Please mail the completed and signed application with supporting documentation to:

Yellowstone Insurance Exchange, RRG
4301 Hillsboro Pike, Suite 310
Nashville, Tennessee 37215
Tel. 866-216-7433
Fax 866-216-7434

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

PLEASE TYPE OR PRINT LEGIBLY

Personal Information

Requested Coverage Effective Date:_____ **Requested Retro 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_____ 5. County_____
6. Principle Correspondence Address_____
7. Social Security No_____ 8. Business Phone_____ 9. Home Phone _____
10. Your specialty or type of practice for which you are applying for coverage _____
11. Name of Hospital where you are or will be employed _____
    a. Are you going to be an employee of a hospital? ☐ Yes ☐ No
    b. Date of Employment _____
    c. What department? _____ How many hours a week will you be on duty? _____
12. List 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 ☐

13. 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 _____

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

If yes, explain_____

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

If yes, explain_____

16. Are you a member of the staff, or do you practice in an ambulatory care center ☐ Yes ☐ No

17 Do you normally staff an emergency department? ☐ Yes ☐ No How many hours per month?_____

18 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? _____

19. 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 _____

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

If yes, explain_____

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

If yes, describe your duties and hours worked_____

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

23. Are you a U.S. citizen? ☐ Yes ☐ No If no, indicate your status and date of entry into the USA _____

24. In what Medical Associations are you a member in good standing?_____

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

If yes, how many category 1 credit hours? _____

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

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

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

29. Are you U.S. Board Certified? ☐ Yes ☐ No Specify_____

Organization extending certification_____

30. Are you Board Eligible? ☐ Yes ☐ No

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

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

PRACTICES AND PROCEDURES

32. 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?

33. Pain Management Procedures List:

_____

_____

_____

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

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

35. 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 attach an explanation

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 _____

36. 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

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

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

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

If yes, list procedures _____

39. Do you perform laparascopic surgery? ☐Yes ☐No If yes, number of annual procedures performed? _____

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

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

42. Do you assist in surgery? On your own patients _____ On the patients of others _____

43. 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

44. 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 or advanced trng Location _____ Year Completed _____

g. Please explain any gaps in above chronological sequence _____

45. 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 _____

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

47. 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

48. Complete and attach a Claim Information Form for each claim, potential claim, or suite

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).

49. 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 at bottom of pages 6, 7 and 8

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)

Additional Required Information:
Please include with application

- **CV**
- **Names and address of 3 references of a professional nature**
- **Copies of ACLS, PALS, ATLS (if applicable)**
- **10 Years of loss history (Include company loss runs and letters indicating no losses)**

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.

Yellowstone Insurance Exchange, RRG

SUPPLEMENTAL CLAIM INFORMATION

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)