HALLMARK Pro
PROFESSIONAL LIABILITY
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Physician & Surgeons Application

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

All questions require a response. If space is insufficient, please attach additional pages.

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:

Additional Practice Locations:

% of practice: %

% of practice: %

% of practice: %

Practice Phone: Practice Fax: Email Address:

Website:

Are you a current U.S. citizen? ☐ Yes ☐ No If No, what is your current status in the U.S.,and where is your current citizenship?

Are you in current military service? ☐ Yes ☐ No If Yes, in what capacity?

Type of Practice:

☐ Unincorporated Solo Practice ☐ Incorporated Solo Practitioner ☐ Partnership

☐ Professional Corporation ☐ Limited Liability Company ☐ Professional Association ☐ Other

If Other, please explain:

Entity Name and Address:

Do you require coverage for this entity? ☐ Yes ☐ No If Yes, provide the names of all physicians practicing under this entity:

Do you do any business as a D/B/A (doing business as) ? ☐ Yes ☐ No If Yes, provide the name:

Does your practice have:

A Blog? ☐ Yes ☐ No

An EHR (Electronic HealthCare Records) system? ☐ Yes ☐ No

Implemented procedures to comply with the HIPAA privacy rules? ☐ Yes ☐ No

Do you or any organization authorized by you engage in any advertising or solicitation of patients? ☐ Yes ☐ No

If Yes, please attach copies of all advertising material including website address(es).

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

Are you a member of any medical association? ☐ Yes ☐ No If Yes, list memberships:

How many hours of continuing medical education have you taken in each of the past two years?

License Information:

Please provide **Federal DEA License #** _____ Status: _____

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

Hospital Privileges:

Provide the following information for all hospitals and surgical centers where you are currently on staff:

Name:	*City:*	*State:*	*Type of Privileges:*

Office Staffing:

Do you employ, contract with or supervise any physician(s) or surgeon(s)? ☐ Yes ☐ No

If Yes, please provide the name(s), medical specialties and copies of certificates of insurance for each.

Do you employ, contract with or supervise any non-physician health care extenders? ☐ Yes ☐ No

If Yes, please provide the following information: *(Attach separate sheet, if necessary)*

Name:	*Title:*	*Employee:*	*Separate Insurance:**
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

**Please provide a current certificate of insurance for each health care extender with separate coverage.*

Practice Characteristics:

Provide average weekly patient encounters including patients seen by health care extenders you employ or supervise: _____

Provide average weekly practice hours: _____

Does your practice include telemedicine including but not limited to the use of telecommunications technology as a medium for rendering professional services, opinions or advice? ☐ Yes ☐ No

If Yes, identify all states involved in the telemedicine practice: _____

Provide % of practice devoted to these activities: _____ % Are telemedicine services limited to radiology and/or pathology? ☐ Yes ☐ No

Are you in the employ or under contract to any entity (including governmental), other than the primary entity listed in **General Information**? ☐ Yes ☐ No

If Yes, please provide details including your responsibilities:

If under any contracts, do they contain hold harmless agreements? ☐ Yes ☐ No

Are you a Medical Director of a nursing home, commercial enterprise or other organization? ☐ Yes ☐ No

If Yes, please describe duties:

Do any of the following apply to your practice:

Administrative or teaching responsibilities ☐ Yes ☐ No

Locum tenens practice ☐ Yes ☐ No

Moonlighting activities ☐ Yes ☐ No

Provide services for any adult or juvenile inmates in any local, state or federal correctional facility, jail, prison or holding facility ☐ Yes ☐ No

If Yes to any above, please describe duties:

Practice Description:

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.

Do you own or operate a Laboratory? ☐ Yes ☐ No

If services are provided for other than your own patients, describe:

Do you now, or have you ever performed experimental or investigational procedures or prescribed/ dispensed experimental drugs? ☐ Yes ☐ No

If Yes, describe:

Do you work in an Emergency Room for other than fulfilling your requirement for hospital privileges? ☐ Yes ☐ No

If Yes, describe:

Are you a sports team physician or health care provider? ☐ Yes ☐ No

If Yes, please check the following: ☐ High School ☐ College ☐ Professional ☐ Other

If Other, describe:

If you, or any health care extender that you employ or supervise, perform any of the following procedures, check all that apply.
For each procedure indicate where the procedure is performed: **H = Hospital; O = Office; S = Surgi-center**

	Location:		*Location:*
☐ Abortions – 1st Trimester	☐ **H** ☐ **O** ☐ **S**	☐ Chelation Therapy – other than heavy metal poisoning	☐ **H** ☐ **O** ☐ **S**
☐ Abortions – 2nd/3rd Trimester	☐ **H** ☐ **O** ☐ **S**	☐ Cholecystectomies	☐ **H** ☐ **O** ☐ **S**
☐ Acupuncture	☐ **H** ☐ **O** ☐ **S**	☐ Cleft Lip or Palate Surgery	☐ **H** ☐ **O** ☐ **S**
☐ Adenoidectomy/Tonsillectomy	☐ **H** ☐ **O** ☐ **S**	☐ Clinical Trials	☐ **H** ☐ **O** ☐ **S**
☐ Amputations	☐ **H** ☐ **O** ☐ **S**	☐ Colonoscopies	☐ **H** ☐ **O** ☐ **S**
☐ Anal Fissures	☐ **H** ☐ **O** ☐ **S**	☐ Complex Flaps and Grafts	☐ **H** ☐ **O** ☐ **S**
Anesthesia – Non-obstetrical:		☐ Conization of Cervix	☐ **H** ☐ **O** ☐ **S**
☐ General	☐ **H** ☐ **O** ☐ **S**	☐ Cosmetic implantation or injection of silicone or other material	☐ **H** ☐ **O** ☐ **S**
☐ Spinal	☐ **H** ☐ **O** ☐ **S**	☐ Cryosurgery – other than on benign or pre-malignant dermatological lesions	☐ **H** ☐ **O** ☐ **S**
☐ Epidural	☐ **H** ☐ **O** ☐ **S**	☐ Culdocentesis	☐ **H** ☐ **O** ☐ **S**
Anesthesia – Obstetrical:		☐ Dermabrasion/Chemical Peels	☐ **H** ☐ **O** ☐ **S**
☐ General	☐ **H** ☐ **O** ☐ **S**	☐ Dilation & Curettage	☐ **H** ☐ **O** ☐ **S**
☐ Spinal	☐ **H** ☐ **O** ☐ **S**	☐ Discograms	☐ **H** ☐ **O** ☐ **S**
☐ Epidural	☐ **H** ☐ **O** ☐ **S**	☐ Electroconvulsive Therapy	☐ **H** ☐ **O** ☐ **S**
☐ Other Describe:	☐ **H** ☐ **O** ☐ **S**	☐ Erectile Dysfunction Therapy	☐ **H** ☐ **O** ☐ **S**
☐ Angiography	☐ **H** ☐ **O** ☐ **S**	☐ Endoscopic procedures	☐ **H** ☐ **O** ☐ **S**
☐ Angioplasty	☐ **H** ☐ **O** ☐ **S**	☐ Hair Transplants or Suturing of Hairpieces	☐ **H** ☐ **O** ☐ **S**
☐ Anti-aging procedures -	☐ **H** ☐ **O** ☐ **S**	☐ Hemorrhoidectomies	☐ **H** ☐ **O** ☐ **S**
Other than use of human growth hormone, describe:		☐ Hernioplasty	☐ **H** ☐ **O** ☐ **S**
☐ Arteriography	☐ **H** ☐ **O** ☐ **S**	☐ Herbal Medicine	☐ **H** ☐ **O** ☐ **S**
☐ Assisting in Surgery – on own patients or the patients of others	☐ **H** ☐ **O** ☐ **S**	☐ Homeopathy	☐ **H** ☐ **O** ☐ **S**
☐ Bariatric	☐ **H** ☐ **O** ☐ **S**	☐ Hyperbaric Medicine	☐ **H** ☐ **O** ☐ **S**
☐ Breast Implants	☐ **H** ☐ **O** ☐ **S**	☐ Hysterectomies	☐ **H** ☐ **O** ☐ **S**
☐ Breast Reductions	☐ **H** ☐ **O** ☐ **S**	☐ Joint Replacement Surgery	☐ **H** ☐ **O** ☐ **S**
☐ Catheterization – other than umbilical cord, urethral or arterial line in a peripheral vessel	☐ **H** ☐ **O** ☐ **S**	☐ Laparoscopies	☐ **H** ☐ **O** ☐ **S**
		☐ Laser skin resurfacing	☐ **H** ☐ **O** ☐ **S**

Location:

- ☐ Laser Surgery - Describe: ☐ H ☐ O ☐ S
- ☐ Lymphangiography ☐ H ☐ O ☐ S
- ☐ Mesotherapy ☐ H ☐ O ☐ S
- ☐ Minimally invasive surgery - Describe: ☐ H ☐ O ☐ S
- ☐ Moh's micrographic surgery ☐ H ☐ O ☐ S
- ☐ Myelography ☐ H ☐ O ☐ S
- ☐ Needle biopsies - Describe: ☐ H ☐ O ☐ S

Obstetrics:

- ☐ Prenatal Care ☐ H ☐ O ☐ S
- ☐ Normal deliveries annual no. ☐ H ☐ O ☐ S
- ☐ Caesarean sections annual no. ☐ H ☐ O ☐ S
- ☐ VBAC deliveries annual no. ☐ H ☐ O ☐ S
- ☐ Home or non-hospital deliveries ☐ H ☐ O ☐ S

- ☐ Open Reduction of Fractures (Plating and Pinning) ☐ H ☐ O ☐ S
- ☐ Orchidectomy ☐ H ☐ O ☐ S
- ☐ Organ Transplants ☐ H ☐ O ☐ S
- ☐ Osteopathic Manipulation ☐ H ☐ O ☐ S
- ☐ Pain Management - Describe: ☐ H ☐ O ☐ S
- ☐ Pedicle Screw Insertion ☐ H ☐ O ☐ S
- ☐ Pericardiocentesis ☐ H ☐ O ☐ S

Location:

Plastic – Cosmetic Procedures:

- ☐ Blepharoplasty ☐ H ☐ O ☐ S
- ☐ Collagen injections ☐ H ☐ O ☐ S
- ☐ Botox injections ☐ H ☐ O ☐ S
- ☐ Liposuction under 3500 cc's volume ☐ H ☐ O ☐ S
- ☐ Liposuction 3500 cc's or more volume ☐ H ☐ O ☐ S
- ☐ Phalloplasty or penile implant ☐ H ☐ O ☐ S
- ☐ Rhinoplasty ☐ H ☐ O ☐ S
- ☐ Silicone implants ☐ H ☐ O ☐ S
- ☐ Silicone injections ☐ H ☐ O ☐ S
- ☐ Other procedures - Describe: ☐ H ☐ O ☐ S

- ☐ Pneumoencephalography ☐ H ☐ O ☐ S
- ☐ Prolotherapy/proliferative therapy ☐ H ☐ O ☐ S
- ☐ Radial Keratotomy ☐ H ☐ O ☐ S
- ☐ Radiation Therapy ☐ H ☐ O ☐ S
- ☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae ☐ H ☐ O ☐ S
- ☐ Refractive surgery: LASIK, PRK, AK, PTK,ICR ☐ H ☐ O ☐ S
- ☐ Sex reassignment/sex change surgery ☐ H ☐ O ☐ S
- ☐ Silicone injection ☐ H ☐ O ☐ S
- ☐ Spinal surgery (incl. chemonucleolysis orpercutaneous, lumbar discectomy) ☐ H ☐ O ☐ S
- ☐ Thrombectomy of Arteries and Veins ☐ H ☐ O ☐ S
- ☐ Trans Myocardial Laser procedures ☐ H ☐ O ☐ S
- ☐ Tubal Ligation ☐ H ☐ O ☐ S

Prior Coverage and Experience:

Please provide the following information regarding the past 5 years of professional liability coverage:

Policy Period	Insurer	Policy Limits	Deductible	Policy Type	Premium	Total# of Claims*
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ 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, provide explanation: _____

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 your 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, provide details: _____

NOTICE TO THE APPLICANT—PLEASE READ CAREFULLY

If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy.

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom, shall be excluded from coverage under the proposed insurance.

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 policy.

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 or the Applicant to purchase the insurance.

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

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

The policy for which application is made applies only to "Claims" first made during the "Policy Period".

Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by "Claim Expenses" and, in such event, the Company will not be liable for "Claim Expenses" or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy.

Unless amended by endorsement, "Claim Expenses" shall be applied against the "Deductible".

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.

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.