APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

CLAIMS-MADE PROFESSIONAL LIABILITY RENEWAL APPLICATION

For Physicians & Surgeons

A' A Prime Unsurpassed Financial Stability Rating® Demotech, Inc.

Ed.9/2013

GENERAL INFORMATION

Policy Number | **Renewal Date** | **Broker**

Policyholder's Full Name | **Practice Website**

Principal Office Practice Address

Mailing/Billing Office Address

Office Phone | **Office Fax** | **E-Mail Address**

PRACTICE AND UNDERWRITING INFORMATION

(Please explain all "Yes" answers in the "Supplemental Section" of the Renewal Application)

1. Has your practice location(s) and/or contact information changed since your last application to us?	☐ **Yes** ☐ **No**
2. Have you formed a new corporation? If yes, please provide name of corporation and date formed.	☐ **Yes** ☐ **No**
3. Do you desire coverage for any existing or new professional corporations? If yes, please provide formal name of corporation.	☐ **Yes** ☐ **No**
4. Are you Board Certified? If yes, indicate specialty and date.	☐ **Yes** ☐ **No**
5. Do you provide services at a nursing home, skilled nursing facility or assisted living center? If yes, indicate the % of your practice devoted to these services.	☐ **Yes** ☐ **No**
6. Please indicate the average number of hours you work per week (include office hours, administrative activities for your practice as well as any hospitals, procedures, direct patient care, consultations, etc.) ☐ 10 hours or less per week ☐ 11 to 20 hours per week ☐ 21 to 30 hours per week ☐ 31 hours or more per week	
7. Please indicate the practice hours to be insured by AMS RRG:	
8. If part-time, when did you begin practicing on a part-time basis?	
9. Estimate the number of patients you see on an average day of clinical practice:	

PRACTICE AND UNDERWRITING INFORMATION

(Please explain all "Yes" answers in the "Supplemental Section" of the Renewal Application)

Please answer the following questions. Have you EVER:	
10. Had or become aware of any chronic illness or physical defect that impairs or could possibly impair your ability to practice any aspect of medicine?	☐ **Yes** ☐ **No**
11. Been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, non-renew or revoke your clinical privileges?	☐ **Yes** ☐ **No**
12. Been treated, evaluated, or hospitalized for any of the following disorders? (Please check all that apply) ☐ Alcohol ☐ Narcotics ☐ Central nervous systems stimulants or depressants ☐ Mental or emotional disorders	☐ **Yes** ☐ **No**
13. Been indicted and/or convicted of a crime other than minor traffic violations?	☐ **Yes** ☐ **No**
14. Been under investigation by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your narcotics license ever been denied, revoked, suspended or limited in any way?	☐ **Yes** ☐ **No**
15. Had Medicare/Medicaid fraud charges filed against you?	☐ **Yes** ☐ **No**
16. Been suspended, restricted, or put on probation by any governmental health program (e.g. Medicare or Medicaid)?	☐ **Yes** ☐ **No**
17. Since your last application to us, have there been any judgments, settlements, or dismissals of any previously reported claims, regardless of insurance carrier?	☐ **Yes** ☐ **No**

In order to determine eligibility and qualify for a loss free discount on the renewal of your medical malpractice insurance through AMS RRG, Inc., please submit a recently valued loss run (dated within the most recent 60 days) from all previous insurance carriers and return with this completed renewal application.

ADDITIONAL HEALTHCARE PROVIDERS

18. Please indicate if you employee or contract and of the following Healthcare Providers:

Healthcare Provider	**Number Employed**	**Coverage Needed**	**# Independent Contractor**	**Coverage Needed**
Physician Assistant		☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**
Surgical Assistant		☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**
Anesthesia Assistant		☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**
Certified Nurse Midwife		☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**
Certified Nurse Practitioner		☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**
Certified Registered Nurse Anesthetist		☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**

Healthcare Provider Name	**Designation/ Type**	**Employed**	**Contracted**	**Supervise only**	**Limits Shared (S) Separate (P) Other Insurer (O)**
		☐	☐	☐	☐ **S** ☐ **P** ☐ **O**
		☐	☐	☐	☐ **S** ☐ **P** ☐ **O**
		☐	☐	☐	☐ **S** ☐ **P** ☐ **O**

19. If you supervise Certified Nurse Practitioners, Nurse Midwives, or Physicians Assistants, what is the average Paramedical Employee/Physician Ratio?	_____%
20. Does any of the Paramedical Employees (excluding physicians) practice at a location geographically separate from yours? If YES, describe.	☐ **Yes** ☐ **No**

SPECIALTY CLASSIFICATION SECTION

21. Has your specialty or procedures performed changed since your last application to us? **Please indicate your specialty here:**	☐ **Yes** ☐ **No**
22. Do you solicit or advertise to weight control patients?	☐ **Yes** ☐ **No**
23. Do you prescribe medications for weight loss? (If yes, indicate the medications in the Supplemental Section.)	☐ **Yes** ☐ **No**
24. Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? If yes, please describe.	☐ **Yes** ☐ **No**

25. Cosmetic Procedures – Please Check All That Apply					
☐	Abdominoplasty	☐	Blepharoplasty	☐	Coronal Lift
☐	Hair Implants	☐	Penile Cosmetic Surgery	☐	Sex Reassignment Surgery
☐	Autologous Fat Injection	☐	Breast Augmentation	☐	Breast Reduction
☐	Endoscopic Forehead Lift	☐	Implants other than Breast	☐	Rhinoplasty (cosmetic)
☐	Thread Lift	☐	Breast Reduction	☐	Facial Laser Resurfacing
☐	"Lifestyle" Lift	☐	Rhytidectomy	☐	Other (Describe below)
☐	Large Volume Liposuction (over 5,000 cc) in a Hospital				
☐	Large Volume Liposuction (over 5,000 cc) in a Freestanding Surgery Center or Surgical Suite				
Please use the Supplemental Information Worksheet to provide any further details regarding these procedures					

26. Please indicate if you or any of your staff perform the following procedures:			
Procedure	**Physician**	**Non-Physician Licensed Staff**	**Non-Licensed Staff**
Botox Injections	☐	☐	☐
Chemical Peel	☐	☐	☐
Collagen Injections	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Micro-Dermabrasion	☐	☐	☐
Permanent Make-up	☐	☐	☐
Sclerotherapy	☐	☐	☐
Other _____	☐	☐	☐

27. Please answer the following questions:	
Are you credentialed to provide Conscious sedation?	☐ **Yes** ☐ **No**
Moderate Sedation	☐ **Yes** ☐ **No**
Deep Sedation	☐ **Yes** ☐ **No**
Are you certified in ACLS?	☐ **Yes** ☐ **No**
Are you certified in ATLS?	☐ **Yes** ☐ **No**
Are you certified in PALS?	☐ **Yes** ☐ **No**
Do you perform any procedures, techniques, or treatment modalities that are not typical of your specialty or that required separate hospital credentialing? If yes, please describe these procedures.	☐ **Yes** ☐ **No**

28. Please indicate if you have completed 4 hours of risk management CME's through Law & Med during the preceding policy year, which entitles you to a 2% premium discount at renewal:	☐ **Yes** ☐ **No**

GROUP POLICES ONLY

29. If rated on a "per visit" basis, please indicate the actual number of patient visits for the current policy year, and the projected number of patient visits for the next policy year. For all, use annualized visits.

Type of Visit	Current Visits	Projected Visits
ED Patient Visits		
Fast Track/Ambulatory Patient Visits		
Hospitalist Patient Visits		

30. For all group policies, please provide roster of all active and inactive physicians/physician extenders, including specialty, hours worked per week, Board Certified, retroactive dates and termination dates (if applicable).

Physician/ Physician Extender Name	Specialty	Hours Worked Per Week	Board Certified (Y/N)	Retroactive Date	Termination Date

31. Indicate all hospital locations where services are currently being provided. Please include the state, start date of contract, and termination date of contract (if applicable).

Name of Hospital	State	Retroactive Date	Termination Date

If prior acts coverage is being provided by AMS RRG, please provide recently valued loss runs (dated within the most recent 60 days) from all previous insurance carriers and return with this completed renewal application.

SUPPLEMENTAL INFORMATION WORKSHEET

Please use this page to provide all additional information that you feel is necessary to accurately complete the application. Please label each answer with the question that it applies to within this application.

Question # **Answer**

PHYSICIAN OR AUTHORIZED REPRESENTATIVE CERTICATION

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts. I agree to immediately notify the company in writing if there is any future material change in any answer to this application, including without limitation, any change in my professional status, specialty, affiliation, or working arrangement with any other physician, firm, or professional association, and I understand and agree that such changes are material to the risks covered by the policy of insurance I am applying for.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) offered me a premium quote, and (3) received, as a precondition to coverage, the total premium due or, if the company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the company any information regarding me, which the company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

NOTICE TO FLORIDA APPLICANTS

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, incomplete or misleading information is guilty of a felony in the third degree.

By your signature, you indicate to all the rules and regulations set by Applied Medico-Legal Solutions Risk Retention Group

Print Name:_____

Insured Signature or Authorized Representative:_____ Date:_____

Please remit your completed application to:

Applied Medico-Legal Solutions Risk Retention Group, Inc.
c/o Best Practices Insurance Services, LLC
23 Route 31 North, Suite A-20
Pennington, New Jersey 08534

Phone: 609-737-1154
Toll-free 866-461-1221
Fax: 609-737-1186