HAMILTON

Clear Form

PHYSICIANS AND SURGEONS APPLICATION

Required documents, in addition to this application:

- Curriculum vitae (CV)
- Currently Valued Loss runs for the last five (5) years
- Full copy of the expiring medical malpractice policy, if applicable

GENERAL INFORMATION

Applicant Name:				
	First Name	Middle Name	Last Name	Designation

DBA/Business name (if applicable):	
Home Address:	
Principal Office Address:	
Preferred Mailing Address:	
Website Address (if applicable):	

Date of Birth:		**Place of Birth**		**Social Security #**	

Are you a citizen of the United States of America?	Yes ◯	No ◯
If "No", please indicate your status and date of entry into the United States:		

Medical License Number(s)

State	License Number	Expiration Date	% of Practice

If additional space is needed, please provide information via separate attachment

DEA Registration Number:	

COVERAGE REQUESTED

Policy Period:	From:		To:	
Retroactive Date:		Expiring Declarations Page required to confirm		

Limits of Insurance:	☐ $100,000/300,000	☐ $250,000/750,000	
☐ $500,000/500,000	☐ $500,000/1,000,000	☐ $1,000,000/2,000,000	
☐ $1,000,000/3,000,000	☐ Other:	☐ $	

Deductible:	☐ $0	☐ $1,000	☐ $2,500
☐ $5,000	☐ $10,000	☐ $25,000	☐ Other: $

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APPLICANT INFORMATION

1. Professional Training			
(a) Medical School		Location	
Degree(s)		Dates	
(b) Internship Facility		Location	
Specialty		Dates	
(c) Residency Facility		Location	
Specialty		Dates	
(d) Fellowship Facility		Location	
Specialty		Dates	
Other Training:			

2. List all memberships in professional societies:	

3. Are you American Board Certified?	Yes ◯	No ◯
If yes, please provide the Medical Specialty(ies) and date(s) certified:		

4. What is your medical or surgical specialty?	
Percentage of practice dedicated to this specialty?	%

5. What is your subspecialty?	
Percentage of practice dedicated to this specialty?	%

6. Do you limit your practice to the specialties above?	Yes ◯	No ◯
If no, please explain:		

7. Has there been a change in your specialty, sub-specialty, procedures or practice activity in the last five (5) years, or a change expected?	Yes ◯	No ◯
If yes, please explain:		

PRACTICE INFORMATION

8. Primary practice location			
a. Entity or Facility Name:			
b. Entity/Facility address:			
c. Interest (owner, partner, employee, independent contractor):			
d. Employment Date:		e. Ownership % if (applicable)	%
f. Are you seeking coverage for your services at this facility?	Yes ◯	No ◯	

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g. Are you seeking coverage for the entity or facility?	Yes ◯	No ◯
If yes to the above, what is the number of weekly patient encounters for all staff?		

For any "No" answers to f. or g., please provide evidence that coverage is in place elsewhere

9. Additional practice location 2			**N/A** ☐
a. Entity or Facility Name:			
b. Entity/Facility address:			
c. Interest (owner, partner, employee, independent contractor):			
d. Employment Date:		e. Ownership % if (applicable)	%
f. Are you seeking coverage for your services at this facility?	Yes ◯	No ◯	
g. Are you seeking coverage for the entity or facility?	Yes ◯	No ◯	
If yes to the above, what is the number of weekly patient encounters for all staff?			

For any "No" answers to f. or g., please provide evidence that coverage is in place elsewhere

10. Additional practice location 3			**N/A** ☐
a. Entity or Facility Name:			
b. Entity/Facility address:			
c. Interest (owner, partner, employee, independent contractor):			
d. Employment Date:		e. Ownership % if (applicable)	%
f. Are you seeking coverage for your services at this facility?	Yes ◯	No ◯	
g. Are you seeking coverage for the entity or facility?	Yes ◯	No ◯	
If yes to the above, what is the number of weekly patient encounters for all staff?			

For any "No" answers to f. or g., please provide evidence that coverage is in place elsewhere

11. For the practice location(s) for which you are seeking coverage, please provide:	
a. The approximate hours worked per week:	
b. The number of weekly non-surgical patient encounters seen **by you**:	
c. The number of weekly surgeries performed **by you**:	

12. Are you contracted as Medical Director for any facility(ies)?	Yes ◯	No ◯
If yes, provide the name(s) of the facility(ies):		
Are you seeking coverage for your services as a medical director?	Yes ◯	No ◯

For consideration of such coverage, please provide a copy of the contract, including scope of work

13. Do you provide any of the following (check all that apply)?				
a. Services at, or for, long term care facilities?	☐	Coverage needed?	Yes ◯	No ◯
b. Services at, or for, correctional facilities?	☐	Coverage needed?	Yes ◯	No ◯
c. Services for an emergency department?	☐	Coverage needed?	Yes ◯	No ◯
d. Any obstetrical and/or prenatal care?	☐	Coverage needed?	Yes ◯	No ◯
e. Services for a governmental entity?	☐	Coverage needed?	Yes ◯	No ◯
If any of the above are checked, please explain:				

14. Do you currently have privileges in any hospital?	Yes ◯	No ◯
a. If yes, provide the name(s) of the hospital(s):		

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b. Please briefly describe the type and extent of your hospital privileges in the space below:		
c. Are you Chief or Head of a hospital department?	Yes ◯	No ◯
If yes, which department(s):		
Are you seeking coverage for these services?	Yes ◯	No ◯
d. Do you provide hospital emergency room services?	Yes ◯	No ◯
If yes, how many hours per month?		
Is the emergency room care only for your patients?	Yes ◯	No ◯
Is the emergency room care required for staff privileges?	Yes ◯	No ◯
Does the hospital cover you for malpractice for emergency room care?	Yes ◯	No ◯
Are you seeking coverage for these services?	Yes ◯	No ◯

15. Do you offer professional advice to the public (website, radio, TV, etc)?	Yes ◯	No ◯
If yes, please provide details:		

16. Do you advertise or prescribe any off-label use of drugs?	Yes ◯	No ◯
If yes, please provide details:		

17. Do you anticipate any changs in your practice in the next 12 months?	Yes ◯	No ◯
If yes, please provide details:		

STAFF INFORMATION

18. Please provide the number of professionals you employ or with whom you contract to provide services, and confirm whether they carry their own medical malpractice coverage:

	Employed	Contracted	Insured elsewhere?		Coverage desired?	
Physicians			Yes ◯	No ◯	Yes ◯	No ◯
Physicians Assistants			Yes ◯	No ◯	Yes ◯	No ◯
Nurse practitioners			Yes ◯	No ◯	Yes ◯	No ◯
Surgical Assistants			Yes ◯	No ◯	Yes ◯	No ◯
CRNAs			Yes ◯	No ◯	Yes ◯	No ◯
Chiropractors			Yes ◯	No ◯	Yes ◯	No ◯
RNs			Yes ◯	No ◯	Yes ◯	No ◯
LPNs, Nurse Aids			Yes ◯	No ◯	Yes ◯	No ◯
Other:			Yes ◯	No ◯	Yes ◯	No ◯
Other:			Yes ◯	No ◯	Yes ◯	No ◯

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19. Are all the above individuals licensed in accordance with applicable state and federal regulations?	Yes ◯	No ◯
If no, please provide an explanation:		

20. For any Physician Assistants or Nurse Practitioners noted above, do you maintain practice agreements, delegation of service agreements, collaboration agreements, or the equivalent with such providers where/as required by state law?	Yes ◯	No ◯

If yes, please attach a list separately of all that qualify

NON-SURGICAL PROCEDURES

21. Does your practice include prescribing opioids?	Yes ◯	No ◯
a. If yes, what percentage of your practice is derived from opioid prescriptions?		%
b. Do you fully comply with the CDC Guideline for Prescribing Opioids?	Yes ◯	No ◯
c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business?	Yes ◯	No ◯
d. Do you also dispense the opioids?	Yes ◯	No ◯

22. Does your practice include pain management?	Yes ◯	No ◯
a. If yes, what percentage of your practice is Prescription Only Pain Management?		%

23. Please indicate the procedures you perform (check all that apply):			
Category 1:			
☐	Facet Joint Blocks	☐	Radio Frequency Nerve Ablation
☐	Lesioning	☐	Rapid Opiate Detoxification
☐	Percutaneous Discectomy	☐	Selective Nerve Root Block
☐	Percutaneous Endoscopic Nerve Root Decompression	☐	Sympathetic Blocks
☐	Peripheral Nerve Block	☐	Trigger Point Injections
Category 2:			
☐	Dorsal Column Simulator Implants/Reprogramming	☐	Epidural or Spinal Catheters
☐	Spinal Infusion Implants/Pumps	☐	Vertebroplasty
☐	Intradiscal Electrothermal Therapy	☐	Discectomy
☐	Peripheral Nerve Stimulation		

24. Does your practice include weight management?	Yes ◯	No ◯
a. If yes, please provide a brief description of your weight management practice below:		
b. What percentage of your practice is derived from weight management?		%
c. What percentage of your patients are treated exclusively for weight management?		%
d. Please list the following:		
Weight loss drugs prescribed:		
Weight control supplements dispensed:		

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	Weight control injection medications in use:		
e.	Are any weight loss drugs compounded?	Yes ◯	No ◯
	If yes, what percentage?		%
	If yes, are they being compounded with sodium or acetate?	Yes ◯	No ◯
f.	Do you use written informed consent documents for all treatments?	Yes ◯	No ◯
	If yes, attach a copy of all forms in use. If no, please explain in the space below:		
g.	Is blood work performed prior to treatment?	Yes ◯	No ◯
h.	Are physical exams performed prior to treatment?	Yes ◯	No ◯

25. Please indicate any alternative and other procedures that may apply to your practice:

☐ Abortion or abortion reversal medication	☐ Acupuncture
☐ Alternative Cancer Treatments – non-chemo (describe below)	☐ BHRT Pellets, testosterone injections
☐ Botox Injectors for Pain or Cosmetics	☐ Chelation Therapy
☐ Chemobrasion/Dermabrasion	☐ Covid 19 treatments (describe below)
☐ Cryotherapy	☐ Electroshock Therapy
☐ Erectile Dysfunction Treatments	☐ Hair Transplants
☐ HBOT - elective	☐ HBOT – wound care
☐ Hypnotherapy	☐ IV hydration/vitamin injections
☐ Ketamine Therapy	☐ Lithotripsy
☐ Medical marijuana evaluation	☐ Mesotherapy
☐ Naturopathy/Homeopathy/Herbal Medicine	☐ Needle biopsies
☐ Osteophathic/Chiropractic Manipulation - no anesthesia	☐ Osteophathic/Chiropractic Manipulation - under anesthesia
☐ Ozone Therapy	☐ Neural therapy
☐ Rapid Opiate Detoxification	☐ Prolotherapy
☐ Regenerative Medicine – stem cells or exosomes	☐ Regenerative Medicine – Other
☐ Transcranial magnetic stimulation (TMS)	☐ Sclerotherapy
Other:	

Please provide additional details on requested procedures above or Other treatments offered

SURGICAL PROCEDURES

26. Do you perform any type of surgery, including minor surgery *(other than incision of boils or superficial abscesses or suturing skin and superficial fascia)*?	Yes ◯	No ◯

If No to the question above, please skip to Question 33. If yes, to any of the above, please continue with questions below.

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27. Do you assist in surgery on your own patients?	Yes ◯	No ◯

28. Do you assist in surgery on patients of others?	Yes ◯	No ◯

29. Do you perform surgery in your office?	Yes ◯	No ◯
If yes, please list the surgical procedures in the space below:		

30. Do you perform surgery in other non-hospital facilities?	Yes ◯	No ◯
If yes, please list the surgical procedures and type of facility in the space below:		

31. In the course of surgery, does a Board Certified Anesthesiologist provide the anesthesia?	Yes ◯	No ◯
If no, please explain in the space below:		

32. Please indicate the surgical procedures you perform (check all that apply):	
☐ Abortions	☐ Angiography/Arteriography
☐ Angioplasty	☐ Cardiac Catheterization
☐ Bariatric surgery (list procedures below)	☐ Cholecystectomies – open/other
☐ Cryosurgery/Malignant Lesions	☐ Cholecystectomies – laparoscopic
☐ Dilation & Curettage (D&C)	☐ Endoscopic Procedures
☐ Fertility/Infertility treatments	☐ Hysterectomies – open/other
☐ Interventional Radiology	☐ Hysterectomies – laparoscopic
☐ Neurosurgery	☐ Orthopedic Surgery – Spine
☐ Organ Transplants	☐ Orthopedic Surgery – Other
☐ Plastic Surgery - Reconstructive	☐ Plastic Surgery – Elective
☐ Radiation Therapy (including implants)	☐ Research/Clinical Trials
☐ Sex Change Operations (list procedures below)	☐ Surgical procedures for research
☐ Tonsillectomies/Adenoidectomies	☐ Spinal Surgery
☐ Vasectomies/Reversals	☐ Vascular/Thoracic Surgery
☐ Vision Correction (list procedures below)	☐ Other Surgical Procedures (list below)
Cosmetic Surgery	
☐ Breast Augmentation	☐ Breast Reduction
☐ Fat Recycling (list body parts below)	☐ Liposuction (list max cc's below)
☐ Silicone Implants (list body parts below)	☐ Penile Lengthening/enhancements
Please provide additional details on requested procedures above	

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INSURANCE HISTORY

33. Are you being cancelled or non-renewed by your current insurer for similar professional liability or medical malpractice insurance?	Yes ◯	No ◯

34. Medical Professional Liability/Medical Malpractice Insurance History (last 5 years)					
Insurer	Policy Period	Limits of Insurance	Deductible	Premium	Retro Date
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

LOSS HISTORY

For any "Yes" answers to the following questions, please provide detailed information in the Supplemental Information section of this application or provide separate attachments.

35. Has any insurance company ever rescinded, cancelled or non-renewed a professional liability or medical malpractice policy for any applicant? **If "Yes", please explain in the space provided below.**	Yes ◯	No ◯
36. Has the applicant or any other person proposed for this insurance ever been subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? **If "Yes", please provide a copy of the Complaint and Consent Order.**	Yes ◯	No ◯
37. Has the applicant or any other person proposed for this insurance ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered such license? **If "Yes", please explain in the space provided below**	Yes ◯	No ◯
38. Has the applicant or any other person proposed for this insurance ever been convicted for an act committed in violation of any law or ordinance, other than traffic offenses? **If "Yes", please explain in the space provided below.**	Yes ◯	No ◯
39. Has the applicant or any other person proposed for this insurance ever been treated for or required to be evaluated for alcoholism or drug addiction or undergone personal psychiatric treatment? **If "Yes", please explain in the space provided below.**	Yes ◯	No ◯
40. Has any claim ever been made, or suit ever been filed against the applicant or any other person proposed for this insurance? **If "Yes", please complete supplemental claim/incident form for each.**	Yes ◯	No ◯
41. Is the applicant or any other person proposed for this insurance aware of any known losses, claims or suits that have not yet been reported? **If "Yes", please complete supplemental claim/incident form for each.**	Yes ◯	No ◯
42. Is the applicant or any other person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from a patient or their attorney which may result in a claim? **If "Yes", please complete supplemental claim/incident form for each.**	Yes ◯	No ◯

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SUPPLEMENTAL INFORMATION

Please use this section to provide additional details for Questions 35-42, or for any other questions requiring additional space for answers.

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO CALIFORNIA INSUREDS: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposeof defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant Signature _____ **Title:** _____

(Must be signed by an owner, principal, partner or officer) **Date:** _____