



APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

**CLAIMS-MADE
PROFESSIONAL LIABILITY
INSURANCE APPLICATION**

For Physicians & Surgeons





APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

APPLICATION INSTRUCTIONS & CHECKLIST

We would like to thank you for taking the time to apply to Applied Medico-Legal Solutions Risk Retention Group, Inc. (AMS RRG). You are joining physicians across the country that have helped AMS RRG grow into one of the most successful medical liability insurance risk retention groups. Below, is a checklist which will help you in completing our application.

- All questions must be answered. Write in, "I do not know," if necessary.
- The Supplemental Information Worksheet is available to provide any additional information requested or to better explain you're answers.
- A "Loss Run" from your current and prior carriers covering the last 15 years. Please complete a separate claim worksheet for each reported claim as thoroughly as possible providing brief narrative description of each claim.
- A "No Known Loss" Letter, attached to this application.
- Please enclose a copy of the following with your application:
 - Current Declarations for Professional Liability Insurance
 - Curriculum Vitae
 - Medical and DEA Licenses
 - Purchased Extended Reporting Endorsements
 - Practice letterhead for each location you practice
 - Advertising material you have been using

INSURANCE NOTICE

Insurance coverage is subject to underwriting approval and payment of the initial premium. 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. This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services, and B) are first made against you and are reported to the company while the policy is in force.



APPLIED MEDICO-LEGAL SOLUTIONS

RISK RETENTION GROUP, INC.

GENERAL INFORMATION

First Name	Middle Name	Last Name	Suffix (Jr./Sr.)	Title (MD/DO)
Social Security Number		Date of Birth	Female	Male
- -		/ /	<input type="checkbox"/>	<input type="checkbox"/>
Current Policy Expires		Requested Effective Date	Joining Group insured with AMS RRG	
/ /		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Requested Retroactive Date (What date do you need coverage back to?)			/ /	
Please indicate your Primary Specialty of Practice:				
Please indicate the Counties where you practice:			1)	
Please use the Supplemental Information Worksheet to list more locations.			2)	
			3)	
Please enter the formal name of your Partnership, Corporation or Employer:				

Office Phone Number	Cell Phone Number	Home Phone Number
() -	() -	() -
Fax Number	Practice Web Site Address	E-Mail Address
() -		

PRIMARY PRACTICE STREET ADDRESS			Bldg./Suite
County	City	State	Zip Code
Number of years at current location:		Percentage of your practice at this location:	

Use the Supplemental Information Worksheet to list additional locations where you render professional services. Copies of letterhead for these locations will suffice.



BOARD CERTIFICATION

Are you currently Board Certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please describe your Board Certification Status Below – Use the Supplemental Information Worksheet if needed				
Name of Board	Status Cert. Elig.	Date Certified	Dates Expires	Date Eligibility Expires
		/ /	/ /	/ /
		/ /	/ /	/ /
		/ /	/ /	/ /

If you are NOT Board Certified, please answer the following questions:	
I am awaiting results of my most recent exam:	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have taken Part 1 of the exam and have qualified to take part 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am planning to take the Boards on the following date:	/ /
I am not planning on taking any further Board Examinations:	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRACTICE INFORMATION

Are you entering practice for the first time since completing an internship, residency or fellowship program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you practiced continuously for the past ten (10) years? If NO, please explain in the Supplemental Information Worksheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your specialty, procedures, location(s), etc., changed in the past ten years? If YES, please explain noting dates of changes in the Supplemental Information Worksheet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you perform any work, either full-time or part-time, for any state government or the federal government? If YES, please explain in the Supplemental Information Worksheet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on active duty in the U.S. Military Service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate the average number of hours you work per week (include office hours, administrative activities for your practice as well as any hospitals, procedures, direct patient care, consultations, etc.)	
<input type="checkbox"/> 10 hours or less per week <input type="checkbox"/> 11 to 20 hours per week <input type="checkbox"/> 21 to 30 hours per week <input type="checkbox"/> 31 hours or more per week	
Please indicate the practice hours to be insured by AMS RRG:	
If part-time, when did you begin practicing on a part-time basis?	
Estimate the number of patients you see on an average day of clinical practice:	



EDUCATION

Medical School Attended	Location	Degree	Date Graduated
			/ /
Name of Internship Program	Location	Specialty	Dates Attended
Was Program successfully completed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Residency Program	Location	Specialty	Dates Attended
Was Program successfully completed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Fellowship Program	Location	Specialty	Dates Attended
Was Program successfully completed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain any additional years spent in any training programs:			

Please explain any gaps in training from medical school to completion of your training:

If you are a graduate of a non-U.S. medical school, are you certified by the Educational Council for Foreign Medical School Graduates?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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Please specify states where you are or have been licensed.					
State	Year	License #	Permanent	Temporary	Status

→ If any of your licenses are or have been inactive, suspended, restricted or revoked, please explain on the Supplemental Information Worksheet.

PRIOR PRACTICE EXPERIENCE

Please list all of your practice locations for the past ten (10) years other than your current practice. Please explain any gaps in your practice of medicine on the Supplemental Information Worksheet.

Practice Name	County	State	Start-End Dates

TEACHING/MEDICAL DIRECTORSHIPS

Do you have any teaching and/or medical director responsibilities for any insurance or health care related organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you hold any positions outside of your principal medical or surgical practice (e.g., moonlighting in an E.R. or part-time at a clinic or nursing home)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered YES to either question above, please complete the following:	
Name of Facility:	
County/State:	
Title/Position:	
Do you receive medical malpractice coverage from the any of the above entities for either:	
a. Administrative activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Direct patient care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What percentage of your time is devoted to teaching?	%

STAFF PRIVILEGES

List all facilities, including non-hospital facilities, where you have staff privileges, listing the principal location first. Please use the Supplemental Information Worksheet if necessary.				
Facility	County	State	Department	% of Practice



INSURANCE HISTORY

Please detail your insurance carriers for the previous fifteen years. Please explain any gaps in your coverage on the Supplemental Information Worksheet.

Dates Mo/Yr		Insurance Carrier	Policy #	Type of Policy	Retroactive Date	
From	To					
/	/					
/	/					
/	/					
/	/					
/	/					
/	/					

Have you ever practiced without insurance or allowed a clams-made policy to lapse without the purchase of tail or nose coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had professional liability insurance refused, declined, non-renewed, cancelled, or accepted on special terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
→ If you answered YES to any of the above three questions, please provide a detailed explanation on the Supplemental Information Worksheet.	

Please indicate the Limits of Liability you are requesting listed as per claim/yearly aggregate:	
<input type="checkbox"/> \$100,000 /\$300,000	<input type="checkbox"/> \$1,000,000/\$3,000,000
<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$1,300,000/\$3,900,000 (NY Only)
<input type="checkbox"/> \$250,000/\$750,000	<input type="checkbox"/> \$2,000,000/\$6,000,000 (VA Only)
<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> Other →

Indicate the Limits of Liability you are currently carrying. (If you are requesting different limits of liability than what you are currently carrying, please provide explanation on the Supplemental Information Worksheet).	/
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Please indicate if you are requesting a per claim Deductible for your policy (Please check one)	
<input type="checkbox"/> None	<input type="checkbox"/> \$50,000
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$100,000
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$150,000
<input type="checkbox"/> \$25,000	<input type="checkbox"/> Other →

**Please note that for any deductible requested in an amount greater than \$25,000, a Letter of Credit may be required.*



PRIOR ACTS COVERAGE (RETROACTIVE COVERAGE)

A claims-made policy covers claims resulting from medical professional services provided or withheld on or after the retroactive date shown on the policy and first reported while the policy is in force. If your current policy or any previous policies are claims-made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage) from that carrier, there will be NO COVERAGE for any claim arising from any act or omission that took place during that period of claims-made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims-made policy. Retroactive coverage insures claims made against you for incidents that took place while your previous claims-made insurance was in effect, but that were not brought to your attention until after the effective date of the AMS RRG policy.

Retroactive coverage does NOT cover claims filed against you and/or reported to the previous insurers prior to the effective date of the policy with AMS RRG. Any claims and all conduct, circumstances, or incidents that could reasonably be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

I have read and understand the above statement.

_____ / ____ / _____
 SIGNATURE DATE (MM/DD/YY)

Will you purchase an extended reporting endorsement (tail coverage) from your current carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, do you wish to purchase retroactive coverage from AMS RRG?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Desired retroactive date: _____ / ____ / _____

Please indicate the reason for termination of your latest policy.

Please note that retroactive coverage is not granted automatically. It is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.



PRACTICE/CORPORATE STRUCTURE

Indicate all practice situations that apply to you:			
<input type="checkbox"/>	"Solo" Physician (unincorporated)	<input type="checkbox"/>	Locum Tenens
<input type="checkbox"/>	"Solo" Professional Corporation (PC)	<input type="checkbox"/>	I employ other physicians (If not insured with AMS RRG, please submit proof of current coverage)
<input type="checkbox"/>	Stockholder of a PC with more than 1 physician		
<input type="checkbox"/>	Employed by another physician/corporation already insured by AMS RRG	<input type="checkbox"/>	Employed by another physician/corporation insured by a different Medical Malpractice Insurer

If applicable, please indicate the names of all the above professional entities including retroactive dates	
Entity Name	Retroactive Date

Date of Incorporation	/ /	<input type="checkbox"/> N/A
Corporate Tax Identification Number		<input type="checkbox"/> N/A
Do you have office or expense sharing arrangements with any other physician(s) or practice group(s) not disclosed?		<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wish corporation coverage for any of the above listed entities? If YES, do you wish to share your individual limits with this business entity, or do you desire separate limits of liability for the business entity?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Shared <input type="checkbox"/> Separate

If you are requesting separate corporate limits, please check which limit per claim/yearly aggregate:	
<input type="checkbox"/> \$100,000 /\$300,000	<input type="checkbox"/> \$1,000,000/\$3,000,000
<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$1,300,000/\$3,900,000 (NY Only)
<input type="checkbox"/> \$250,000/\$750,000	<input type="checkbox"/> \$2,000,000/\$6,000,000 (VA Only)
<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> N/A

List all physicians practicing in the Professional Entities noted above:		
Physician Name	Now Insured with AMS RRG	If Not Insured with AMS RRG, list current carrier
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate the total number of physicians listed here and on the Supplemental Information Worksheet		



PRACTICE/CORPORATE STRUCTURE

Do you require vicarious liability coverage under a separate corporate policy for former employees?			
Physician Name	Vicarious coverage	Employment Start Date	Employment Stop Date
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate the total number of physicians listed here and on the Supplemental Information Worksheet			

SPECIALTY CLASSIFICATION SECTION

Please indicate the percentage of your time devoted to the following specialties (must total 100%). As an example, a Family Practitioner who has an Obstetrics practice should indicate the percentage of each:			
	Administration Medicine		Allergy
	Bariatric Surgery		Colon & Rectal Surgery
	Cardiology		Cardiology w/Catheterization
	Endocrinology		Cardiology w/Angioplasty
	Family Practice		General Medicine
	Gastroenterology		General Surgery
	Gynecology – No Surgery		Gynecology-Minor Surgery
	Hand Surgery		Hematology
	Hospitalist		Infectious Disease
	Internal Medicine		Neonatology
	Neurology		Obstetrics & Gynecology
	Orthopedic Sx. – No Spine		Orthopedic Sx – with Spine
	Otolaryngology – Major Sx.		Otolaryngology w/Cosmetic
	Pathology		Pediatric Surgery
	Physiatrist/Rehab Medicine		Plastic Surgery
	Psychiatry		Public Health
	Radiation Therapy		Radiology – Diagnostic
	Radiology Neuro-intervention		Rheumatology
	Trauma Surgery		Urology
	Pain Management-incl implants		Other – Please Describe →
			Anesthesiology-Inpatient
			Anesthesiology-Outpatient
			Dermatology
			Emergency Medicine
			Preventive Medicine
			Geriatrics
			Gynecology-Major Surgery
			Oncology
			Intensive Care Medicine
			Nephrology
			Occupational Medicine
			Otolaryngology – Minor Sx.
			Fertility Medicine
			Pediatric Medicine—under age 17
			Podiatry
			Pulmonary Medicine
			Radiology – Mammography
			Thoracic Surgery
			Vascular Surgery

Please indicate the percentage of your practice devoted to the following activities (must total 100%):			
	Hospital Rounds		Home visits
	Office Rounds		Hospital Surgery / Surgicenter
	Nursing Home Patients		Moonlighting
	Other -----		Please describe -----
			In office Surgery
			Freestanding Surgery Center
			Emergency Room Work

Please note that physicians should indicate above the percentage of time they spend treating children under the age of 17 (Pediatrics) and the time they spend treating neonates (Neonatology) by filling in the appropriate box above.

SPECIALTY CLASSIFICATION SECTION

Please indicate which one of the following best describes your practice:	
<input type="checkbox"/>	No Surgery – Includes incision of boils and superficial abscesses, or suturing of skin or superficial fascia
<input type="checkbox"/>	Minor Surgery – Any operation that involves a surgical incision into the dermis, epidermis and superficial fascia or suturing of skin or superficial fascia and does not enter below the superficial fascia or any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis.
<input type="checkbox"/>	Major Surgery – Includes any operation done under general anesthesia, or any operation that presents a distinct hazard to life such as removal of tumors, reduction of open fractures, amputations, abortions, tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, abortions, vasectomies, the removal of any gland or organ, plastic surgery. This includes assisting in surgery.

Cosmetic Procedures – Please Check All That Apply					
<input type="checkbox"/>	Abdominoplasty	<input type="checkbox"/>	Blepharoplasty	<input type="checkbox"/>	Coronal Lift
<input type="checkbox"/>	Hair Implants	<input type="checkbox"/>	Penile Cosmetic Surgery	<input type="checkbox"/>	Sex Reassignment Surgery
<input type="checkbox"/>	Autologous Fat Injection	<input type="checkbox"/>	Breast Augmentation	<input type="checkbox"/>	Breast Reduction
<input type="checkbox"/>	Endoscopic Forehead Lift	<input type="checkbox"/>	Implants other than Breast	<input type="checkbox"/>	Rhinoplasty (cosmetic)
<input type="checkbox"/>	Thread Lift	<input type="checkbox"/>	Breast Reduction	<input type="checkbox"/>	Facial Laser Resurfacing
<input type="checkbox"/>	“Lifestyle” Lift	<input type="checkbox"/>	Rhytidectomy	<input type="checkbox"/>	Other (Describe below)
<input type="checkbox"/>	Large Volume Liposuction (over 5,000 cc) in a Hospital				
<input type="checkbox"/>	Large Volume Liposuction (over 5,000 cc) in a Freestanding Surgery Center or Surgical Suite				
<i>Please use the Supplemental Information Worksheet to provide any further details regarding these procedures</i>					

Please indicate if you or any of your staff perform the following procedures:			
Procedure	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Peel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collagen Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Tattooing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Wrinkle Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Micro-Dermabrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent Make-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sclerotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIALTY CLASSIFICATION SECTION

OPHTHALMOLOGY – Please indicate which of the following you perform	
Medical Procedures Only	<input type="checkbox"/>
Minor Surgical Procedures including :	<input type="checkbox"/>
Assisting in Surgery, Laser Iridotomy, Laser Ablation of Corneal Lesion	
Suture Tarsorrhaphy, Thermage, Laser Capsulotomy, Laser Iridoplasty	
Wedge resection of noncancerous lesion	
Laser Capsulotomy or Iridoplasty	
Lasik – Indicate # of Procedure/month	_____
Major Surgery/All procedures	<input type="checkbox"/>

CARDIOLOGY – Please indicate which of the following you perform	
Non-invasive Cardiology – includes echocardiography, stress testing, TEE	<input type="checkbox"/>
Nuclear Medicine	<input type="checkbox"/>
Cardiac Catheterization: Non-interventional	<input type="checkbox"/>
Cardiac Catheterization: Interventional – including angioplasty, stent placement etc.	<input type="checkbox"/>
Electrophysiology – including placement of AICD	<input type="checkbox"/>

OBSTETRICS/GYNECOLOGY AND ENDOCRINOLOGY – Please indicate which of the following you perform	
Number of deliveries per year – vaginal	_____
Number of deliveries per year – C-section	_____
Percentage of deliveries with Neonatologist present	_____
Number of termination of pregnancies performed per year	_____
Number of Vitro Fertilization procedures per year	_____

ORTHOPEDIC SURGERY – Please indicate which of the following you perform	
No spinal surgery	<input type="checkbox"/>
Limited Spinal Surgery – Lumbar Spine only	<input type="checkbox"/>
Full Spinal Surgery including the C-Spine	<input type="checkbox"/>

GENERAL SURGERY – Please indicate which of the following you perform	
Gastric Bypass Surgery – If yes, please enter the approximate number per year	<input type="checkbox"/> _____
Gastric Banding Procedures – If yes, please enter the approximate number per year	<input type="checkbox"/> _____
Vascular Surgery – Standard procedures	<input type="checkbox"/>
Vascular Surgery – Including Carotid Artery Stents	<input type="checkbox"/>

SPECIALTY CLASSIFICATION SECTION

PATHOLOGY – Please indicate which of the following you need coverage for	
Interpretation of Pap Examinations	<input type="checkbox"/>
I will sign final reports for my colleagues without reviewing the slides	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRIMARY CARE – Please indicate which of the following you perform	
Treatment of children under the age of 17	<input type="checkbox"/>
Treatment of infants and/or neonates	<input type="checkbox"/>
Assist in Surgery performed in an operating room or Surgery Center – use Supplemental Information Worksheet to describe	<input type="checkbox"/>
Perform Surgery in an operating room or Surgery Center – use Supplemental Information Worksheet to describe	<input type="checkbox"/>
I interpret the x-rays performed in my office, without a Radiologist over read	<input type="checkbox"/>
Sigmoidoscopy – other than Gastroenterologists or General Surgeons	<input type="checkbox"/>
Colonoscopy – other than Gastroenterologists or General Surgeons	<input type="checkbox"/>

OTOLARYNGOLOGY – Please indicate which of the following you perform	
Office procedures only	<input type="checkbox"/>
Acoustic tumor surgery	<input type="checkbox"/>
Radical Neck Surgery – if yes, please indicate approximate number per year - _____	<input type="checkbox"/>

CONCIERGE MEDICINE – Please answer the applicable questions below	
Do you have a concierge medicine practice? – If yes, please answer the following questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many years have you had a concierge medicine practice?	_____ Yrs
What percentage of your practice does this represent?	_____ %
How many patients do you have at present and how many will you accept at a maximum?	_____ / _____

Please answer the following questions	
Are you credentialed to provide Conscious sedation? Moderate Sedation Deep Sedation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you certified in ACLS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you certified in ATLS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you certified in PALS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you perform any procedures, techniques, or treatment modalities that are not typical of your specialty or that required separate hospital credentialing? If yes, please describe these procedures below.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you solicit or advertise to weight control patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you prescribe medications for weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? Describe below.	<input type="checkbox"/> Yes <input type="checkbox"/> No



ADDITIONAL HEALTHCARE PROVIDERS

Healthcare Provider	Number Employed	Coverage Needed	# Independent Contractor	Coverage
Physician Assistant		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgical Assistant		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesia Assistant		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Certified Nurse Midwife		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Certified Nurse Practitioner		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Certified Registered Nurse Anesthetist		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Healthcare Provider Name	Designation/ Type	Employed	Contracted	Supervise only	Limits Shared (S) Separate (P) Other Insurer (O)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> S <input type="checkbox"/> P <input type="checkbox"/> O

If you supervise Certified Nurse Practitioners, Nurse Midwives, or Physicians Assistants, what is the average Paramedical Employee/Physician Ratio?	_____ %
Does any of the Paramedical Employees (excluding physicians) practice at a location geographically separate from yours? If YES, describe below.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Use this space to provide further details necessary for your Midlevel Providers



UNDERWRITING & ELIGIBILITY SECTION

Please answer the following questions. Have you EVER :	
Had or become aware of any chronic illness or physical defect that impairs or could possibly impair your ability to practice any aspect of medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, non-renew or revoke your clinical privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been treated, evaluated, or hospitalized for any of the following disorders? (Please check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Alcohol <input type="checkbox"/> Narcotics <input type="checkbox"/> Central nervous systems stimulants or depressants <input type="checkbox"/> Mental or emotional disorders 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been indicted and/or convicted of a crime other than minor traffic violations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been under investigation by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended or limited in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had Medicare/Medicaid fraud charges filed against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been suspended, restricted, or put on probation by any governmental health program (e.g. Medicare or Medicaid)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

→ If you answered **YES** to any of the above questions, please provide full details on the Supplemental Information Worksheet. In addition, if you answered any question related to your personal health with a **YES**, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

KNOWN CLAIMS AND MEDICAL INCIDENTS

Have you EVER been involved in a malpractice claim or suit with an incident date, report date or close date occurring within the last fifteen (15) years or are you presently involved in malpractice litigation? – Please submit a separate incident/claim information worksheet for each of these events.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?	INITIAL BELOW	
A. A request for records from a patient and/or attorney related to an adverse outcome?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
B. A letter from a patient and/or attorney regarding your medical treatment of a patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
C. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
D. Has your hospital filed any governmental reports regarding a complication related to your treatment of a patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Are you aware of a patient's dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Have all circumstances that might reasonably lead to an incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None to Report	_____
→ If you answered YES to any of the above questions, please provide all of the specifics for each case on a separate Prior Claims Information Worksheet.		

Included with your application materials is a separate No Known Loss Letter. If you have not received one, please contact AMS RRG.

I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier.	
_____ SIGNATURE	____/____/____ DATE (MM/DD/YY)



PRIOR CLAIMS INFORMATION WORKSHEET

Please copy this page as necessary to summarize all medical malpractice claims that you have experienced in your complete practice history. This includes all patients requesting payment to avoid a lawsuit, all notices of intent to sue that did not lead to a lawsuit and information on all lawsuits filed whether or not a payment was made.

Name of Patient:						
Name of Insurance Carrier:						
Nature of the Claim: (check all that apply)	<input type="checkbox"/>	Incident	<input type="checkbox"/>	Claim Letter	<input type="checkbox"/>	Notice of Intent to Sue
	<input type="checkbox"/>	Lawsuit	<input type="checkbox"/>	State Board Investigation		

Date of Medical Incident:	/ /	Date Reported to your insurer	/ /
Current Status:	<input type="checkbox"/> Open	<input type="checkbox"/> Closed → note date	→ / /
For Closed Claims			
Amount Paid On Your Behalf:	\$	Amount Paid for all Defendants	\$
For Open Claims			
Expense Reserves	\$	Indemnity Reserves	\$

Please provide a detailed account of the events surrounding this claim. This will help us better understand the nature of the claim. In addition, this information will be used to help our physicians reduce their risk of future claims. Please use the Supplemental Information Worksheet as necessary. Again, Please be detailed in your description.

Note: You may be requested to provide additional information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.



ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign to my employer, _____, both the right to cancel my policy and the return of any unearned premium due to policy changes (e.g. termination of coverage, limit decrease, etc.) for which my employer has paid the premium. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

→ Initial Here []

AUTHORIZATION TO RELEASE SHARES OF STOCK

I hereby authorize the release of all shares of stock to my employer, _____, for which my employer has paid the capital contribution. (Professional Entity/Payor must also be approved for and accept coverage through AMS RRG).

→ Initial Here []

MANDATORY PIPAC MEMBERSHIP

I hereby confirm that I am a member in good standing of Preferred Integrated Provider Access Corporation ("PIPAC") or that I will be a member in good standing of PIPAC upon the effective date of the insurance policy I am applying for. I understand that I must be a member of PIPAC at all times during the period of coverage under the policy I am applying for. I further understand that if my membership in PIPAC terminates for any reason during the period of coverage, such termination will constitute a material breach by me of an agreement between me and AMS RRG and AMS RRG will cancel my policy in accordance with the cancellation provisions of the policy.

→ Initial Here []

PHYSICIAN CERTIFICATION

Incomplete or incorrect information could result in a retroactive upward premium adjustment or could lead to a denial of liability in the event of a claim. I also understand that any material misrepresentation or omission made by me on this application may render any contract of insurance null and without effect or provide the company with the right to rescind it.

I hereby declare that the statements and responses I have provided in this application are complete and true and that I have not knowingly suppressed or misstated any material facts. I agree to immediately notify the company in writing if there is any future material change in any answer to this application, including without limitation, any change in my professional status, specialty, affiliation, or working arrangement with any other physician, firm, or professional association, and I understand and agree that such changes are material to the risks covered by the policy of insurance I am applying for.

By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued. I understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) offered me a premium quote, and (3) received, as a precondition to coverage, the total premium due or, if the company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

GENERAL FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

ARKANSAS FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment for 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.

COLORADO FRAUD WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA FRAUD 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 FRAUD NOTICE WARNING: 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 in the third degree.

KENTUCKY FRAUD WARNING: 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 FRAUD WARNING: 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.

MARYLAND FRAUD WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK FRAUD WARNING: 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 violation.

NEW MEXICO FRAUD WARNING: 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 civil fines and criminal penalties.

OHIO FRAUD WARNING: 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 a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

VIRGINIA FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**By your signature, you indicate to all the rules and regulations set by
Applied Medico-Legal Solutions Risk Retention Group, Inc.**

Print Applicant Name:	
Applicant Signature:	
Date:	/ /



AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance with Applied Medico-Legal Solutions Risk Retention Group, Inc. (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Company may have a bearing upon the undersigned's acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for any state in which he has practiced, or resided, and any and all physicians or any other third party having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon the undersigned's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or entities releasing the information described above, their agents, servants and employees, and the Company and any of its present or former directors, officers, employees, agents and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

The undersigned hereby acknowledges that the persons and entities releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or entities releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and entities described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Print Applicant Name:	
Applicant Signature:	
Date:	/ /



Please remit your completed application to:

**Applied Medico-Legal Solutions Risk Retention Group, Inc.
157 Summers Street, Suite 305
Charleston, West Virginia 25301**

**Toll-free 888-206-6983
Fax: 304-556-4870**

