HALLMARK Pro
PROFESSIONAL LIABILITY

20 North Wacker Drive, Suite 770, Chicago, Illinois 60606 MEDMAL@hallmarkgrp.com

# Locum Tenens Application

## Physicians & Surgeons Medical Professional Liability Insurance Claims Made & Reported Coverage

Please answer all questions that apply. State "not applicable" to those question that do not apply.

**General Information:**

Full Name: *(Include Professional Designation)*

Residence Address:

County: PO Box: State: Zip Code:

Residence Phone: SSN: Date of Birth:

Practice Address:

County: PO Box: State: Zip Code:

Practice Phone: Practice Fax: Email Address:

Website:

---

**Medical Training:**

Medical Specialty: % of Practice: %

Sub Specialty: % of Practice: %

| ***Training:*** | ***Hospital/School:*** | ***City & State:*** | ***Completed?*** | ***Dates From/To:*** |
|---|---|---|---|---|
| Medical School: | | | ☐ Yes ☐ No | |
| Internship/1st Year Residency: | | | ☐ Yes ☐ No | |
| Residency: | | | ☐ Yes ☐ No | |
| Additional Residency: | | | ☐ Yes ☐ No | |
| Fellowship: | | | ☐ Yes ☐ No | |

Are you a Foreign Medical School Graduate?: ☐ Yes ☐ No If Yes, Provide Date of ECFMG Certification:

Are you currently certified by the American Board of Medical Specialties? ☐ Yes ☐ No If Yes, Provide Name of Board:

Expiration Date Certification/Re-certification: If No, do you plan to take the Board Exam?: ☐ Yes ☐ No

**License Information:**

Please provide the following information for all of the states in which you have practiced:

| *State:* | *License#:* | *Effective Date:* | *Expiration Date:* | *Active?* |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

Please provide Federal DEA License # and status:

---

**Practice Description:**

During the period of your *locum tenens* coverage, will your practice vary materially from that of the physician you are replacing, in terms of hours practiced, patient count, procedures, personnel or any other clinical detail? ☐ Yes ☐ No

If Yes, Please Explain:

*Does your practice include the following?*

☐ No Surgery: No surgery with the exception of suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.

---

☐ Minor Surgery: Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology who may perform any of the following techniques or procedures:

Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography, pneumatic or mechanical esophageal dilation,(not with bougie or olive), angiography, arteriography, catheterization—arterial, cardiac or diagnostic (applies only to internists who have completed cardiovascular subspecialty training), needle biopsy including lung, breast, prostate and superficial and subcutaneous tissue, radiopaque dye injection into blood vessels lymphatics, sinus tracts or fistulae.

No procedures performed on a patient while under general anesthesia.

---

☐ Major Surgery: Involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It also includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography, and radiation therapy. Also included is removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.

---

**Current Individual Coverage and Experience:**

Please provide the following information regarding your current professional liability coverage:

| Policy Period | Insurer | Policy Limits | Deductible | Policy Type | Premium | Total# of Claims* |
|---|---|---|---|---|---|---|
| | | | | ☐ CM ☐ Occ | | |
| | | | | ☐ CM ☐ Occ | | |

** Total # of claims by carrier regardless of payment, no payment, dismissed or open.*

Have you ever practiced without professional liability insurance? ☐ Yes ☐ No

If Yes, please indicate dates: From: _____ To: _____

Have you ever had insurance company decline, cancel, rescind or non-renew any Professional Liability policy? ☐ Yes ☐ No
(Response not required in State of Missouri.)

If Yes, Please Explain: _____

*Please complete the following:*

| | |
|---|---|
| Have you had or been involved now or ever in a professional liability claim or suit? If "Yes", please complete the **Supplemental Claim Information** form for each. | ☐ Yes ☐ No |
| Have you had any losses or claims that have not been reported to a prior insurance carrier or any other source from which payment could be made? | ☐ Yes ☐ No |
| Are you aware of any specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim that has not been reported to a prior insurance carrier? | ☐ Yes ☐ No |
| Have you had any requests for medical records by a patient or his/her attorney which might result in a claim? | ☐ Yes ☐ No |
| Do you have any information relating to service(s) on a Board which may result in a claim? | ☐ Yes ☐ No |
| Have you had any prior professional liability carrier refuse coverage for, or decline to accept a report of a specific act, omission or circumstance involving a particular and specific professional service(s) that may result in a claim, threat of a claim, letter of intent, adverse result notice or attorney contact? | ☐ Yes ☐ No |
| Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other health care organization to deny, limit, suspend non-renew or revoke your privileges? | ☐ Yes ☐ No |
| Has your license to practice medicine or you permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? | ☐ Yes ☐ No |
| Have you ever 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 |
| Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? | ☐ Yes ☐ No |
| Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse? If "Yes", complete the **Substance Abuse Supplement**. | ☐ Yes ☐ No |
| Have you ever been evaluated, treated or hospitalized for mental or emotional disorders? | ☐ Yes ☐ No |
| Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation would limit your ability to safely practice in your medical specialty? | ☐ Yes ☐ No |

If Yes to any above, please provide details: _____

**NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY**

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the *locum tenens* endorsement.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide an endorsement.

**NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY (Continued)**

If the information in this application or any attachment materially changes between the date this application is assigned and the effective date of the endorsement, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any agreement to issue an endorsement.

**WARRANTY:**

I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy, I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.

Must be signed by the proposed locum tenens physician within 60 days of the proposed effective date.

**Signature:** _____ Date: _____

Name of Applicant: (Please Print) _____ Title: _____

**Signing this form does not bind the Applicant or the Company to complete the Insurance.**

**Notice to Applicants:** 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 subjects the person to criminal and civil penalties.