

List all locations at which you have practiced in the last ten (10) years. (Do not list training locations from Section C.) Explain any gaps in time and attach additional pages as needed.

Name of Practice/Employer	Address	From Mo./Yr.	To ____ Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. List professional liability insurance for each of the past ten years. If none, state none.

<u>Insurance Company</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Premium</u>	<u>Coverage Dates</u>	<u>Claims-Made/ Occurrence</u>	<u># of Claims</u>

16. Insurance

- (a) Have you ever practiced without insurance or allowed a Claims-Made policy to lapse without the purchase of tail or nose coverage?
If yes, explain in Remarks #45. Yes No
- (b) Have you ever had professional liability insurance refused, declined, cancelled or accepted on special terms?
If yes, explain in Remarks #45. Yes No
- (c) Have you ever been required to pay an additional merit-rated premium or have you ever been involved in an appeal concerning the imposition of such a surcharge?
If yes, explain in Remarks #45. Yes No

E. PRACTICE INFORMATION

17. (a) I practice as:

- A Surgical Podiatrist A Non-Surgical Podiatrist (does not perform bone surgery)
 A Preceptee

(b) If you are a preceptee, please give the name, address and telephone number of your preceptor.

18. What percentage of your practice involves:

Sports Medicine _____ % Diabetic Patients _____ %
 Children _____ % Other _____ %
 List _____

19. Are you involved in the practice of podiatry/medicine in any other capacity? Yes No
 If yes, please provide details: _____

20. List the number of procedures you perform monthly as the primary podiatrist:

	Office	Hospital	Other Facility*	
# Soft tissue	_____ +	_____ +	_____ =	Total _____
# Bone surgery	_____ +	_____ +	_____ =	Total _____
Percentage of time	_____ +	_____ +	_____ =	100%

* Please describe other facility _____

21. Do you advertise? Yes No
 If yes, please attach samples or copies of your advertisements to this application.

- 22.
- (a) Are you a member of the American Podiatric Medical Association (APMA)?
 Yes No
- (b) Are you a member of the American College of Foot and Ankle Surgeons (ACFAS)?
 Yes No
- (c) Are you a member of the Academy of Ambulatory Foot Surgery (AAFS)?
 Yes No
- (d) List any other professional organizations or associations of which you are a member.

F. COVERAGE/BILLING OPTIONS

23. Please check the appropriate limits of liability for which you are applying:
 \$500,000 per claim \$1,500,000 Annual Aggregate
 \$1,000,000 per claim \$3,000,000 Annual Aggregate

24. Coverage Type. PRI offers both Claims-Made and Occurrence Coverage

- A Claims-Made policy covers claims which arise and are made while the policy is in force.
- Occurrence Coverage protects you against any claim arising during your policy period irrespective of when the claim is reported.

Select Coverage type: Claims-Made Occurrence

25. Prior Acts

- (a) Is this policy to replace an existing Claims-Made policy? Yes No
- (b) Do you wish prior acts coverage (nose) beginning on the initial date of your Claims-Made policy? Yes No

If yes, a Conversion Supplemental Application (E-104A) must accompany this application along with a copy of your most recent declarations page.

- (c) For the period that Prior Acts coverage is desired, are you aware of any incidents that occurred that may give rise to a claim, but that you have not reported to your previous carrier?
 Yes No

If yes, please explain: _____

- (d) Has there been any interruption in your professional liability coverage? Yes No

26. Please bill my premium on the following basis: Annually Quarterly Monthly

I agree that the billing option I choose will remain in effect until I send a written request to change the option, and I understand that this option may only be changed on my policy anniversary date.

 Signature of Insured

 Date

27. Scope of Coverage:

I am requesting coverage for my podiatric practice as described in this application. However, I do not want PRI coverage for the part of my podiatric practice listed below.

(Complete the following section to specify the part of your practice for which you do not want PRI coverage. Be sure to include the location and proof of coverage for the professional liability carrier providing coverage for that aspect of your practice).

Practice/Location	Carrier/Limits	Dates
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Practice/Location	Carrier/Limits	Dates
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Practice/Location	Carrier/Limits	Dates
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28. Have you completed a formal Risk Management Training Program in the last year? Yes No
- If so, give date: _____ If yes, give name of sponsoring organization _____
-

G. MEDICAL CONDUCT INFORMATION

29. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice podiatry? Yes No
If yes, explain Remarks #45 and submit a letter from your treating physician.
30. Have you ever been convicted of a felony? Yes No
If yes, explain in Remarks #45.
31. Has any governmental agency ever investigated, suspended, revoked or taken any other action against either your narcotic license or your license to practice podiatry? Yes No
If yes, explain in Remarks #45.
32. Have you ever had privileges at any hospital or other institution reduced, revoked, restricted or suspended? Yes No
If yes, explain in Remarks #45.
33. Have you ever been involved in a peer review committee hearing? Yes No
If yes, explain in Remarks #45.
34. Have you ever been subject to fee review? Yes No
If yes, explain in Remarks #45.
35. Have you **ever** been named as a defendant in a malpractice claim or suit with an **incident date, report date or close date** occurring within the last ten years, or are you presently involved in malpractice litigation? Yes No
- If yes, submit a separate **Claim Information form** (see page 12) for each case in the last ten years.

H. PRACTICE ASSOCIATIONS

REMINDER: Answers to the questions in this section should reflect your intended practice as of the date you wish this policy to become effective.

36. Practice Situation

(a) Indicate all practice situations that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> "Solo" Podiatrist. | <input type="checkbox"/> Employed Podiatrist without ownership interest in the employer. |
| <input type="checkbox"/> "Solo" Medical Corporation. | <input type="checkbox"/> Independent Contractor/Contractee. |
| <input type="checkbox"/> Medical Corporation with more than one Podiatrist shareholder. | <input type="checkbox"/> Use of assumed name (DBA). |
| <input type="checkbox"/> Medical Partnership. | <input type="checkbox"/> Employed by another Podiatrist. |
| <input type="checkbox"/> Limited Liability Company or Partnership (LLC or LLP). | <input type="checkbox"/> Employs another Podiatrist. |
| | <input type="checkbox"/> Other _____ |

If you check any boxes above other than "Solo" Podiatrist or "Solo" Medical Corporation, list below the name of the applicable entity(ies) and/or any physician(s). Attach copies of your letterhead(s), if any, to this application.

Name of Entity(ies)	Name of Physician Employer or Employee	Professional Liability Insurance Carrier
_____	_____	_____
_____	_____	_____
_____	_____	_____

37. Do you wish coverage for any of the above entities? Yes No
 If yes, which one(s)? _____

If P.C., LLC, LLP or Partnership Coverage is desired, please submit a copy of the Certificate of Incorporation, or Certificate of Partnership and filing receipt.

38. Do you employ any Podiatrists? Yes No
 (a) Does your practice include any independent contractors? Yes No
 If yes, list name(s): _____

(b) Do the independent contractors provide their own professional liability coverage? Yes No
 If yes, with what insurance carriers? _____

And for what limits?

Please indicate the number of employees as follows:

- A. Employed Podiatrists* _____
- B. Podiatric Associates _____
- C. Nurses _____
- D. Preceptees& _____
- E. Residents* _____

* Note: Employed Podiatrists and residents must secure individual professional liability insurance for their own protection. PRI is able to insure a preceptee if it insures the preceptor. If coverage for a preceptee is desired, he/she must complete an application.

I. MEDICAL DIRECTOR AND TEACHING RESPONSIBILITIES

39. Additional Responsibilities

Do you have any Medical Director or teaching responsibilities? Yes No

If yes, complete the following questions (a-d). Attach additional pages as needed.

a. Name of entity and location: _____

b. Your title: _____

c. Describe your responsibilities: _____

- d. Does the entity provide you with coverage for:
 - i) Your administrative responsibilities? Yes No
 - ii) Your direct patient care? Yes No

- 40. a) Do you serve as the director of any residency program? Yes No
- b) Are you the Chief of any Department? Yes No

i) Name of entity and location _____

ii) Your title _____

iii) Describe your responsibilities _____

NOTE: Please be advised that coverage is not provided for any liability assumed solely in your role as medical director of any facility. However, coverage is provided for direct patient care.

J. PRACTICE AND PROCEDURES: GENERAL QUESTIONS

41. (a) Do you perform procedures in a non-hospital setting where anesthesia/sedation is administered? Yes No

If yes, check type used:

- Spinal General Local Intravenous Analgesia

If yes:

- i) Location Surgicenter Office Other Non-Hospital Facility

ii) Who administers the anesthesia? _____

- iii) Do you employ or contract with an anesthesiologist? Yes No

(b) For Surgicenter or other Non-Hospital Facility, please provide the name and address of the facility.

(c) List the surgical procedures you perform in your office or other non-hospital facility:

Procedure	# Weekly	Where Performed
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a protocol regarding pre-op clearance in the office or non-hospital setting?

- Yes No

(d) Is there a documented clinical evaluation pre-op by any of the following:

- Yes No

- Anesthesiologist CRNA Operating Surgeon

(e) Does a professional staff member monitor the patient post-op?

- Yes No

Is this documented?

- Yes No

(f) Do you have formal discharge criteria?

- Yes No

Does your discharge criteria require that a physician discharge the patient?

- Yes No

(g) Do you maintain a full emergency cart?

- Yes No

i) Do you follow a protocol for checking the cart on a regular basis?

- Yes No

ii) Are the checks documented?

- Yes No

iii) Do you maintain a written transfer agreement with a nearby hospital?

- Yes No

42. (a) Do you use a laser in your treatment of patients? Yes No
If yes, what procedures do you perform with the laser? _____

(b) How many laser procedures do you perform each week? _____ (number) per week.

(c) What type of laser training did you receive? Check all that apply.

- Seminar Course Preceptorship Hands On Other

If yes, please provide written proof of training

I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not withheld any information which is calculated to influence the judgement of the Company in considering this application for professional liability insurance.

The application duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY 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.

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any podiatry society, podiatrist, hospital, insurance company, underwriter, and insurance agent to furnish any information concerning me or my podiatry practice which the Company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

Signature _____

Date _____

CLAIM INFORMATION

Be Sure to Answer All Questions Fully. Leave No Blanks

- A. Name of claimant or plaintiff: _____
- B. Date of alleged incident _____
- C. Name of Defense Counsel _____
- D. Name of Plaintiff's Counsel _____
- E. Location of Incident (County and State) _____
- F. Date of Incident _____
- G. Report Date _____
- H. Issue or type of injury claimed - What was the objective issue contested in this Claim?
 Injury: Emotional Only Cosmetic Temporary Disability
 Permanent Disability Death Injury with Economic Impact
 Treatment Involved: _____
 Please state allegations filed against you by patient: _____

At what point in the treatment provided could this incident have been avoided either by a different action on your part or help from another treating podiatrist? Please be candid.

- I. Were other Podiatrists or hospitals involved as co-defendants? Yes No
 If yes, please list their names

If you were one of many defendants in this legal action and your treatment was criticized by any of the podiatrists involved, what were the allegations against you?

- J. Name of the insurance company defending you: _____
- K. Was claim or suit actually brought against you, merely threatened, or limited to claimant's attorney contact? _____
- L. If suit was filed, include the court docket number, if known: _____
- M. Disposition of Claim: What happened to the claim?
 * OPEN Current Status: _____

How much has the insurance company set aside in reserve for this claim?
(if known) _____

* CLOSED Date Closed: _____

Won by defense Judgment Verdict

Won by claimant

Amount paid on your behalf? _____

Reason for payment on your behalf: _____

PHOTO COPY THIS FORM AND SUPPLY US WITH A SEPARATE SHEET FOR EACH CLAIM, SUIT OR INCIDENT.