South Pinellas Medical Trust
2727 16th Street N
St. Petersburg, FL 33704

ASSESSABLE POLICY

Professional Liability Insurance Application

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1. **Your Name:** ____

2. **Name of Corporation/ Partnership/ Association**:

____

3. **Mailing Address:** ____

____

4. **Social Security #:** ____________________ **Date of Birth:** ____________________

   Employer Tax ID #: ____________________ **County:** ____________________

5. **All Business Location Addresses:** ____

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   Phone #__________________ **Fax #**__________________ **Office contact name:**__________________

   Email address: ______________________________

6. **Professional Liability Limits you are requesting:**

   $250,000 per claim/ $750,000 annual Aggregate,

   $500,000/ $1,000,000 **$750,000/ $1,500,000** **$1 million/ $2 million**

   Billing Cycle Preference: **ANNUAL,** **SEMI-ANNUAL,** **QUARTERLY**

7. **Effective Date of Coverage:** ____________________ **Retroactive Date:** ____________________

8. **Have there been any complaints against you to any health regulatory agency?** **Y** **N**
   (If yes, provide details on page 7.)

9. **Have you ever had any claim or suit against you?** **Y** **N** **(If yes, provide details on page 7.)**

   Are you aware of any circumstances that might lead to such a claim? **Y** **N**
   (If yes, provide details on page 7.)

10. **Are you Board Certified?** **Y** **N**

    Did it take you more than three attempts to pass any section of the Boards? **Y** **N**

    If yes, how many times did you take the Boards before you passed them? ______________

NOTE: If you have other licensed health-care professionals in your practice, we require that they have their own professional liability insurance coverage. Please submit evidence of their insurance with this application, if currently available, or as soon as evidence becomes available.

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UNDERWRITING DATA: PROFESSIONAL LIABILITY

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Note: Every question must have an answer. Do not leave any gaps in dates following graduation from college. If more space is needed, attach additional pages.

11. College: ____

Dates of attendance: ____________________ **Yr. Graduated:** ____________________

12. Medical School: ____

Dates of attendance: ____________________ **Yr. Graduated:** ____________________

13. Post Graduate Training, Residency, Fellowship, etc.

Type	**From**	**To**	**Completed?**
a.______________________	__________	__________	__________
b.______________________	__________	__________	__________
c.______________________	__________	__________	__________

If foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?

Yes **No**

14. Dates and places you practiced medicine.

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15. Medical Specialty ____________________ **Sub-Specialty:** ____________________

a. What percentage do you practice your sub-specialty? ____________________

b. If part-time, date began: __________, **days working:** __________, **hours per wk:** __________

c. Indicate average weekly patient load: ______________________________

d. Percentage of practice outside Fla: ______________ **(not covered by us).**

e. Percentage of practice devoted to practicing as locum tenens. __________

16. Your Florida medical license number: __________ **expiration date:** __________

Your Narcotics license number: __________

Has your license to practice medicine in any state (or narcotics license) ever been revoked, suspended or subject to probation? Yes No (A "Yes" answer requires an explanation)

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17. A. Please indicate membership:

1) Board Certified: No Yes - name of Board(s): ______________________________

2) Board Eligible: No Yes - date of exam: ______________________________

3) Board Qualified (complete required training) No Yes

If Board Eligible for over 5 years, but not Board Certified, please explain: ______________

____

____

4) Medical Organizations: County: __________ State: __________ National: __________

B. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked or voluntarily surrendered?

No Yes- explain: ____

____

18. A. Do you practice medicine, in whole or in part, as an employee of or consultant to a commercial enterprise, governmental body, military service, educational facility or professional sports organization?

No Yes - for whom? ____________________ Constituting what percentage of your practice? ____________

B. Are you contracted or employed in an Emergency Room? No Yes - specify your duties and number of hours per month:

C. Approximate number of emergency surgeries annually: ______________________________

D. Are you under contract to a PPO, HMO, or IPA? No Yes

E. Are you under contract in any capacity involving the practice of medicine which increases your liability exposure (except with your P.C.)? No Yes - please attach a copy of your contract.

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19. A. Check appropriate box: Solo Practice Partnership Professional Corporation (other than individual P.C.) Group Practice

If you are not in solo practice, please name other physicians below or attach a list. (NOTE: Each physician must complete a separate application.)

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____

B. Is there any physician, not named above, who practices within your office premises? No Yes
State relationship.

Space Sharing:
Other:

C. The business, corporate or partnership name is:

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20. A. Do you employ any of the following support personnel? If so, please list how many: Also, if they are licensed, they are to carry individual professional liability coverage. Please enclose a copy of coverage

Med Lab Tech ____________ LPN ________________ X-Ray Tech __________________
Pharmacist ____________ RN __________________ Physiotherapists _______________
Scrub Nurse __________ Optometrists __________ Psychologists __________________
Med. Assistant ________ Optician ______________ Other: _______________________

B. 1. Midwife ___________________
2. CRNA _____________________
3. Nurse Practitioner ___________
4. Physician Assistant ___________
5. Surgeon Assistant ____________
6. Paramedic ___________________
7. O/R Tech ____________________

C. If you employ any personnel in categories B 1-6, please name and describe their qualifications and duties: ____
____

D. Are any of the above independent contractors? No Yes
If independent contractors, do they have individual coverage, independent of you?
No Yes

21. Do you perform chelation therapy? No Yes - Explain: ____
____

22. Do you administer X-Ray therapy? No Yes

23. Do you administer shock therapy? No Yes (other than cardioversion)

24. If you perform (not just interpret) any of the following specialty procedures, indicate by checking the appropriate procedure:

A.
1. Colonoscopy
2. Endoscopic Retrograde Cholangiopancreatogoraphy
3. Laparoscopy (Peritonoscopy)
4. Discograms
5. Needle Biopsy (lung & prostate only)
6. Epidural Steroid Injections
7. Radiopaque Dye Injection into blood vessles, lymphatics, sinus tracts and fistulae

B.
1. Acupuncture (other than acu- puncture anesthesia)
2. Coronary Balloon Angioplasty
3. Balloon Valvoplasty
4. Cathererization (arterial, cardiac, diagnostic)
5. Swan-Ganz
6. Lymphangiography
7. Myelography
8. Phlebography
9. Pneumoencephalography

C.
1. Temporary Pacemaker insertion
2. Balloon Valvoplasty
3. Permanent Pacemaker insertion
4. Intraortic Balloon Placement
5. Use of Chymopapain
6. Hair Transplants
7. Dermabrasion
8. Injection of silicones
9. Shock Therapy

Gastroenterology - Special Procedures

1. Laser
2. Colonoscopy with Polypectomy
3. Upper Endoscopy with Polypectomy
4. Sclerotherapy
5. Gastric Bubble

25. A. **Do you perform or assist in organ transplantation? No Yes- Explain: ______________________**
____ Number of procedures: __________________________

B. **Do you perform or assist in any:**
1. **experimental surgery or procedures? No Yes- Explain: ______________________**
____ Number of procedures: ________________________

2. **investigational surgery or procedures? No Yes- Explain: _________________________________**
____ Number of procedures: __________________________

26. A. **Do you use lasers? No Yes- Explain:____**
____

B. **Do you use Botox? No Yes- Explain:____**
____

C. **Do you perform vein Sclerotherpy? No Yes- Explain:______________________________________**
____

D. **Do you give Collegen injections? No Yes- Explain:____**
____

27. A. **Do you perform procedures and/or surgery for weight control? No Yes- Name them: ________**
____ Number of procedures: ________________

B. **Do you prescribe or dispense drugs for weight control? No Yes- to what percent of your patients? ______%.**
Name weight control medications prescribed: ____
____

28. **Do you perform or engage in any surgical procedure in your office, surgi-center or other similar non-hospital facility during the course of which anesthesia (other than topical, drugs such as Valium or Demerol, or by means of local infiltration) is administered either by you or others? No Yes - Explain: _______________**
____

B. **If a surgi-center, is it state licensed? No Yes**

How many CRNA's are in your employment? ____

Attach the following:

1. **Written CRNA practice protocol including emergency situations when MDA is not present.**
2. **CRNA job description including procedures performed by CRNA without direct supervision of MDA.**
3. **Employment or service contracts.**

29. **Do you prescribe or recommend Medical Marijuana? ☐ Yes ☐ No. If so what percentage of you practice is this? _______________.**

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30. Do you perform surgery? No Yes - complete the following:

	% of Procedures	**Approximate Number of Procedures Annually**
Minor Surgery (Other than incision of boils and superficial abscesses or suturing of skin and superficial fascia)		
Major Surgery *		
Assisting in Surgery: On own patient only ____________________ Patients of others	____________________	____________________
Cosmetic Plastic Surgery		
Obstetrics		
Thoracic		
Vascular		
Orthopaedic		

* Tonsillectomies, Adenoidectomies, Cesarean Sections, Abortions and Open Fracture Reductions are Major Surgery.

Does your practice include pre-natal care for high risk pregnancies? No Yes - please explain: ___________

Also, if you are an OB/GYN do you participate in NICA? □ No □ Yes-Please enclose copy of current certificate.

31. A. Name hospitals in which you have staff membership or privileges: ______________________________

B. Nature and privilege at each: ____

C. If easily available, attach a copy of Delineation of Privileges Form from all hospitals in which you have privileges. Delete procedures that you do not perform.

D. Has any hospital ever restricted, suspended, or revoked your privileges or invoked probation?
No Yes - Explain: ____

E. Have your hospital privileges been expanded during the last 12 months, to include procedures for which you completed additional required training by the State Licensing Board and/or your Board Specialty? No Yes

32. Have Medicaid authorities brought documented charges against you for alleged inappropriate fees?
No Yes - Please explain on a separate sheet and attach it to this application.

33. Have you ever been indicted in a criminal suit? No Yes - Please explain on a separate sheet and attach it to this application.

34. Have you ever been treated for alcoholism or drug addiction which has or could impair your ability to practice medicine? No Yes - Explain, giving full details. ______________________________________

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35. **Have you now, or have you ever had any chronic physical defect or emotional impairment which inhibited your practice of medicine No Yes - Describe fully: ____**

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36. **A. Has your malpractice insurance ever been cancelled, non-renewed, restricted or special rated, or have you ever received a letter from your carrier of such intent? No Yes - When? ____________________ Please explain: ____**

B. Name of current carrier: ____
Effective Date: ________________________________ Limits of Liability: __________________________________

C. An Extended Reporting Period is generally available as an option of your expiring policy.
(1) Are you exercising this option? No Yes. If eligible,
(2) Do you want SPMT to afford coverage for prior acts (claims for incidents which may have occurred, but as yet no indication thereof has been made to you)? No Yes
(3) Date you wish Prior Acts Coverage to begin: ____
(4) Have all circumstances that might reasonably lead to an incident, claim or suit been reported to your current or prior professional liability carrier? No Yes
(5) Provide description of any changes during the last five years in: specialty, procedures, certifications, partnerships, contracted activities or association (services provided under a different insurance carrier other than prior carrier): ____

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37. **Have there been any formal complaints made against you in your practice of medicine? This includes regulatory agency complaints, hospitals, etc. No Yes - Explain ____**

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38. **Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of any circumstances (with or without merit) that might reasonably lead to such a claim or suit? No Yes - Give full details below.**

A.
Patient's Name: ____
Carrier: ____ Date of Occurrence: ________________________________
Allegations: ____

____

____

Amount of Settlement (or if pending, amount in reserve by carrier): ____
Date Claim Settled: ____

B.
Patient's Name: ____
Carrier: ____ Date of Occurrence: ________________________________
Allegations: ____

____

____

Amount of Settlement (or if pending, amount in reserve by carrier): ____
Date Claim Settled: ____

C.
Patient's Name: ____
Carrier: ____ Date of Occurrence: ________________________________
Allegations: ____

____

____

Amount of Settlement (or if pending, amount in reserve by carrier): ____
Date Claim Settled: ____

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39. **Please complete:**

Past Years	Professional Liability Insurer	Limit of Liability per Claim/Aggregate	Policy Period	(Check one) "Claims Made" or "Occurrence"
1				
2				
3				
4				
5				

If further space is required, please attach a separate sheet. When listing additional suits, please include name, carrier, date of occurrence, allegations and amount of settlement or reserve. Additional information may be required.

ATTACHMENTS SHOULD INCLUDE:

1. **A COPY OF THE COVER SHEET OF YOUR PRIOR OR CURRENT PROFESSIONAL LIABILITY COVERAGE**
2. **A COPY OF YOUR CURRENT CURRICULUM VITAE**
3. **A RECENT PHOTOGRAPH OF YOURSELF**
4. **LIST THE PHYSICIANS THAT YOU COVER FOR AND WHO COVER FOR YOU**
5. **LIST THREE SOUTH PINELLAS MEDICAL TRUST MEMBERS AS REFERENCES. A LIST IS AVAILABLE AT THE TRUST OFFICE FOR YOUR REVIEW. IF YOU ARE NEW TO THE AREA AND NOT JOINING AN EXISTING TRUST MEMBER'S PRACTICE AND DO NOT KNOW ANY MEMBERS, PLEASE LIST THREE NON-MEMBERS ALONG WITH PHONE NUMBERS.**

This questionnaire is the basis for coverage. Therefore, any incorrect or incomplete statements or answers could nullify coverage.

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.

I understand that, as a condition of my consideration for Insurance with South Pinellas Medical Trust (SPMT), or as a condition of my continued Insurance with SPMT, SPMT may obtain a consumer report that includes, but is not limited to, my creditworthiness or similar characteristics, Insurance and education verifications, social security verification, criminal and civil history, personal interviews, DMV records, any other public records and any other information bearing on my credit standing, credit capacity, character, general reputation, personal characteristics and trustworthiness. I hereby authorize and consent to SPMT'S procurement of such a report. I understand that, pursuant to the federal Fair Credit Reporting Act, SPMT will provide me with a copy of any such report if the information contained in such report is, in any way, to be used in making a decision regarding my fitness for Insurance with SPMT. I further understand that such report will be made available to me prior to any such decision being made, along with the name and address of the reporting agency that produced the report.

I hereby warrant and represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my protection.

______________________________ ____________________

Signature in Full | Date

Section 817.234(1) (b), F.S. "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, or misleading information is guilty of a felony of the third degree."

______________________________ A276436

Agent's Signature | Agent's License Number

**APPLICATION FOR INDIVIDUAL MEMBERSHIP IN THE
SOUTH PINELLAS
MEDICAL MALPRACTICE RISK MANAGEMENT ASSOCIATION**

Applicant's Name: ____

Applicant's Home Address: ____

____

Telephone Number: ____

Applicant's Principal Business Address: _____________________________________

____

Telephone Number: ____

I, ____, hereby formally apply for membership in the South Pinellas Medical Malpractice Risk Management Association (hereinafter referred to as the "Association") and in doing so warrant and represent that:

(1) I am a medical doctor duly licensed to practice medicine in the State of Florida;

(2) The applicant information set forth above is accurate to the best of my knowledge;

(3) I have read and understood the Rules and Regulations of the Association, including the assessment provisions contained therein, and agree to be bound (upon the effective date of the acceptance of this application as hereinafter provided) by the provisions thereof; and

(4) I have read and understood the South Pinellas Medical Malpractice Risk Management Self-Insurer's Fund Professional Liability Insurance Policy (hereinafter referred to as "Policy"), including the declaration and any endorsements a part thereof, that will be issued to me in the event of my acceptance as a member of the Association.

I understand that this application also constitutes an application for insurance for purposes of the Policy and that any willful misrepresentation of a material fact herein contained shall constitute grounds for cancellation of the Policy and expulsion from the Association.

EXECUTED this _____________________day of ______________________, 20_____.

____
APPLICANT