Application

FOR PHYSICIANS

AND

SURGEONS

Medical Professional Liability Insurance Policy
Claims-Made
Non-Assessable

Home Office:

First Professionals Insurance Company
1000 Riverside Avenue, Suite 800
Jacksonville, Florida 32204
1-800-741-3742 ~ 904-354-5910

FAX: 904-358-6728
www.firstprofessionals.com

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. 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.

Help us expedite the processing of your application:

- Please print your responses in ink or type.
- Answer every question or mark it "not applicable" (N/A).
- Use the "Remarks" section to amplify your answers, where requested (see #49).
- If you have had claims, incidents, or suits filed against you, please make certain you have completed a Claims Information form for each claim or suit in the past fifteen (15) years. (See page 13.)
- Signatures required on pages 12 and 13.
- Copy of your CV/Résumé.
- Copy of your business letterhead.
- Incomplete answers and/or missing attachments **will** delay our processing of the application.
- Please use the "Remarks" section (#49) if you need to expand on any answers or if you run out of space anywhere on the application.

FPIC®

First Professionals Insurance Company

Application for Physicians and Surgeons

1. **If my application is approved, make coverage effective at 12:01 a.m. on ______/____/______ with a retroactive date of ______/____/______.**

2. **Name:** ______________________________ ☐ MD ☐ DO (Check One)
   First Middle Last

3. **Date of Birth:** ____________ **Place of Birth:** ______________ ☐ **Male** ☐ **Female**

4. **Social Security Number:** ______________

5. **List all medical license numbers:**

   a. ______________________ c. ______________________
   State Lic. # Status State Lic. # Status

   b. ______________________ d. ______________________
   State Lic. # Status State Lic. # Status

6. **Primary Address for which coverage is desired:**

   ____
   Number Street City State Zip % of Practice time at this location

   ____
   Telephone # Fax # E-Mail Address

   ____
   Web site

7. **List additional practice locations including all offices, nursing homes, urgent care clinics and other non-hospital locations. Please identify additional location, i.e., additional office, nursing home, clinic, etc.**

   ____
   Type of Practice

   ____
   Number Street City State Zip % of Practice time at this location

   ____
   Telephone # Fax # E-Mail Address

   a. Do you treat patients that were admitted to nursing homes by other physicians? ☐ YES ☐ NO

8. **Scope of Coverage:**

   I do **not** want coverage under this policy for the part of my medical practice listed below.

   ____
   Practice Name Address Start Date (mm/dd/yy) - End Date (mm/dd/yy)

   ____
   Practice Name Address Start Date (mm/dd/yy) - End Date (mm/dd/yy)

   Please use Remarks #49 if additional space is needed. Provide evidence of separate coverage.

9. **Home Address:** ______________________ (   ) ______________
   Number Street Telephone

   ______________________ (   ) ______________
   City State Zip Fax

10. Mailing Address (choose one): ☐ Home ☐ Primary Address

☐ Other (specify) ____________________

11. a. What is your average weekly patient load? ____________________

b. What is your total weekly hours of practice time? ____________________

c. If semi-retired or practice part-time, indicate approximate monthly practice time. ____________________

d. When did you begin practicing on a part-time basis? ____________________(mm/dd/yy)

e. Do you expect to continue the reduced practice for at least the next year? ☐ YES ☐ NO

f. Are you involved in another part-time practice for which you already have coverage? ☐ YES ☐ NO

If **"Yes"** then please outline that practice and coverage information in the "remarks" section (#49).

12. a. List all hospitals where you currently *have* or *have applied* for staff privileges (include courtesy staff privileges) and percentage of your hospital practice. **Policy information, including cancellation, will be released to these facilities.**

Hospital	City/State	% of Practice

b. If you do not have admitting privileges, please describe in detail your procedure for handling your patients who may require immediate in-patient care.

____

____

13. Specialty:

a. Medical specialty currently practiced ____________________ Sub-Specialty ____________________

b. Specialty for which you want coverage ____________________

14. Medical Education: ____________________ ____________________ ____________________

Medical School City/State/Country Graduation Date

15. Postgraduate Medical Training:

a. Internship ____________________ ____________________ ____________________

Hospital City/State/Country From: Mo./Yr. To: Mo./Yr.

b. Residency ____________________ ____________________ ____________________ Completed?

Hospital City/State/Country From: Mo./Yr. To: Mo./Yr. ☐ YES ☐ NO

Specialty: ____________________

c. Explain any additional years spent in a residency program: ____________________

____

d. Explain any gaps in time from date of medical school graduation to completion of residency: ____________________

____

e. Fellowship: ____________________ ____________________ ____________________

Hospital City/State/Country From: Mo./Yr. To: Mo./Yr.

____________________ Completed? ☐ YES ☐ NO

Type of Fellowship

16. Board Certification

a. Are you Board Certified? ☐ YES ☐ NO

Name of Board	Date Certified	Date Certification Expires

b. If not Board Certified, what is your precise position in the board process?

☐ Applied and waiting for application approval from the Board to sit for the ____________ exam.

(Date)

☐ Currently scheduled to take ☐ Part I ☐ Part II of the exam on ____________.

☐ Other (please explain) ____________.

c. How many times have you taken the Board exam for certification? Oral ______ Written ______

17. Changes in Practice

a. Have you practiced continuously for the past ten (10) years? ☐ YES ☐ NO

If **No**, please explain in Remarks #49

b. Have your practice procedures, specialty, location(s), etc., changed in the past ten (10) years? ☐ YES ☐ NO

If **Yes**, please explain, noting dates of changes: ____________

c. Are you a military physician? ☐ YES ☐ NO

If **Yes**, is/was your military obligation in remuneration for medical school tuition? ☐ YES ☐ NO

18. You may qualify for one of the following discounts. Please check all that apply:

a. Are you a member of a state, county or specialty medical society? ☐ YES ☐ NO

Please list each membership

____________ ____________

____________ ____________

b. Are you a member of a network/IPA? ☐ YES ☐ NO

c. Are you a member of the Neurological Injury Compensation Association (NICA)?** ☐ YES ☐ NO

** *Applies to Florida physicians only.*

19. Prior Insurance

Insurance history for the previous fifteen (15) years:

Coverage Period From / To Mo./Yr. Mo./Yr	Insurance Carrier	Policy #	Type of Policy Claims-Made/Occurrence	Retroactive Date

20. Insurance

a. Have you **ever** practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage? ☐ YES ☐ NO

b. Have you **ever** had professional liability insurance refused, declined, non-renewed cancelled, or accepted on special terms? ☐ YES ☐ NO

c. 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? ☐ YES ☐ NO

If **Yes** to a, b or c, please explain in Remarks #49.

21. Limits of Liability (Please check the desired limits of liability)

☐ $250,000 per claim/$750,000 aggregate per single policy year
☐ $500,000 per claim/$1,500,000 aggregate per single policy year
☐ $1,000,000 per claim/$3,000,000 aggregate per single policy year
☐ Other: ____

Optional coverages:

a. Do you desire license investigation defense coverage for ALL investigations? * ☐ YES ☐ NO

b. Do you desire Medefense (Medicare/Medicaid Fraud & Abuse) coverage? * ☐ YES ☐ NO
NOTE: Option b. is only available if option a. is selected.

* *In Florida and Arkansas our Broad Form Investigation Defense Coverage includes these coverages and others at no additional charge.*

22. Prior Acts

If your expiring policy is on a Claim-Made basis, an extended reporting period endorsement "tail" is generally available as an option of your expiring Claims-Made policy.

a. Are you exercising this option? ☐ YES ☐ NO

b. If **NO**, do you want us to provide coverage for prior acts (claims or incidents which may have occurred but, as yet, no indication has been made to you)? *(If **Yes**, please attach a copy of your current Declarations page.)* ☐ YES ☐ NO

c. Indicate reason for termination of latest policy: ____

Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

23. If you are practicing in **FLORIDA** are you using an arbitration agreement in your practice? ☐ N/A ☐ YES ☐ NO

If **Yes**, please include a copy when submitting your application.

If **No**, would you like to receive information about FPIC's arbitration package? ☐ YES ☐ NO

24. Have you **ever**:

a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other health care facility to deny, limit, suspend, nonrenew or revoke your privileges? ☐ YES ☐ NO

b. had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ☐ YES ☐ NO

c. 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, unprofessional or unethical conduct? ☐ YES ☐ NO

d. been charged with or convicted of a felony or misdemeanor other than minor traffic violations? ☐ YES ☐ NO

e. been evaluated, treated or hospitalized for any of the following: ☐ YES ☐ NO

☐ alcohol ☐ central nervous system stimulants or depressants
☐ mental or emotional disorders ☐ narcotics

f. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? If **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. ☐ YES ☐ NO

g. had Medicare/Medicaid fraud charges filed against you? ☐ YES ☐ NO

If you answered Yes to any of the above questions, please provide full details in Remarks #49.

25. 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, including any expression of an intent (i.e. closed records requests, incident reports and Notices of Intent, even if suit was never filed), or are you presently involved in malpractice litigation? ☐ YES ☐ NO

*If **yes**, how many? ________

*If **Yes**, submit a separate form for each case in the last fifteen (15) years (See page 13).

26. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome? ☐ YES ☐ NO

b. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? ☐ YES ☐ NO

c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? ☐ YES ☐ NO

d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
   i. Cardiac arrest ☐ YES ☐ NO
   ii. Postoperative coma ☐ YES ☐ NO
   iii. Postoperative neurological deficits ☐ YES ☐ NO
   iv. Unexpected death within 48 hrs. postoperatively ☐ YES ☐ NO
   v. All others ____

27. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ YES ☐ NO

28. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding 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 carrier? **If yes, please explain.** ☐ YES ☐ NO

____

IMPORTANT: If you answered Yes to Questions 24-28, please provide full details in Remarks #49 and attach any additional documentation. An Incident/Claim Information Form must be completed for each incident, potential claim, claim or suit. Any incident, potential claim, claim or suit reported above in questions 24-28 or that may occur before the effective date of coverage requested in this application must be reported to your current carrier for coverage and will not be covered by any FPIC policy issued to you based upon this application.

ANSWERS TO THE FOLLOWING QUESTIONS SHOULD REFLECT YOUR INTENDED PRACTICE AS OF THE DATE YOU WANT THIS FPIC POLICY TO BECOME EFFECTIVE.

29. Practice Situation

a. Indicate all practice situations that apply to you:

☐ "Solo" Physician
☐ "Solo" Medical Corporation (please include name of corporation on next page)
☐ Stockholder of a Medical Corporation with more than one physician shareholder (please include name of corporation on next page)
☐ Nursing Home ________%
☐ Urgent Care Clinic
☐ Independent Contractor
☐ Use of assumed name (DBA)
☐ Employed by another physician
☐ Employ another physician (If this employee is not

☐ Medical Partnership (please include name of partnership on next page)

☐ Locum Tenens

insured by FPIC, please submit current proof of coverage.)

☐ Other Non-Hospital Facility ____________________

If you checked any boxes on the previous page ***other than*** "Solo" Physician, list below the name of Applicable entity(ies) and/or any physician(s).

Name(s) of Entity(ies)	Name(s) of Physician Employer or Employee	Professional Liability Insurance Carrier	Employment/Contract Date (mm/dd/yy)

b. Do you wish coverage for any of the above entities? ☐ YES ☐ NO

If **Yes**, which one(s): ____________________

Please submit a copy of the Corporate Charter.

c. If you are in a group of two or more, do you want separate corporate limits of liability for the entities for which you have requested FPIC coverage? ☐ YES ☐ NO

If **Yes**, the retroactive date for the separate corporate limit is ____________________

30. Other Physicians: Do you practice with other physicians not listed above? ☐ YES ☐ NO

If **Yes**, list the physician(s) with whom you practice and describe the association.

Physician(s)	Association

31. Non-Hospital Births

Do you provide direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital? ☐ YES ☐ NO

If **Yes**, give full details: ____________________

____

32. Terminations of Pregnancy

Do you perform terminations of pregnancy? ☐ YES ☐ NO

If **Yes**, please provide the following information:

Location		Name	# Performed Monthly at Each Location	Maximum Gestational Age at Each Location
Office	☐			
Hospital	☐			
Other	☐			

33. Non-Hospital Procedures

a. Do you perform procedures in a non-hospital setting where other than local anesthesia is administered? ☐ YES ☐ NO

If **Yes**, type(s) used: ____________________

i) Location ☐ Surgicenter ☐ Office ☐ Other Non-Hospital Facility

ii) Who administers the anesthesia? ____________________

b. For surgicenter or other non-hospital facility, please provide the name and address of such.

____

c. List the surgical procedures you perform in your office or other non-hospital facility:

Procedure	# Weekly	Where Performed	Do you have privileges at an accredited hospital for this procedure?

d. Do you maintain a full emergency cart? ☐ YES ☐ NO

i) Do you follow a protocol for checking the cart on a regular basis? ☐ YES ☐ NO
ii) Are the checks documented? ☐ YES ☐ NO

34. Weight Control

a. Does your practice involve weight reduction or control, other than prescribing exercise? ☐ YES ☐ NO
(Percentage of patients exclusively for weight reduction or control ______%.)

If **Yes**, please explain fully including name of medication(s) prescribed or dispensed, or surgery performed:

____

____

b. Do you solicit or advertise for weight control patients? ☐ YES ☐ NO

If **Yes**, submit copies of all advertisements.

35. Experimental and Investigative Procedures

Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? ☐ YES ☐ NO

If **Yes**, indicate which of the following applies:

☐ Use of experimental drug, device or material under U.S. Food and Drug Administration or other governmental agency investigational protocol and licensure.

☐ Other experimental, investigative or unconventional drug or therapy.

PROCEDURES: ____

____

36. Please indicate with an "X" below which of the following procedures, techniques or practices you perform or intend to perform.

☐ Assisting in Major Surgery
☐ Baker's Chemical Peels
☐ Blepharoplasty
☐ Cardiac Catherization (left Heart)
done annually __________
☐ C-Sections
☐ Chelation therapy (other than for the treatment of heavy metal poisoning)
☐ D & C (diagnostic only)
☐ Deliveries (# done in past 5 years ____________)
☐ Elective Cosmetic Procedures if you are not a Dermotologist or Plastic Surgeon
☐ Experimental Surgery
☐ Hair Transplants
☐ Hydrogen Peroxide Therapy
☐ Pain Management (if yes, explain in Remarks #49)
☐ Polymethylmethacrylate injections (bone cement)
☐ Prenatal Care
☐ Radiation Oncology
☐ Scalp Reductions
☐ Sclerotherapy (deep vein)
☐ Shock Therapy
☐ Spine Surgery
☐ Suction Lipectomy - type and areas of use *(submit proof of training if outside of residency)*:
____
☐ Telemedicine (if yes, explain in Remarks #49)
☐ Ultraviolet Light Therapy (other than UVB or PUVA)
☐ Vasectomies

☐ **I do not perform any of these procedures**

37. Unusual Procedures ☐ N/A

List any unusual procedures that you perform within or outside of your specialty: ______________________________

____

38. Do you provide any E-medicine Services? ☐ YES ☐ NO

____

____

39. Employees

Do you employ any of the following health care professionals listed below? ☐ YES ☐ NO

*If **Yes**, please include number of each and date employed.

	Number	**Date Employed (mm/dd/yy)**		**Number**	**Date Employed (mm/dd/yy)**
Chiropractor	________	______________	Optometrist	________	______________
Nurse anesthetist	________	______________	Physician's asst.	________	______________
Nurse midwife	________	______________	Podiatrist	________	______________
Nurse practitioner	________	______________			

***In order for vicarious/defense coverage to be provided to you*:**

These individuals must provide proof of individual coverage with this application or apply to FPIC for coverage. Proof of insurance must show policy limits of at least $250,000/ $750,000 and reflect the retroactive date.

Do you employ or supervise any CRNA's? ☐ YES ☐ NO

If **Yes**, please complete the following: Number employed _______ Number supervised _______

Do the CRNA's give anesthesia while not under your personal directions? ☐ YES ☐ NO

If **Yes**, please describe: ____

40. Do you provide health care services for payment on a capitation basis where you are responsible in whole or in part for paying, or your compensation is materially effected by, the costs of the services performed by health care providers to whom you refer? ☐ YES ☐ NO

41. Is it reasonable to conclude from the facts, terms or circumstances that you have entered into any agreement, arrangement or understanding with any health care provider, to whom you refer, to accept fees for medical services that are below fair market value for certain patients? ☐ YES ☐ NO

If **yes**, please describe____

SPECIALTY SPECIFIC INFORMATION - PLEASE ANSWER ALL THAT APPLY TO YOUR PRACTICE

42. Obstetrics and Gynecology ☐ N/A

1. Do you limit your practice to gynecology only? ☐ YES ☐ NO
   If **Yes**, is your practice strictly office-based? ☐ YES ☐ NO
2. Do you render prenatal care exclusive of delivery? ☐ YES ☐ NO
3. How many deliveries do you perform annually? ______________

43. Pain Management/Physical Medicine and Rehabilitation ☐ N/A

Do you perform any of the following procedures?

		# of Annual Procedures
1. Cervical Epidural Injections?	☐ YES ☐ NO	______________
2. Thoracic Epidural Injections?	☐ YES ☐ NO	______________
3. Celiac Plexus Blocks?	☐ YES ☐ NO	______________

# of Annual Procedures

4. Epidural-Caudal, Translumbar or Selective Injections? ☐ YES ☐ NO ______
5. Facet-Cervical or Lumbar Injections? ☐ YES ☐ NO ______
6. Sacroiliac Joint and Gleno-humeral Joint Injections? ☐ YES ☐ NO ______
7. Hip Joint Injections? ☐ YES ☐ NO ______
   If **Yes**, explain ______
8. Assisted Spinal Endoscopy (Percutaneous Laser Discectomy)? ☐ YES ☐ NO ______
9. Insertion of spinal stimulator wires in the epidural space? ☐ YES ☐ NO ______
   a. Do you go higher than vertebral level T4? ☐ YES ☐ NO ______
10. Insertion of epidural catheter for drug infusion? ☐ YES ☐ NO ______
    (Do not include post-op epidural for acute pain management)
    a. Do you go higher than vertebral level T4? ☐ YES ☐ NO ______
11. Insertion of intrathecal catheter for drug infusion? ☐ YES ☐ NO ______
    a. Do you insert higher than vertebral level L2? ☐ YES ☐ NO ______
12. For the procedures listed in #9, 10 and 11, please complete the following:
    a. Is placement verified with fluoroscopy? ☐ YES ☐ NO
    b. Have you been trained through a program of study that incorporated hands-on experience? ☐ YES ☐ NO
    c. Have you been credentialed by the hospital for these procedures? ☐ YES ☐ NO
    If **No**, please explain: ______
13. Are you certified in Pain Management? ☐ YES ☐ NO
    a. By the American Board of Pain Medicine? ☐ YES ☐ NO
    b. Other ☐ YES ☐ NO
       Please specify______
14. What percentage of your practice is Chronic Pain Management? ______%
15. What new techniques do you now use which you did not use three years ago? ______

44. Radiology ☐ N/A

I practice as a: ☐ Diagnostic Radiologist
☐ Interventional Radiologist
☐ Neuroradiologist

Please check any of the following procedures/services that you will perform:

- ☐ Diagnostic angiography
- ☐ Urinary Tract Procedures
- ☐ Abscess Drainage
- ☐ Gastrointestinal Procedures

45. Ophthalmology Surgery ☐ N/A

1. How many major surgical procedures (excluding Laser Refractive Surgical procedures) have you performed in the last 12 months? ______
2. How many Laser Refractive surgical procedures have you performed in the last 12 months as primary surgeon? ______
3. Do you perform Clear Lensectomy? ☐ YES ☐ NO
4. Do you perform Oculo Plastic Surgery procedures? ☐ YES ☐ NO

THE FOLLOWING SECTION SHOULD BE COMPLETED BY ALL PHYSICIANS WHO PERFORM SURGICAL PROCEDURES

46. Surgery ☐ N/A

1. List the number of major surgical procedures performed in the last 12 months
   a. as primary surgeon ______
   b. as assisting surgeon ______

2. Indicate the percentage of surgical time devoted to the following surgical activities:

____%	Bariatrics	____%	Organ Transplants	____%	Plastic (reconstructive)
____%	Cardiovascular	____%	Orthopaedic	____%	Spine
____%	Colon and Rectal	____%	Otorhinolaryngology	____%	Thoracic
____%	General	____%	Pediatric	____%	Urological
____%	Gynecology	____%	Pediatric-Neurosurgery	____%	Vascular
____%	Hand	____%	Plastic (cosmetic)	____%	Other

3. **If you are involved in any Bariatric Procedures, then you must complete a supplemental form.** (This includes taking call for other Bariatric Surgeons. Please ask your agent for the supplemental form.)

47. Surgery - Orthopaedic ☐ N/A

Do you currently perform spinal surgery? ☐ YES ☐ NO

If **No**, have you ever performed spinal surgery? ☐ YES ☐ NO
When did you discontinue the performance of spinal surgery? ______________________________

48. Anesthesiology ☐ N/A

Do you or your group supervise student anesthetists in association with a teaching program? ☐ YES ☐ NO

49. REMARKS

Question #

Please make additional copies of this page, as necessary

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with First Professionals Insurance Company (FPIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FPIC in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by FPIC and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by FPIC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Professionals Resource Network, individuals and FPIC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by FPIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FPIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FPIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FPIC.

__________________________ **X**______________________________________MD/DO

Date Signature of Applicant

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or FPIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

Fraud Statement
Section 817.234(1)(b), Florida Statutes
(if applicable)

The statute requires the statement to contain in substance the following language:
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.

HOW DID YOU HEAR OF US?

Please take a moment to check the appropriate box(es):

☐ Advertisement	☐ County Medical Society	☐ Group Association	☐ Professional Society
☐ Agent	☐ Direct Mail	☐ Hospital Group	☐ Risk Management
☐ Colleague	☐ Former Insured	☐ Internet	☐ State Medical Association
☐ Convention			

INCIDENT/CLAIM INFORMATION

All incidents/claims reported to current and prior carriers should be reported on this form (including incidents/claims which occurred during residency).

1. Name of patient: ______________________ **2.** Age: ________

3. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): ________

____

4. Details of allegation(s): ______________________

5. Date of incident: ______________ **6.** Report date: ______________

7. Insurance carrier: ______________________

8. Name of your defense attorney: ______________________

9. Other defendants: ______________________

10. Present status of incident/claim **(check applicable answer and fill in amounts where needed)**

- ☐ Precautionary/Incident report only
  Reserve Amount $ __________
- ☐ Suit threatened, no action taken
  Reserve Amount $ __________
- ☐ Notice of Intent/Suit
  Reserve Amount $ __________
- ☐ Dropped by claimant
- ☐ Summary judgment in your favor
- ☐ Court trial in your favor
- ☐ Dismissed with no settlement made on my behalf
- ☐ Out of court settlement:
  Date Paid ________ (mm/dd/yy) Amount Paid $________
- ☐ Court settlement:
  Date Paid ________ (mm/dd/yy) Amount Paid $________

11. Location of incident: ______________________

12. Condition and diagnosis at time of incident: ______________________

____

13. Dates and description of treatment rendered: ______________________

____

____

14. Condition of patient subsequent to treatment (and DATES OF FOLLOW-UP TREATMENT) ________

____

____

15. Describe, if any, what preventive measures you have taken to avoid this type of claim in the future.________

____

____

16. Was the corporation sued: ☐ YES ☐ NO

If Pending, Reserve Amount $ __________

Was payment made on its behalf? ☐ YES ☐ NO If **Yes**, amount paid $ __________

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND I ACKNOWLEDGE AND UNDERSTAND THAT ANY INCIDENT, POTENTIAL CLAIM, CLAIM OR SUIT REPORTED ABOVE OR THAT MAY OCCUR BEFORE THE EFFECTIVE DATE OF COVERAGE REQUESTED IN THIS APPLICATION MUST BE REPORTED TO MY CURRENT CARRIER FOR COVERAGE AND WILL NOT BE COVERED BY ANY POLICY ISSUED TO ME BASED UPON THIS APPLICATION.

Signed: **X**______________________ Date Signed: ______________________

NOTICE
First Professionals Insurance Company, Inc.
Florida Experience Rating Program

FPIC has established the following guidelines for the application of Loss Free Discounts and Surcharges for Losses. Any interruption of insurance or going without insurance (going bare) will require that the experience period start over as of the date insurance was continuously maintained. The number of Loss Free years is calculated from January 1 of the year practice began.

Loss Free Years	Discount
0 – 4	None
5 – 9	10%
10 – 14	20%
15 or more	25%

Number of Claims*	Surcharge
2	50%
3	200%
4	500%

“Loss” means:
Any indemnity payment of $50,000 or greater, or any indemnity reserve of $100,000 or greater.

* Provided the physician remains eligible for standard coverage from an underwriting standpoint, each and every claim shall have a determination of whether it is chargeable. The surcharge once assessed shall apply for a three-year period commencing on the next renewal date. An additional claim under an already surcharged policy will result in a new surcharge period beginning. FPIC reserves the right to decline an applicant in lieu of utilizing this surcharge program.

For further information please contact your FPIC Representative or contact the FPIC Underwriting and Policyholder Divisions at the number shown in the documents to which this notice is attached.