Quick Underwriting Checklist for Physicians

Please submit completed application and supporting documents 30 days prior to start date.
Each item on the checklist must be complete prior to submitting the application.

1. ☐ Application completed

2. ☐ Pages 6, 7 and 8 of the application signed and witnessed. (Page 7 must be signed and witnessed even if no claims)

3. ☐ CV

4. a. ☐ Copies of all state licenses
   b. ☐ Copies of DEA, ACLS, PALS, ATLS, BLS, NRP, etc. certifications
   Each physician must have these certifications by their first Yellowstone renewal date or one year upon entry into the company…
   Physicians in the ED/Urgent Care must have BLS, ACLS and PALS. ATLS is highly recommended.
   Physicians working with Pediatrics in any setting must have PALS.
   Physicians in Clinic/Office must have BLS. ACLS and PALS are highly recommended.
   For Inpatient care an ACLS is required and PALS highly recommended. BLS is also required for primary providers outside of the hospital (other specialists). CRNA and Anesthesiologists must have both ACLS and PALS.
   Physicians in OB must have BLS, ACLS and NRP. PALS highly recommended
   Psychologists/Psychiatrists must have BLS. ACLS and PALS highly recommended

   NOTE: Items 5 and 6 below- The attached form "REQUEST FOR CERTIFICATE(S) OF INSURANCE AND LOSS RUN/INFORMATION" (found on the following page) may be sent to your insurance providers from the last five years to gather this information.

5. ☐ Copies of all Certificates of Insurance for most recent 5 years
   ***Certificate of Insurance- A document providing evidence that certain types of insurance coverages and limits have been purchased for a specific period of time by the party required to furnish the certificate.**

6. ☐ Loss Runs/Claims Histories from each carrier for every employer during the last 5 consecutive years
   ***Claim Loss Runs- A periodic report of claims information provided by insurance companies to their insureds.**

7. ☐ Three written professional references

Your Contact Information:

Name	
Email	
Phone Number	

The information above is complete.

Signature (X) ______________________________ Date ____________________

***Definitions to assist with application completion: (source: International Risk Management Institute)**

CLINICIAN

REQUEST FOR CERTIFICATE(S) OF INSURANCE AND LOSS RUN/INFORMATION

Please send this document to your insurance providers for the most recent 5 years with your email address and signature.

Clinician's Name: ____

I am requesting the following information as soon as possible:

- Certificate(s) of Insurance for my entire coverage period with your company which I believe is from____/_____/_____to_____/___/_____.
- Loss Run(s) for my entire coverage period with your company which I believe is from _____/_____/____to_____/_____/_____.

Please email to me at: ____

Signature: __________________________________ Date: _____________________

**If you are graduating from a residency program and this is your first employed position please ask your educational facility for a certificate of insurance and a letter regarding your loss/litigation experience.*

Please g/mail qt"hcz"the completed and signed cr r nkecvkqp"with supporting documentation to:

Yellowstone Insurance Exchange, RRG
Attn: Underwriting
G/o ckn"wpf gty tkvkpi B {kgtti 0eqo
Hcz/": 88/438/9656
Tel/ 866-216-7433

Yellowstone Insurance Exchange, RRG
APPLICATION FOR HEALTHCARE PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS (CLAIMS MADE)

PLEASE TYPE OR PRINT LEGIBLY

Personal Information

Requested Coverage Effective Date:____________________

1. Full Name of Applicant (include Professional Degree) ____________________
2. Applicant's Date and Place of Birth ____________________
3. Home Address (Street, City, State and Zip Code) ____________________
4. Principle Business Address (Street, City, State and Zip Code) ____________________
5. E-mail ____________________ 6. County __________
7. Principle Correspondence Address ____________________
8. Social Security No. __________ 9. Business Phone __________ 10. Home Phone __________
11. Your specialty or type of practice for which you are applying for coverage ____________________
12. Name of Hospital where you are or will be employed ____________________
    a. Are you going to be a W2 employee of the hospital? ☐ Yes ☐ No
    b. Date of Employment ____________________
    c. What department? __________ How many hours a week will you be on duty? __________
13. List below in chronological order all hospitals where you have or had privileges.
    a. Have you ever been denied privileges? ☐ Yes ☐ No
    b. If "Yes", please explain on a separate attachment.

Hospital Name	Hospital Address	Start Date	End Date	% of Patient Care	Issue Certificate of Insurance?
					YES ☐ NO ☐
					YES ☐ NO ☐
					YES ☐ NO ☐
					YES ☐ NO ☐

14. In what states are you registered and licensed to practice? ____________

Is your license limited? ☐ Yes ☐ No If "Yes", explain ____________

a. Federal DEA No. ____________

b. Medical License No. for each state in which you are licensed ____________

c. Are all the above licenses current? ☐ Yes ☐ No If "No", which are not? ____________

15. Has there been any change in your practice or specialty in the past 5 years? ☐ Yes ☐ No

If "Yes", explain ____________

16. Are you credentialed at any hospital for any procedures, which are not included in your primary medical specialty? ☐ Yes ☐ No

If "Yes", explain ____________

17. Do you practice in an ambulatory care center? ☐ Yes ☐ No

18. Do you normally staff an emergency department? ☐ Yes ☐ No How many hours per month? ____________

19. If your hospital does not employ full-time emergency physicians, do your staff privileges require you to take emergency call on a regular rotation? ☐ Yes ☐ No If "Yes", how many hours per month? ____________

20. Do you work part-time outside of your regular practice ("moonlight")? ☐ Yes ☐ No If "Yes", describe ____________

Is this activity insured by your employer? ☐ Yes ☐ No If "Yes", name of insurance company ____________

21. Are you employed full-time by the Federal Government **or** are you under contract to any government entity? ☐ Yes ☐ No

If "Yes", explain ____________

22. Do you work in either a federal or state prison? ☐ Yes ☐ No

If "Yes", describe your duties and hours worked ____________

23. Are you currently in the Military Service? ☐ Yes ☐ No If "Yes", check whether ☐ Active or ☐ Reserve

24. Are you a U.S. citizen? ☐ Yes ☐ No If "No", indicate your status and date of entry into the USA ____________

25. In what Medical Associations are you a member in good standing? ____________

26. Have you participated in any continuing medical education within the past twelve (12 months)? ☐ Yes ☐ No

If "Yes", how many category 1 credit hours? _____

27. Do you participate in, or are you a member of an HMO, PPO or similar healthcare system? ☐ Yes ☐ No

28. Is there a "hold harmless" clause in your contract requiring your professional liability insurance company to indemnify any hospital or institution? ☐ Yes ☐ No

29. Do you participate in peer review or similar activity with respect to above entities? ☐ Yes ☐ No

30. Are you U.S. Board Certified? ☐ Yes ☐ No Specify ____________

Organization extending certification ____________

31. Are you Board Eligible? ☐ Yes ☐ No

32. Are you entering private practice for the first time? ☐ Yes ☐ No

33. Please use the space below for any comments you feel will help Yellowstone better understand any special circumstances concerning your practice. ____________

____

____

____

____

Practices and Procedures

34. Check the procedures performed by you:

- ☐ Abortion
- ☐ Accupuncture
- ☐ Therapeutic/Local Anesthetic
- ☐ General Anesthetic
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arthroscopy
- ☐ Arteriography
- ☐ Assisting in major surgery
- ☐ Own patients only
- ☐ Own & other than own patients
- ☐ Blepharopigmentation
- ☐ Blepharoplasty-Brow Lifts
- ☐ Cosmetic_____% of practice
- ☐ Reconstructive_____% of practice
- ☐ Breast Implants
- ☐ Cosmetic_____% of practice
- ☐ Reconstruction_____% of practice
- ☐ Bronchoscopy
- ☐ Cataract Surgery
- ☐ Cryosurgery (other than external lesions)
- ☐ ERCP
- ☐ D&C
- ☐ Phenol Facial Peels
- ☐ Diagnostic Embolization
- ☐ General/Spinal/Caudal Anesthesia
- ☐ Pulse Oximetry
- ☐ End Tidal Co2 Analyzer
- ☐ Hair Transplants
  Scalp Excision/Transplantation
  Plug Technique/Minigraph
- ☐ Other Medical Techniques
  Describe:____________________

- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopic
- ☐ Laser Surgery
- ☐ Liposuction
- ☐ Lymphangiography
- ☐ Lithotripsy
- ☐ Major Gynecological Surgery
- ☐ Myelography
- ☐ Needle Biopsy
- ☐ Nerveblocks
- ☐ Lumbar Epidural Steroid
- ☐ Paraspinal
- ☐ Sciatic
- ☐ Facet
- ☐ Paravertebral
- ☐ Peripheral
- ☐ Myofascial
- ☐ Triggerpoint Injection
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Radiopaque Dye
- ☐ Non-Ionic only
- ☐ Shock Therapy
- ☐ Sigmoiodscopy
- ☐ Less than 60 CM
- ☐ Greater than 60 CM
- ☐ Colonoscopy
- ☐ Polypectomy
- ☐ Gastrointestinal Endoscopy

- ☐ Biopsy (Endoscopic)
- ☐ Peritoneoscopy
- ☐ Laser Therapy (Endoscopic)
- ☐ Pacemakers under General Anesthesia
- ☐ Silicone Injections
- ☐ Skin Flap/Grafts
- ☐ Cosmetic_____% of practice
- ☐ Reconstruction_____% of practice
- ☐ Swan-Ganz Catherization
- ☐ Right Heart Catherization (other than CVP lines)
- ☐ Left Heart Catherization
- ☐ Tubal Ligations
- ☐ Vasectomies
- ☐ On own patients
- ☐ On other than own patients
- ☐ Vasectomies
- ☐ On own patients
- ☐ On other than own patients
- ☐ Weight Control Therapy/Surgery
- ☐ _____ % of practice
- ☐ Medication-Weight Control
- ☐ Gastric Bubble
- ☐ Gastric Stapling
- ☐ Other (type)_____
- ☐ Prenatal Practice
- ☐ See patients during the first & second trimester
- ☐ See patients to term but do not perform delivery
- ☐ See patients to term and perform delivery
- ☐ Normal Obstetrical Deliveries
- ☐ How many per year?_____
- ☐ Cesarean Sections
- ☐ How many per year?

35. Pain Management Procedures List:

____

____

____

36. Indicate the percentage of your surgical practice devoted to the following surgical activities:

_____ % Plastic (Reconstructive only)
_____ % Plastic (Cosmetic Enhancement only)
_____ % Hand
_____ % Traumatic
_____ % Thoracic
_____ % Cardiac
_____ % Bariatric
_____ % Obstetrics
_____ % Orthopedic (including back)
_____ % Orthopedic (not including back)
_____ % Other (describe)

37. In the last (10) years,

a. Have you discontinued major surgical procedure? ☐ Yes ☐ No

If "Yes", list procedures and date discontinued ____________________

b. Have you ever been a representative of a Pedicle Screw Manufacturer? ☐ Yes ☐ No

If "Yes", please explain

c. Have you performed weight control surgery or prescribed weight control medication? ☐ Yes ☐ No

d. If "Yes", what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs.

<1% ☐ 1%-10% ☐ 11%-50% ☐ >50% ☐

e. If "Yes", what percentage of your practice (% of patient care) was devoted to performing weight control surgery?

<1% ☐ 1%-10% ☐ 11%-50% ☐ >50% ☐

f. Do you have ownership interests in a weight control clinic? ☐ Yes ☐ No

g. If "Yes", what is the name of the weight control clinic with which you are affiliated ____________________

38. If you use silicone gel/saline breast implants, do you use the manufacturer's informed consent forms in addition to your normal informed consent procedure? ☐ Yes ☐ No

39. Do you use x-ray equipment on your premises? ☐ Yes ☐ No

If "Yes", are your x-rays overread by a radiologist? ☐ Yes ☐ No

40. Do you perform any surgical procedures in your professional office or similar non-hospital facility? ☐ Yes ☐No

If "Yes", list procedures ____________________

41. Do you perform laparascopic surgery? ☐ Yes ☐ No If "Yes", number of annual procedures performed? ______

42. If you administer anesthetics, is there a pre-anesthesia examination and conference with the patient ? ☐ Yes ☐ No

43. Do you use pulse oximetry and capnography with general anesthesia ☐ Yes ☐ No

44. Do you assist in surgery? On your own patients ______ On the patients of others ______

45. Do you participate in any activity (e.g. newspaper columns, broadcasts, etc.) whereby professional advice is offered to the public? ☐ Yes ☐ No

If "Yes", explain ____________________

Education and Training

46. Indicate your educational background (**attach a copy of your Curriculum Vitae)**

a. Undergraduate School ____________________ Year Completed ______

b. Graduate School ____________________ Year Completed ______

c. Medical School ____________________ Location ____________________ Year Completed ______

d. Internship at ____________________ Location ____________________ Year Completed ______

e. Residency at ____________________ Location ____________________ Year Completed ______

f. Fellowship/advanced trng ____________________ Location ____________________ Year Completed ______

g. Please explain any gaps in above chronological sequence ____________________

47. If you have just completed your residency training or fellowship, name the institution where you trained, the director of your program and the telephone number of the department.

Institution ____________________ Program Director ____________________ Telephone ____________________

Institution ____________________ Program Director ____________________ Telephone ____________________

48. Are you a foreign medical school graduate? ☐ Yes ☐ No

49. If “Yes”, are you certified by the Educational Council for Foreign Medical School Graduates? ☐ Yes ☐ No

Insurance

Please list your professional liability policies for the past ten years.

Company	Policy No.	Policy Limits	Deductible			Policy Period
				Claims Made ☐	Occurrence ☐	
				Claims Made ☐	Occurrence ☐	
				Claims Made ☐	Occurrence ☐	
				Claims Made ☐	Occurrence ☐	

If at any time you were without insurance, please indicate on a separate sheet of paper.

Claims

50. Complete and attach a Claim Information Form for each claim, potential claim, or suit

a. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim or suit arising out of the Rendering or failing to render professional services? ☐ Yes ☐ No

If “Yes”, how many?____________

If “Yes”, have these been reported to your insurer? ☐ Yes ☐ No

b. Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? ☐ Yes ☐ No

If “Yes”, how many?____________

If “Yes”, have these been reported to your insurer? ☐ Yes ☐ No

If reported to your insurer, please provide a copy of the report(s).

51. Have you ever: **(explain any yes answers on a separate sheet of paper)**

		YES	NO
a.	Been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	☐	☐
b.	Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses?	☐	☐
c.	Had any state professional license or license to prescribe or dispense narcotic refused, suspended, revoked, renewal refused, restricted or accepted only on special terms?	☐	☐
d.	Had any insurance company or Lloyd’s cancel, notify you of intent to cancel, decline, deny, surcharge, refuse to renew, accept on special term or accept professional liability insurance on a consent-to-rate basis?	☐	☐
e.	Failed any medical licensing or specialty organization examination or not eligible for Boards?	☐	☐
f.	Been named in a claim or suit for professional malpractice?	☐	☐
g.	Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including, but not limited to depression and/or chronic fatigue?	☐	☐
h.	Have you or do you presently have any chronic or life-threatening physical illness or defects?	☐	☐
i.	Have you had any judgment made against you or any out-of-court settlements made on your behalf?	☐	☐

Applicant must sign and have witnessed pages 6, 7 and 8.

Notice: Failure to provide complete and accurate information regarding actual claims, suits, incidents, acts, errors, or omissions which could reasonably be expected to become the basis of a claim or suit will result in no coverage under the policy.

Signing this application does not bind **Yellowstone Insurance Exchange, RRG** to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information, or attempt to defraud or attempt to defraud or lie to **Yellowstone Insurance Exchange, RRG** about any matter contained in this application, then coverage provided by virtue of this application is void.

Date:____

(X)____
(Applicant)

(X)____
(Witness)

About Your Application Submission

Please make certain to refer back to the Application Checklist provided to ensure you have completed each item in the checklist prior to submission of the application to Yellowstone Insurance Exchange, RRG. The quality of your application submission enables underwriting to more quickly process your application and deliver your policy to you in a timely manner. Yellowstone is committed to continuous improvement and enhancing the level of service it provides to members.

Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.

Supplemental Claim Information

This form must be signed and dated even if there are zero claims.

Instructions To The Applicant

A. This form should be completed by the applicant whose signature appears on the **Yellowstone Insurance Exchange, RRG** Professional Liability Insurance Application.

B. One of these forms should be completed for each claim or incident in which the applicant has been involved. If additional forms are needed, applicant may photocopy this form for use in reporting other claims.

C. If space is insufficient to fully provide answers to the questions below, use reverse of this form or separate sheet.

D. Answer all questions completely. Complete information is necessary for the equitable and careful evaluation of your application.

1. Full Name of the Applicant____
2. Full Name of the Individual(s) of your firm involved in this claim____

   ____
3. Full Name of the Claimant____ 4. Age:__________ 5. Sex:__________
6. Indicate whether this was a: ☐ Claim ☐ Incident ☐ or Suit
7. Date of Alleged Error____ 8. Date claim was made____
9. Additional Defendants____

   ____
10. What is the name of the insurer involved in this claim?____
11. What is the insurer's claim number assigned to this claim (if known)?____
12. Description of the claim (please provide enough information to allow for evaluation and use the reverse side of this sheet if necessary)

    Alleged act, error or omission upon which the claimant bases claim:____

    ____

    Description of the type and extent of injury or damage allegedly sustained:____

    ____

    Description of the type and extent of injury or damage allegedly sustained:____

    ____

If claim is closed, answer questions 13 and 14. If claim is pending (open), answer questions 15 through 21.

13. If closed, what was the total loss paid including any deductible that may have applied?____
14. If closed, was this amount paid subsequent to a: ☐ Court judgment or ☐ Out of court settlement
15. If pending (open), what is claimant's settlement demand? $____
16. If pending (open), what is defendant's settlement offer? $____
17. If pending (open), what is insurer's loss reserve? $____
18. If pending (open), what deductible (if any) applies? $____
19. If pending (open), is this claim in suit? ☐ Yes ☐ No $____
20. If claim is in suit, what amount (if any) was asked for in the complaint? $____
21. If pending (open), who is defense counsel (please include address and phone number if known or available)?____

    ____

I hereby understand that information submitted herein becomes a part of and is incorporated with my Professional Liability Application and is subject to the same conditions.

Date:____

(X)____
(Applicant)

(X)____
(Witness)

Yellowstone Insurance Exchange, RRG

Authorization For Release Of Information

I, the undersigned, have provided **Yellowstone Insurance Exchange, RRG** information in their insurance application in order for **Yellowstone Insurance Exchange, RRG** to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including, but not limited to, prior liability carriers, hospitals and their officers, directors, medical staff, and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide **Yellowstone Insurance Exchange, RRG** with any information, whether written or otherwise, which may be material to evaluating my application for insurance with **Yellowstone Insurance Exchange, RRG**. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to **Yellowstone Insurance Exchange, RRG.**

I consent for **Yellowstone Insurance Exchange, RRG** to use photocopies of this "Authorization for Release of Information" to present to those persons or entities supplying information as provided herein. Each photocopy is to be considered an original copy.

Date:__________________________

(X)____
(Applicant)

(X)____
(Witness)