NIF GROUP INC.

SOCIAL SERVICE

PHYSICIANS PROFESSIONAL LIABILITY APPLICATION
☐ CLAIMS-MADE ☐ OCCURRENCE

If claims made, please include the retro date _____

DATE:

APPLICANT_____

PRODUCER_____

1. Name of Individual Practitioner: _____ Degree: ☐ MD ☐ D.O. ☐ Other:

Social Security #: _____ Date of Birth: _____ Date Practice Began: _____

2. Principal Location:

_____

3. What is your relationship to the Social Service Organization: ☐ Owner ☐ Volunteer ☐ Employee ☐ Independent Contractor ☐ Other:

4. List below all professional schools attended:

NAME	CITY	STATE	YRS. ATTENDED	DATE GRADUATED	DEGREE

5. List below the states where you are licensed:

STATE	DATE LICENSE OBTAINED	LICENSE NUMBER	
			☐ Active ☐ Inactive
			☐ Active ☐ Inactive
			☐ Active ☐ Inactive

6. If you are a foreign medical school graduate, are you certified by the Educational Commission for Medical School Graduates? ☐ Yes ☐ No

7. Was your Post Graduate Education an: ☐ Internship ☐ Residency ☐ Other (describe) _____

8. Where was your Post Graduate Education completed? Please list below:

HOSPITAL/FACILITY	CITY	STATE	# YRS. COMPLETED	COMPLETION DATE

9. List your Medical/Surgical Specialty: _____

10. Is your practice limited to this specialty? ☐ Yes ☐ No

11. For my specialty, I am: ☐ Board Eligible ☐ American Board Certified
Dates of Certification:

12. Responsibilities for the Social Service Organization, including any administration or prescription of medication:

_____

_____

13. Have you ever prescribed Fen-Phen or Fen-Phen/Redux to anyone? ☐ Yes ☐ No
If Yes, for how many patients did you prescribe it? _____
Have you been notified of any suits? ☐ Yes ☐ No
If Yes, give details:

_____

_____

14. List the name and date of any risk management seminar or program you have participated in over the last 2 years.

_____

_____

15. How many continuing education credits have you received in the past year? _____

16. What type of informed consent do you use? ☐ Oral ☐ Written ☐ None
If Oral, is chart noted, dated and initialed by patient? ☐ Yes ☐ No

17. Follow-up care and/or other instruction given to the patient are:

☐ Oral ☐ Preprinted ☐ Handwritten ☐ Hospital Form

18. Indicate the level of anesthesia you use when providing services for or on behalf of the Social Service Organization:

☐ Local or Oral ☐ IV Conscious Sedation ☐ General Anesthesia

19. Indicate the
a. Number of hours per week practiced for or on behalf of the Social Service Organization: _____
b. Number of patients treated by you at the Social Service Organization:
Weekly: _____ Annually: _____
c. Number of hours per week you practice in an Emergency Room ☐ None _____
d. Number of hours per week you engage in private practice: _____
e. Number of formal or informal consultations with other physicians in the past year:
_____ Requested by other physicians _____ Provided by other physicians

20. Do you assist in surgery on:
Your own patients? ☐ Yes ☐ No
On patients of others? ☐ Yes ☐ No

21. Check the procedures you perform on behalf of the Social Service Organization or for its patients:

☐ Arteriography	☐ Dermabrasion/Chemabrasion	☐ Hypnosis
☐ Lymphangiography	☐ Needle biopsies	☐ Radial or hexagonal keratotomy
☐ Myelography	☐ * Mohs micrographic surgery	☐ Reconstructive / Cosmetic Surgery
☐ Pneumoencephalography	☐ * Acupuncture anesthesia	☐ Hair Transplants / suturing / hairpieces
☐ Interventional radiology	☐ Varicose Vein Stripping	☐ Open or closed reduction of fractures
☐ Percutaneous transluminal angioplasty	☐ * Prenatal care and deliveries	☐ Experimental research

☐ Percutaneous transluminal embolization
☐ Radiation therapy–deep (includes radium implants)
☐ Electroshock therapy
☐ Dilation and curettage
☐ Non spontaneous, induced abortions
☐ * Other Surgery
☐ Experimental therapy in human patients
☐ Surgery other than incisions of boils & superficial abscesses or suturing skin & superficial fascia

*** Describe on separate sheet of paper**

22. Has any governmental or licensing agency ever investigated you, or suspended, revoked, placed on probation, or taken any other action against either your narcotics license or your license(s) to practice medicine? *If Yes, please give details on a separate sheet*. ☐ Yes ☐ No

23. Has any hospital or other institution reduced, revoked, restricted or suspended your privileges ? *If Yes, give details on a separate sheet.* ☐ Yes ☐ No

24. Have you ever been the subject of a mediation, peer review, investigation, disciplinary proceeding or reprimand by an administrative or governmental agency, professional association or hospital? *If Yes, please give details on a separate sheet:* ☐ Yes ☐ No

25. Do you have or have you had any physical disability or injury, personal health problems, including alcoholism, narcotics addiction or mental illness which affected your ability to practice medicine? *If Yes, please give details on a separate sheet.* ☐ Yes ☐ No

26. Have you or any of your employees ever been convicted of a crime (other than a motor vehicle citation)? *If Yes, please give details on a separate sheet.* ☐ Yes ☐ No

27. Has any medical practitioner, Medicare/Medicaid patient or insurance plan ever filed a complaint against you with any medical society or organization? *If Yes, please give complete details on a separate sheet.* ☐ Yes ☐ No

(In the State of Missouri, the following question does not apply)

28. Has any insurance carrier ever declined, canceled, rescinded or modified coverage or refused to renew your professional liability coverage? *If Yes, give details on a separate sheet.* ☐ Yes ☐ No

29. Has any claim or suit been brought against you on account of alleged malpractice, error or mistake in the past five years? *If Yes, give details for each incident on a separate sheet.* ☐ Yes ☐ No

30. Do you have knowledge of any medical incident or activity which might give rise to a claim against you that you haven't reported to your professional liability insurance company? ☐ Yes ☐ No

31. Is your current professional liability insurance policy an: ☐ Individual Policy ☐ Institution Policy

32. Does your current policy provide coverage for professional employees? ☐ Yes ☐ No

33. Please provide the name(s) of your professional liability carrier(s) and coverage date(s), retroactive date(s), limits and premium(s) for the last three years.

Insurance Company	Coverage Date	Retroactive Date	Policy Limits	Premium	Claims Made Form?
					☐ Yes
					☐ Yes
					☐ Yes

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another (NY: other) person files an application for insurance (NY: 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, (NY: 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) and subjects the person to criminal and civil penalties. In Maine and Virginia, insurance benefits may also be denied.

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any medical society, medical professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my medical practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.

Applicant's Signature

Date

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.