

**The J.P. Anthony Agency LLC  
1200 S. Church Street, Suite 1  
Mt. Laurel NJ 08054**

**APPLICATION  
PROFESSIONAL LIABILITY INSURANCE  
FOR PHYSICIANS AND SURGEONS  
(CLAIMS-MADE FORM)**

Applicant's Instructions:

1. If you have a Curriculum Vitae (C.V.), please attach to application and check here \_\_\_\_\_.
2. Please do not complete application earlier than 45 days before proposed effective date of coverage.

**(PLEASE TYPE OR PRINT IN INK)**

1. A. Name of Applicant \_\_\_\_\_ Degree \_\_\_\_\_  
B. Social Security No. \_\_\_\_\_  
C. Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
D. Are you a U.S. Citizen? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "No", please indicate your status and date of entry into USA on separate sheet and attach
2. A. Principal Office: \_\_\_\_\_  
No. Street City County State Zip  
Phone: ( ) \_\_\_\_\_  
B. Other Offices? (If any) \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_
3. A. Limits of Liability Desired: \$ \_\_\_\_\_,000. Each claim  
(Limits in policy will govern coverage) \$ \_\_\_\_\_,000. Aggregate  
B. Amount of deductible desired: \$ \_\_\_\_\_
4. Desired Effective Date (12:01 a.m.): \_\_\_\_\_
5. I practice as: \_\_\_\_\_ Solo Practitioner (unincorporated) \_\_\_\_\_ Solo Practitioner (incorporated)  
\_\_\_\_\_ Professional Association \_\_\_\_\_ Partnership  
\_\_\_\_\_ Professional Corporation \_\_\_\_\_ Employee of \_\_\_\_\_  
(give name)
6. If you practice other than as an employee OR unincorporated solo practitioner:  
A. List the names of ALL your partners, your employees, or members or your professional association or corporation who practice medicine: \_\_\_\_\_  
\_\_\_\_\_  
B. Give the formal corporate, association, partnership or business name: \_\_\_\_\_  
C. Attach a copy of your letterhead.
7. List states and license numbers where you practice \_\_\_\_\_  
\_\_\_\_\_
8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.  
1. \_\_\_\_\_ %  
2. \_\_\_\_\_ %  
3. \_\_\_\_\_ %  
B. Briefly describe type and extent of your hospital privileges: \_\_\_\_\_  
\_\_\_\_\_  
D. Are you Chief or Head of a hospital department? \_\_\_\_\_ Yes \_\_\_\_\_ No
9. Do you or the firm listed in Question 6.B. above own (wholly or in part) operate, or administer any hospital, nursing home, or other institution where medical services are customarily rendered? \_\_\_\_\_ Yes \_\_\_\_\_ No. If yes, give details, including name, location, size and number of beds.

CURRENT PRACTICE

10. A. What is your medical or surgical specialty? \_\_\_\_\_  
 B. Do you limit your practice to the above specialty? \_\_\_\_ Yes \_\_\_\_ No  
 C. Do you have a sub-specialty? \_\_\_\_ Yes \_\_\_\_ No. If yes, describe: \_\_\_\_\_

11. Do you perform one or more of the following:
- |  | YES     | NO   |
|--|---------|------|
| A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)?<br>If "yes", describe below. If you perform any minimal incision surgery, check here _____<br>_____  | A. ____ | ____ |
| B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? Describe: _____   | B. ____ | ____ |
| C. Arteriography/lymphangiography/myelography/phenmoencephalography?   | C. ____ | ____ |
| D. Interventional radiology-percutaneous transluminal angioplasty or embolization?   | D. ____ | ____ |
| E. Radiation therapy – deep (includes radium implants)?  | E. ____ | ____ |
| F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces?   | F. ____ | ____ |
| G. Mohs micrographic surgery? Describe: _____  | G. ____ | ____ |
| H. Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____<br>_____   | H. ____ | ____ |
| I. Prenatal care and normal deliveries? If "yes",<br>Do you perform home deliveries? ____ Yes ____ No<br>Do you only perform prenatal care? ____ Yes ____ No<br>Do you supervise nurse midwives? ____ Yes ____ No. If "yes", indicate when you refer: ____ weeks gestation | I. ____ | ____ |
| J. Dilation and currettage?  | J. ____ | ____ |
| K. Needle biopsies? Describe: _____  | K. ____ | ____ |
| L. Electroshock therapy or hypnosis? Describe: _____   | L. ____ | ____ |
| M. Radial keratotomy? Indicate where performed: ____ Hospital ____ Office<br>____ Surgicenter  | M. ____ | ____ |
| N. Hexagonal keratotomy? Indicate where performed: ____ Hospital ____ Office<br>____ Surgicenter   | N. ____ | ____ |

12. Do you perform any one or more of the following:
- |  |         |      |
|--|---------|------|
| A. Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia?   | A. ____ | ____ |
| B. Non-spontaneous, induced abortions?<br>____ 1 <sup>st</sup> trimester (Not exceeding 14 weeks gestation)<br>____ 2 <sup>nd</sup> trimester (indicate where performed: ____ Hospital ____ Office<br>____ Surgicenter | B. ____ | ____ |
| C. Sterilization procedures? Describe: _____   | C. ____ | ____ |
| D. Cosmetic plastic surgery, cosmetic body contouring (Suction lipectomy), Implantations, injections and/or blepharopigmentation? Describe: _____<br>_____   | D. ____ | ____ |
| E. Spinal surgery. If you also perform chemonucleolysis, check here ____<br>and/or percutaneous lumbar discectomy, check here ____   | E. ____ | ____ |
|  | YES     | NO   |
| F. Open reduction of fractures? Describe: _____  | F. ____ | ____ |

- G. Administration of general, spinal or caudal block anesthesia? G. \_\_\_\_\_
- H. Hysterectomies? Do you perform laparoscopic hysterectomies? H. \_\_\_\_\_
- I. Cholecystectomies? Do you perform laparoscopic cholecystectomies?  
Indicate number of laparoscopic cholecystectomies performed to date \_\_\_\_\_ I. \_\_\_\_\_
- J. Tonsillectomies and/or Adenoidectomies? J. \_\_\_\_\_
- K. Caesarian sections? K. \_\_\_\_\_
- L. Organ transplantations? Describe: \_\_\_\_\_ L. \_\_\_\_\_
- M. Weight reduction surgery? M. \_\_\_\_\_
- N. Sex change operation? Describe: \_\_\_\_\_ N. \_\_\_\_\_
- O. Experimental research or surgical research or experimental therapy in  
human patients? Describe: \_\_\_\_\_ O. \_\_\_\_\_
- P. Other surgery? Describe: \_\_\_\_\_ P. \_\_\_\_\_
13. A. Do you perform surgery in your office? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", list  
surgical procedures: \_\_\_\_\_
- B. Do you perform surgery in other non-hospital facilities? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", list facilities and surgical  
procedures: \_\_\_\_\_
- C. In course of surgery (described in A or B above) is general anesthesia administered? By you? \_\_\_\_\_ Yes  
\_\_\_\_\_ No, By others? \_\_\_\_\_ Yes \_\_\_\_\_ No
14. A. Indicate number of hours per month devoted to hospital emergency room care: \_\_\_\_\_ hours per month
- B. Is this emergency room care: 1. On you own patients only? \_\_\_\_\_ Yes \_\_\_\_\_ No  
2. Required for staff privileges \_\_\_\_\_ Yes \_\_\_\_\_ No  
3. Other \_\_\_\_\_ Yes \_\_\_\_\_ No
15. Do you assist in surgery: On your own patients? \_\_\_\_\_ Yes \_\_\_\_\_ No. Patients of others? \_\_\_\_\_ Yes \_\_\_\_\_ No
16. If your practice includes plastic surgery, specify percent of practice devoted to traumatic surgery \_\_\_\_\_%;  
cosmetic surgery \_\_\_\_\_%
17. Do you practice weight reduction or control (other than by diet-exercise)? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes",  
percent of patients exclusively weight control \_\_\_\_\_% Do you dispense (as opposed to prescribe) any  
weight control drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", list drugs dispensed \_\_\_\_\_
- Do you use injections for weight control? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", list drugs injected: \_\_\_\_\_
18. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered  
to the public? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", please attach detailed explanation of this activity.
19. A. List number and type of professional employees: IF NONE, STATE NONE.  
\_\_\_\_\_ Physicians (other than yourself) \_\_\_\_\_ Surgeon's Assistants\*  
\_\_\_\_\_ Nurse Practitioners\*/Physician's Assistants\*  
\_\_\_\_\_ Nurse Anesthetists \_\_\_\_\_ Other (describe) \_\_\_\_\_
- \* Describe duties in detail, including extent supervised, on separate sheet
- B. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  
\_\_\_\_\_ Yes \_\_\_\_\_ No. If "no", attach explanation.
20. Have you or any of the above employees: (Attach detailed explanation for any "yes" answers)
- A. Ever been the subject of investigative or disciplinary proceedings  
or reprimanded by a governmental or administrative agency, hospital or  
professional association? (Attach copy of Complaint and Consent Order documents, if applicable.)
- YES NO  
A. \_\_\_\_\_ \_\_\_\_\_

- B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? B. \_\_\_\_\_
- C. 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 you be evaluated for an alleged mental condition and/or alcohol or drug addiction? C. \_\_\_\_\_
- D. 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? D. \_\_\_\_\_
- E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? E. \_\_\_\_\_
- F. Ever failed any medical licensing or specialty organization examination? F. \_\_\_\_\_
- G. Do you have any chronic physician illness or defect? G. \_\_\_\_\_
21. Do you supervise any individuals other than your own employees? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", provide 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 | _____  | _____              |
22. Are you in the employ of any individual, firm or corporation other than your own? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", attach explanation, including details of any responsibilities.
23. Are you under contract to any individual, firm or corporation other than your own? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement copy of contract must be attached to application.
24. Are you in the employ of or under contract to any government entity? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", attach explanation, including details of your responsibilities.
25. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? \_\_\_\_\_ Yes \_\_\_\_\_ No. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", submit copy of ALL the advertisements.
26. A. From what medical school did you graduate? \_\_\_\_\_  
Degree: \_\_\_\_\_ Year: \_\_\_\_\_  
Location of medical school \_\_\_\_\_  
(City) (State) (Country)
- B. If foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", state year and describe: \_\_\_\_\_
- C. Residency? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", complete the following for each residency served:  
Location \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Type \_\_\_\_\_  
Completed? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Location \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Type \_\_\_\_\_  
Completed? \_\_\_\_\_ Yes \_\_\_\_\_ No
- D. Additional Medical Training? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", complete the following:  
Location \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Type \_\_\_\_\_
27. Are you American Board certified? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Medical Specialty \_\_\_\_\_ Date Certified \_\_\_/\_\_\_/\_\_\_ Recertified \_\_\_/\_\_\_/\_\_\_
28. Where have you practiced your profession since completion of training:  
In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
In \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

29. Indicate membership in professional societies: \_\_\_\_\_  
\_\_\_\_\_

30. Have you participated in any continuing medical educational program within the past five years?  
\_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", describe separately.

31. Do you or the firm named in Question 6.B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", attach detailed explanation.

32. A. Has any claim or suit for alleged malpractice been brought against the applicant? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes" how many \_\_\_\_\_? Please complete the *Claim Supplement* and provide currently valued company loss runs for the past 7 years.

B. Has any claim or suit for alleged malpractice been made against the applicant that has NOT been reported to a prior Insurer? \_\_\_\_\_ Yes \_\_\_\_\_ No. . If "yes" how many \_\_\_\_\_? Please complete the *Claim Supplement* and provide currently valued company loss runs for the past 7 years.

C. Is the applicant aware of any acts, errors, omissions or circumstances which may result in a malpractice claim, or suit being made or brought against the applicant? \_\_\_\_\_ Yes \_\_\_\_\_ No. . If "yes" how many \_\_\_\_\_? Please complete the *Claim Supplement* and provide currently valued company loss runs for the past 7 years.

33. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hr. walk-in clinic or birthing center? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", state location and describe \_\_\_\_\_  
\_\_\_\_\_

34. A. Average patient load: \_\_\_\_\_ Patients Weekly \_\_\_\_\_ Total Patients Annually

B. Average number of hours practice time: \_\_\_\_\_ Hours weekly

35. Do you anticipate changes in your practice in the next 12 months? \_\_\_\_\_ Yes \_\_\_\_\_ No. If "yes", explain \_\_\_\_\_  
\_\_\_\_\_

36. Approximate gross annual income from the practice (check one):  
\_\_\_\_\_ Less than \$50,000. \_\_\_\_\_ \$100,000 - \$149,999 \_\_\_\_\_ \$200,000 or more (please estimate)  
\_\_\_\_\_ \$50,000 - \$99,999 \_\_\_\_\_ \$150,000 - 199,999

37. List prior professional liability insurance carried to each of the past five years. If NONE, check here \_\_\_\_\_.

INSURANCE COMPANY	LIMITS OF LIABILITY	PREMIUM	INCEPTION MO/DAY/YR	EXPIRATION MO/DAY/YR	RETROACTIVE MO/DAY/YR	WAS THIS A CLAIMS MADE POLICY FORM?
						<u>YES</u> <u>NO</u>
1. _____						_____
2. _____						_____
3. _____						_____

ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

**Representations**

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

\_\_\_\_\_  
Date Signature of Applicant Title