MEDICAL PROFESSIONAL LIABILITY INSURANCE RENEWAL APPLICATION

Please fill out the application in its entirety and Fax to: (616) 741-1980

APPLICANT INFORMATION		
Applicant's name: (First, Middle Initial, Last Name)		☐ MD ☐ DO
Social Security Number:	Date of Birth (MM/DD/YYYY):	☐ Male ☐ Female
Home address:		
Cellular Number: ( )	Pager: ( )	Email:
Hospital/Office Name where you will be working (if applicable please include DBA name):		
Principal office address:		County:
Office telephone: ( )	Office fax: ( )	
Practice Manager/Primary Contact Name:		
Telephone: ( )	Email:	
Secondary office address, if any:		
Billing and/or Mailing address (if different than Principal Office Address):		

COVERAGE INFORMATION

Type of coverage required:

- ☐ Claims-made: Covers incidents that take place and are reported during the policy period, which begins with the retroactive date. *(Claims-made coverage is only available to physicians currently insured under a claims-made policy)*
  If claims-made coverage is selected, give date when you began your claims-made coverage: _____ (retro date).
  (*Without prior acts coverage, retro date is your requested effective date*)
- ☐ Modified Claims Made: Claims Made policy with tail premium included.
- ☐ Occurrence-basis: Covers incidents that take place during the policy period regardless of when reported as a claim.
- ☐ Moonlighting Only
- ☐ Locum Tenans (substitute)

If your current insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer?

☐ Yes ☐ No ☐ N/a
If Yes, attach a copy of the reporting endorsement.
If No, please explain_____

Requested effective date of insurance:

Limits of liability requested (Occurrence/Aggregate):

☐ $200,000/800,000	☐$300,000/1.2M	☐ $400,000/1.6M
☐ $500,000/2M	☐$1M/4M	☐ $2M/4M

Please check the appropriate box(es) and state the complete name of any medical professional corporation to which you belong.

Name: _____ Tax ID#: _____

☐ Partnership ☐ Association ☐ Corporation ☐ Wholly Owned Corporation or

☐ Joint Venture by which you are employed or to which you belong, if any:

Do you request that the Company's Partnership or Professional Corporation listed above to be endorsed to your policy as an additional insured? ☐ Yes ☐ No

Please Note: No charge is made for this coverage if all individual physicians who are practicing in the partnership or professional corporation are continuously insured by MPIE. If this endorsement is used, the partnership or professional corporation will be insured in accordance with the policy, declarations, and endorsement, only for its liability for your acts or omissions as an individual physician.

Do you request for an additional 9% of your total premium to purchase an endorsement that will provide coverage for Advanced Practice Provider, which we classify as Physician Assistant, Nurse Practitioner, Certified Nurse Midwife & Certified Registered Nurse Anesthetist. ☐ Yes ☐ No

PROFESSIONAL LIABILITY HISTORY

PLEASE NOTE:

If you answered yes to any of the questions below, please provide complete details regarding the event including documentation of recovery/reinstatement actions and resolution on a separate sheet.

Have you ever had your membership in any professional society or association refused, suspended, revoked or ever received any criticism or reprimand from any professional society?	☐ Yes ☐ No
Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended or revoked?	☐ Yes ☐ No
Has any hospital ever restricted, reduced or suspended your privileges or invoked probation?	☐ Yes ☐ No
Have you ever been subject to a state licensing investigation?	☐ Yes ☐ No

Have you ever been sanctioned or terminated from the Medicare or Medicaid program or any other non-governmental Health Plan?	☐ Yes ☐ No
Have you had your license to prescribe or dispense narcotics refused, suspended or revoked?	☐ Yes ☐ No
Have you been treated for alcoholism, narcotics addiction or mental illness within the past year?	☐ Yes ☐ No
Have you ever been convicted of a crime other than traffic offenses?	☐ Yes ☐ No
Have you ever been refused board certification?	☐ Yes ☐ No
Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge, issued on any other special terms, or had renewal refused?	☐ Yes ☐ No
Have you had any malpractice claim(s)/suit(s) for alleged malpractice brought against you within the past ten years?	☐ Yes ☐ No If yes, how many _____? Please provide details on supplemental claim form attached.
Have you ever been involved in a claim whereby a settlement was paid on behalf of the hospital under a self-insured plan and not necessarily for you as a named defendant?	☐ Yes ☐ No If yes, how many _____? Please provide details on supplemental claim form attached.
Other than the claims/suits indicated above, are you aware of any circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim/suit would be without merit?	☐ Yes ☐ No Please provide details on supplemental claim form attached.
Are you doing clinical research?	☐ Yes ☐ No If yes, please explain: _____ _____
Do you practice any forms of alternative medicine (e.g.: Ayurvedic, Chiropractic, Chinese Holistic, Homeopathic or Naturopathic)?	☐ Yes ☐ No If yes, please list: _____ _____
Do you agree to the terms and conditions of the Provider Loss Prevention Program stated in section 7 of the subscriber agreement?	☐ Yes ☐ No If NO, please explain: _____
Do you work in an emergency room for other than your own patients?	☐ Yes ☐ No If yes, how many hours per week?
Do you render patients unconscious for treatment in your office or other non-hospital facility?	☐ Yes ☐ No If yes, please explain: _____ _____
Do you hold any positions as Director or Trustee of any licensed medical institution?	☐ Yes ☐ No If yes, please specify: _____ _____
Have you signed a contract that requires specific limits of liability?	☐ Yes ☐ No If yes, please specify: _____ _____
Does your practice include treating patients located in states other than Michigan, including treatment through remote technology?	☐ Yes ☐ No If yes, identify which states: _____ _____

Do you use medical service, such as remote radiology interpretation, located outside of the state of Michigan in the treatment of patients?	☐ Yes ☐ No If yes, identify which states: _____ _____

MEDICAL PROCEDURES

Average number of hours seeing patients per week:

Any Anesthesia procedures in Office other than local. ☐ Yes ☐ No If Yes, please explain: _____
_____

Select one of the following Surgery types as applicable:

- ☐ No Surgery - Includes incision of boils and superficial abscess, or suturing of skin or superficial fascia.
- ☐ Minor Surgery - Includes obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered *major surgery*. If assisting on own patients, indicate average time per month: _____
- ☐ Major Surgery - Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life. It also includes:
- ☐ Removal of tumors, open bone fractures, the removal of any gland or organ, plastic surgery, and any operation done using general anesthesia.
- ☐ Assisting in Major Surgery - On the patients of others. If assisting, indicate the percentage of total practice spent assisting: _____%.

PROCEDURES PERFORMED

Please indicate the total number of procedures you perform annually below:

- — Abortions
- — Acupuncture
- — Amniocentesis
- — Anesthesia-general, spinal, epidural or caudal
- — Angiography/Angioplasty or lymph angiography
- — Arteriography
- — Bariatric Procedures
- — Biopsy, Percutaneous or diagnostic study of organs or structures other than skin or superfacial fascia
- — Breast implants and/or reduction
- — Bronchoscopy
- — Catheterization other than proctoscopy or sigmoidoscopy
  - o Right Heart
  - o Left Heart
  - o Arterial
  - o Urinary
- — Deliveries: Vaginal
- — Chelation therapy
- — Cholecystectomy
- — Circumcision
- — Colonoscopy
- — Cryosurgery
- — Cystoscopy Procedure
- — D & C's
- — Deliveries: Cesarean
- — Deliveries: VBAC
- — Dermatological procedures:
  - o Botox injection
  - o Chemical Peels
  - o Dermabrasion
  - o Sclerotherapy
  - o Surface veins
  - o Deep Veins
  - o Dermal Fillers (such as collagen)
  - o Hair Transplant
  - o Laser Hair Removal
  - o Laser Skin Resurfacing
  - o Mesotherapy
  - o Mircrodermabrasion
  - o MOHS Surgery
  - o Tattoo Removal
  - o Thread Lifts
- — Discograms
- — Electromyography
- — Endoscopic Retrograde Cholangiopancreatomography (ERCP)
- — Endoscopy other than proctoscopy or sigmoidoscopy
- — Fluoroscopy
- — Fracture reductions-closed
- — Fracture reductions-open
- — Hair transplants
- — Hemorrhiodectomy- Internal or External
- — Herniorrhaphy
- — Hysterectomy
- — Intravenous Pyelogram (IVP)
- — Laparoscopy
- — Laser surgery
- — Liposuction
- — Lumbar puncture
- — Myelography
- — Obstetrics, considered to be major surgery, (including Cesarean sections)
- — Obstetrics, not considered to be major surgery
- — Ophthalmology
- — Orthopedic – Major surgery
  - o Spines
  - o No Spines
- — Pain management
- — Plastic surgery-cosmetic or reconstructive
- — Pre-natal care
- — Radial keratotomy (Lasik surgery)
- — Radiation oncology
- — Radiopaque dye injections
- — Silicone injections
- — Surgery-assisting in major surgical procedures on other than your own patients
- — Surgery-pedicle screws for spinal surgery
- — Surgery-major, other than tonsillectomies, adenoidectomies and hemorrhoidectomies
- — Surgery-minor, other than the or suturing of skin and superficial fascia
- — Surgery-total joint procedure
- — Thoracentesis
- — Tonsillectomies/adenoidectomies
- — Total joint replacement
- — Tubal ligations
- — Vasectomy
- — Venography

Other:
_____
_____
_____
_____

Non-procedural Physicians:
☐ Behavioral Medicine
☐ Hospitalist
☐ Occupational Medicine
☐ Urgent Care
☐ Other:
_____

I hereby certify that the information provided herein is complete, accurate and truthful to the best of my knowledge. I understand that misrepresentations in this application may result in cancellation rescission of coverage.

Signed this day of ,

(Print Name) (Subscriber Signature)

(Address)

MICHIGAN PROFESSIONAL EXCHANGE SERVICES
By:
Michelle Hoppes, President