LANCET INDEMNITY
"THE INSURANCE COMPANY PHYSICIANS TRUST"

Lancet Indemnity RRG Application Checklist

☐ Complete Application

☐ Completed claim form for every previous medical malpractice claim

☐ Curriculum Vitae

☐ Declaration sheet from your current carrier

☐ Copy of your license(s)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions; if a question is not applicable, state “NOT APPLICABLE”.
2. If Space is insufficient to answer any questions fully, attach a separate sheet.
3. The Application must be signed and dated by the applicant.
4. It the answer to any question is none, state “NONE”.
5. Please do not complete the application earlier than 60 days before proposed effective date of coverage.

Preparers Signature x_____ Date _____

2810 West St. Isabel Street, Suite 100, Tampa, Florida 33607 **P** 877.370.2262 **F** 813.290.7070
www.LancetIndemnity.com

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS
THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY
(PLEASE TYPE OR PRINT IN INK)

APPLICANT:

Full Name of Applicant: _____ MD ☐ DO ☐ Other ☐

Date of Birth: ____/_____/_____ Place of Birth: _____ SS#: _____

Federal DEA#: _____Are You A US Citizen? Yes ☐ No ☐

If, No please indicate your status and entry into the US on a separate sheet. Include a copy of your current Permanent Visa.

Principal Office Address: **(This will be mailing address unless noted differently)**

Street: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____ Email: _____

Number of Year At Current Office Location: _____

Residence Address:

Street: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (_____) _____-_____

Preferred Mailing Address: ☐ Practice Address ☐ Home Address ☐ Other (Please list on Notes Pages)

From what medical school did you graduate? _____
Degree: _____ Year: _____
Location of Medical School (City, State, Country) _____

If a foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? ☐ Yes ☐ No
If "yes" state, year and describe _____
_____

Where did you do your Residency? (Please complete for each residency served. If more is needed please attach)

Location: _____ From: _____ To: _____
Type: _____ Did you complete? _____

Location: _____ From: _____ To: _____
Type: _____ Did you complete? _____

Do you have any additional Medical Training? ___ Yes ___ No If Yes, Location: _____
Type: _____ From: _____ To: _____

Are you Board Certified? ☐ Yes ☐ No ☐ Eligible
If certified in multiple specialties please indicate.

Indicate any membership in professional societies:

American Board in Medical Specialties: _____
Special Medical Societies: _____
Specialty Colleges: _____
County Medical and Other: _____

Have you participated in any continuing medical education program within the past five years? ☐ Yes ☐ No

Please describe (include photocopies of CME certificates) _____
_____
_____

PROFESSIONAL PRACTICE INFORMATION:

Medical Specialty: _____ % of Practice: _____

Sub Specialty: _____ % of Practice: _____

List all counties in which you practice: _____

Average Weekly Patient Load: _____ Number of weekly Practice Hours: _____

% of practice outside of office location: Nursing Home _____, Rehab _____, Other (attach explanation) _____

Have there been any significant changes in your practice during the past 5 years? ☐ Yes ☐ No
If yes, attached an explanation.

Indicate the Extent of Surgery You Perform:

☐ No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing of minor lacerations
☐ Minor Surgery – includes circumcisions other than on newborns and vasectomies # Annually _____
☐ Major Surgery – includes all procedures done under general, spinal or caudal anesthesia # Annually _____
☐ Perform obstetrical procedures
☐ Assisting in surgery on your own patients # Annually _____
☐ Assisting in surgery on patients other than your own # Annually _____
☐ Hospitalist

Limits of Liability Requested: (per incident/ annual aggregate)

☐ $100,000 / $300,000
☐ $200,000 / $600,000
☐ $250,000 / $750,000
☐ $500,000 / $ 1 Million
☐ $1 Million / $3 Million
☐ Other (Limits in policy will govern coverage)

List all states where you are licensed to practice: (If more please attach)

State _____ License #_____ ☐ Permanent or ☐ Temporary?
State _____ License #_____ ☐ Permanent or ☐ Temporary?
State _____ License #_____ ☐ Permanent or ☐ Temporary?

List the hospitals you have privileges at, show percentage of work and status: (If more please attach)

_____ _____ % ☐ Permanent or ☐ Temporary?
_____ _____ % ☐ Permanent or ☐ Temporary?
_____ _____ % ☐ Permanent or ☐ Temporary?

Please describe the type and extent of these privileges:

_____
_____
_____
_____

Are you a Chief or Head of a hospital department? ☐ Yes ☐ No ***If yes, please attach details.***

____List number and type of professional employees: If none, check here: ____

_____ Physicians (other than yourself) _____ Physicians Assistants
_____ Surgeons Assistants _____ Nurse Midwives
_____ Nurse Practitioners _____ Nurse Anesthetists
_____ Other (describe with duties in detail, including extent supervised on a separate sheet and attach)

Are all the above individuals license in accordance with applicable state and federal regulations? ☐ Yes ☐ No
If no, attach an explanation.

Was your practice during the period for which you are requesting Prior Acts Coverage different I any way from your practice as described in this application for Medical Professional Liability Claims-Made Coverage? For instance, did you practice formerly include obstetrical care or emergency room services that you are no longer providing or did you ever perform silicone implants of any kind? ☐ Yes ☐ No

Did any of your policies contain any coverage restrictions? ☐ Yes ☐ No If YES, please describe, including all applicable dates. Attach additional pages if needed. _____
_____
_____

INSURANCE COVERAGE INFORMATION:

Requested Effective Date: ____ / ____ / _____

Do you wish to have prior medical acts covered by this policy? (Prior Acts Coverage)

☐ Yes ☐ No ☐ Not sure, please discuss with broker

If yes, what is your retroactive date? ____ / ____ / _____

Do you Practice as a:
☐ Solo Practitioner (unincorporated) ☐ Professional ☐ Corporation
☐ Solo Practitioner (incorporated) ☐ Partnership
☐ Professional Corporation
☐ Employee of: _____

If you practice other than as an employee or an unincorporated solo practitioner; List the names of ALL your partner, your employees or members of your professional association or corporation who practice medicine and their current insurance carriers:

_____
_____
_____
_____
_____

Provide the formal corporate, association, partnership or business name, Tax ID#:

_____

Do you or the firm listed above own (wholly or in part), operate or administer and hospital, nursing home or other institution where medical services are customarily rendered? ☐ Yes ☐ No ***If yes, please attach details.***

Please indicate the following procedures which you perform. If none, check here ____

(For all items with and "*" please complete a supplemental application)

Primary	Assisting		Primary	Assisting	
☐	☐	Abortions - # per Year ____*	☐	☐	Hyperbaric Chamber Treatment
☐	☐	Acupuncture or acupressure	☐	☐	Hysterectomies*
☐	☐	Adenoidectomies	☐	☐	Hypnosis
☐	☐	Anesthesia, general*	☐	☐	Insertion of intrauterine or subcutaneous contraceptive devise
☐	☐	Angiography, angioplasty, arteriography, cardiac catheterization	☐	☐	Laparoscopy
☐	☐	Appendectomies	☐	☐	Lasers – used in therapy or surgery
☐	☐	Banding Hemorrhoids	☐	☐	Liposuction
☐	☐	Blepharoplasty	☐	☐	Lumbar puncture - # per year _____
☐	☐	Bronchoscopy	☐	☐	Needle biopsy
☐	☐	Cesarean sections - # per year ____*	☐	☐	MOHS microscopic surgery
☐	☐	Chemabrasion	☐	☐	Obstetrical deliveries - # per year: ____*
☐	☐	Circumcisions – Other than newborn	☐	☐	OB deliveries at other than a licensed acute care hospital *
☐	☐	Colonoscopy	☐	☐	Office x-rays – Over read: ☐ Yes ☐ No By whom: _____
☐	☐	Cosmetic injection or implants of any kind, including Botox, collagens, free fat, silicone	☐	☐	Open reductions of fractures
☐	☐	Cosmetic plastic surgery or procedures (elective)	☐	☐	Pain Management *
☐	☐	Cosmetic plastic surgery (reconstructive)*	☐	☐	Prenatal care
☐	☐	Cryosurgery	☐	☐	Radial keratotomy, LASIX, PRK, AKL, or PTK
☐	☐	D & C's	☐	☐	Radiation therapy
☐	☐	Dermabrasion or laser skin resurfacing	☐	☐	Spinal anesthesia
☐	☐	Electro Convulsive Therapy	☐	☐	Spinal surgery
☐	☐	Endoscopic procedures	☐	☐	Telemedicine
☐	☐	Endoscopic Retrograde Cholangiopancreatography	☐	☐	Tonsillectomies
☐	☐	Esophageal Gastro Dilation	☐	☐	Thoracic Surgery ____%
☐	☐	Facelift	☐	☐	Tubal Ligation *
☐	☐	Fertility / Infertility Treatment	☐	☐	Transplant Surgery
☐	☐	Gastric by-pass / stapling or other weight control surgery or procedures	☐	☐	Trigger point injections
☐	☐	Hair Growing, transplant or scalp reduction surgery	☐	☐	Urological Surgery *
☐	☐	Hemorrhoidectomy	☐	☐	Vascular Surgery ____%
☐	☐	Hernias	☐	☐	Vasectomies
			☐	☐	V.B.A.C.'s - # per year _____ *
☐	☐	Other: _____			

If you practice emergency room care how many hours per month do you devote to this? _____

Is the emergency room care; On your own patients only? ☐ Yes ☐ No
Required for staff privileges? ☐ Yes ☐ No
Other (details) ☐ Yes ☐ No

If yes, to any of the above please complete Emergency Medicine Supplemental Application

Do you perform or assist in surgery? ☐ Yes ☐ No ***If yes, please complete General Surgery Supplemental Application***

Do you perform surgery in your office? ☐ Yes ☐ No
If yes, please list surgical procedures: _____
_____
_____

Do you perform surgery in other non-hospital facility? ☐ Yes ☐ No
If yes, please list surgical procedures: _____
_____
_____

In the course of surgery, is general anesthesia administered? ☐ Yes ☐ No
By you? ☐ Yes ☐ No
By other? ☐ Yes ☐ No

Do you practice weight reduction or control (other than by diet-exercise)? ☐ Yes ☐ No
If yes, please complete Bariatric Supplement Application

Do you supervise any individuals other than your own employee? ☐ Yes ☐ No If yes provided a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also indicate, by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

Do you practice in a surgi-center, abortion clinic, drug control clinic, emerge-center, extended hours walk-in clinic or birthing center?
☐ Yes ☐ No If YES, state location and describe: _____
_____
_____

Have you ever practiced without medical professional liability insurance? ☐ Yes ☐ No

If yes, what day did you resume coverage? ____ / ____ / _____ ***or,*** ☐ ***still not covered***

List prior professional liability insurance carried for each of the past ten years. **IF NONE, STATE NONE**.

Insurer Policy	# Policy Limit	Deductible	Premium	Inception	Expiration	Claims Made or Occurrence

IF YOU ANSWR YES TO ANY OF THE BELOW QUESTIONS PLEASE PROVIDE EXPLINATION ON "ADDITIONAL NOTES PAGE"

Have you ever had your license to practice medicine, permit to dispense or prescribe drugs, or your privileges with a hospital, managed care organization, or other healthcare facility denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited; or are any currently under investigation? ☐ Yes ☐ No

Have you ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations? ☐ Yes ☐ No

Have you ever been evaluated, treated, or hospitalized for: alcohol, mental or emotional disorders, narcotics, or central nervous system stimulants or depressants? ☐ Yes ☐ No

Are you currently involved in or have you ever been involved in a malpractice claim or suit including any expression of intent by a third party (i.e. records request, incident reports and Notices of Intent, even if the suit was never filed)? ☐ Yes ☐ No

Do you know or is it reasonably foreseeable from the facts, reasonable inferences, or circumstances (including, but not limited to, complications, unexpected or potentially problematic results or any communication from a patient or patient's representative, friend, relative or attorney) regarding any procedure, treatment or diagnosis you have performed or made in the past that might reasonably lead to a claim or suit being brought against you? ☐ Yes ☐ No

Are there outstanding incidents, claims or suits, or potential incidents, claims or suits (even if you believe the outstanding claim or suit would be without merit) that have not been reported to your current or prior professional liability insurance carrier? ☐ Yes ☐ No

If you have answered YES to any of the above three indented questions please attach detailed information.

Total # of Claims _____ # of Open / Reserved _____ # of Closed _____

Have you ever been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, alleged improper care of a patient, unprofessional conduct, unethical conduct or fraud? ☐ Yes ☐ No

Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

Ever failed any medical licensing or specialty organization examination? ☐ Yes ☐ No

Have any chronic physical illness or defect? ☐ Yes ☐ No

Are you in the employ of any individual, firm or corporation other than your own? ☐ ☐

Are you under contract to any individual, firm or corporation other than your own? If this contract contains a hold-harmless agreement, a copy of the contract must be attached to the application. ☐ Yes ☐ No

Are you in the employment or under contract of any governmental entity? ☐ Yes ☐ No

Do you advertise your professional services in any manner (other than a simple listing in the telephone directory)? ☐ Yes ☐ No

Are you associated with any agency or organization that engages in any kind of advertising for solicitation of patients? ☐ Yes ☐ No ***If 'yes' submit copy of ALL the advertisements.***

Additional Notes Page

Please use this page for explanation to any of the questions noted on previous pages. Also please use this page for any additional information that you feel is important for Lancet to know in reference to your medical malpractice coverage. If additional space is need please supply and attach.

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 1 of this application to (present date) have been reported to my current insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

WARRANTY

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

ACKNOWLEDGED AND AGREED: _____

APPLICANT (Signature Required) _____ Date: _____

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force. Furthermore the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense. The applicant, by signing this application below confirms (his/her) understanding of all provisions represented by the Insurer.

Signature of Applicant_____Date_____

IMPORTANT – YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING

Any person who knowingly includes false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime may be subject to fines and confinement in state prison.

District of Columbia: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: 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 concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: 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.

Missouri: An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

Ohio: 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 false or deceptive statement is guilty of insurance fraud.

Consent, Warranty, Representations and Acknowledgement of Understanding

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance that may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, Its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communication, reports, records, statement, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and is not evidence of coverage.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant and that my application will be evaluated by authorized personnel. Submission of a payment or a deposit with this application and provisional receipt thereof by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment will be returned to the applicant. I further acknowledge that incomplete or incorrect information could result in retroactive premium adjustment, denial of coverage or voidance of any policy issued in reliance on such information.

Signature _____ **Date _____**

Printed _____