APPLIED MEDICO-LEGAL SOLUTIONS
RISK RETENTION GROUP, INC.

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

For Physician Extenders

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

Ed.03/17

APPLIED MEDICO-LEGAL SOLUTIONS
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APPLICATION INSTRUCTIONS & CHECKLIST

We would like to thank you for taking the time to apply to Applied Medico-Legal Solutions Risk Retention Group, Inc. (AMS RRG). You are joining physicians across the country that have helped AMS RRG grow into one of the most successful medical liability insurance risk retention groups. Below, is a checklist which will help you in completing our application.

- ☐ **All questions must be answered. Write in, "I do not know," if necessary.**
- ☐ **The Supplemental Information Worksheet is available to provide any additional information requested or to better explain you're answers.**
- ☐ **Complete the claim/suit section of the application for each reported claim as thoroughly as possible providing brief narrative description of each claim.**
- ☐ **A "No Known Loss" Letter, attached to this application.**
- ☐ **Please enclose a copy of the following with your application:**
  - ☐ **Copy of Certificate or Licensure**
  - ☐ **Purchased Extended Reporting Endorsements**

INSURANCE NOTICE

Insurance coverage is subject to underwriting approval and payment of the initial premium. This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services, and B) are first made against you and are reported to the company while the policy is in force.

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GENERAL INFORMATION

First Name	Middle Name	Last Name		
Social Security Number		Date of Birth	Female	Male
- -		/ /	☐	☐
Requested Effective Date:			/ /	
Requested Retroactive Date (What date do you need coverage back to?):			/ /	
Current Policy Expires:			/ /	

Office Phone Number	Cell Phone Number	Home Phone Number
( ) -	( ) -	( ) -
Fax Number	Practice Web Site Address	E-Mail Address
( ) -		

Primary Practice Street Address			Bldg./Suite
County	City	State	Zip Code
Number of years at current location:		Percentage of your practice at this location:	

EDUCATION

School/Hospital	Location	Dates	Degree/Certification

PRACTICE INFORMATION

Type of Physician Extender – Classification (please check one):			
☐	Physician Assistant (PA)	☐	Certified Nurse Midwife (CNM)
☐	Nurse Practitioner (NP)	☐	Surgeon Assistant (SA)
☐	Certified Registered Nurse Anesthetist (CRNA)	☐	O.R. Technician
☐	Optometrist	☐	Psychologist
☐	Physical Therapist	☐	Chiropractor

Are you a/an (please check one):			
☐	Employee	☐	Independent Contractor
☐	Practice Owner	☐	Other (describe) _____

Please indicate your Employer's Name:	
Please indicate Employer's AMS RRG Policy Number:	
Please indicate Supervising Physician Name:	
Do you practice at the same location as the supervising physician:	**☐ Yes ☐ No**
Please indicate the average number of hours you work per week at this medical practice:	
Please provide explanation of duties and scope of practice for which coverage is being requested:	

Please check if you perform the following procedures	Total Number of Procedures Projected for the Next 12 Months	Physician Supervised	Type of procedure
☐		**☐ Yes ☐ No**	Botox Injections
☐		**☐ Yes ☐ No**	Chemical Peel
☐		**☐ Yes ☐ No**	Collagen Injections
☐		**☐ Yes ☐ No**	Cosmetic Tattooing
☐		**☐ Yes ☐ No**	Laser Hair Removal
☐		**☐ Yes ☐ No**	Laser Wrinkle Removal
☐		**☐ Yes ☐ No**	Micro-Dermabrasion
☐		**☐ Yes ☐ No**	Permanent Make-up
☐		**☐ Yes ☐ No**	Sclerotherapy
☐		**☐ Yes ☐ No**	Other _____
For any procedure that you are performing, please provide proof of training and/or certification			

PRIOR PRACTICE EXPERIENCE

Please list all of your practice locations for the past ten (10) years other than your current practice. Please explain any gaps in your practice of medicine on the Supplemental Information Worksheet.

Practice Name	County	State	Start-End Dates

INSURANCE HISTORY

Please detail your insurance carriers for the previous fifteen years. Please explain any gaps in your coverage on the Supplemental Information Worksheet.

Dates Mo/Yr		Insurance Carrier	Policy #	Type of Policy	Retroactive Date
From	To				
/	/				
/	/				
/	/				
/	/				

Have you ever practiced without insurance or allowed a clams-made policy to lapse without the purchase of tail or nose coverage?	☐ **Yes** ☐ **No**
Have you ever had professional liability insurance refused, declined, non-renewed, cancelled, or accepted on special terms?	☐ **Yes** ☐ **No**
Have you ever been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge?	☐ **Yes** ☐ **No**
→ If you answered YES to any of the above three questions, please proved a detailed explanation on the Supplemental Information Worksheet.	

Do you require Shared or Separate Limits of Liability?	☐ **Shared** ☐ **Separate**
If you selected separate limits of liability, please indicate the Limits of Liability you are requesting listed as per claim/yearly aggregate (Please note that you may not carry limits of liability higher than your employer):	
☐ **$100,000 /$300,000**	☐ **$1,000,000/$3,000,000**
☐ **$200,000/$600,000**	☐ **$1,300,000/$3,900,000 (NY Only)**
☐ **$250,000/$750,000**	☐ **$2,000,000/$6,000,000 (VA Only)**
☐ **$500,000/$1,500,000**	☐ **Other →**

UNDERWRITING & ELIGIBILITY SECTION

Please answer the following questions. Have you **EVER**:	
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**
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**
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**
Been indicted and/or convicted of a crime other than minor traffic violations?	☐ **Yes** ☐ **No**
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**
Had a CMS investigation as to fraud or abuse?	☐ **Yes** ☐ **No**
Been suspended, restricted, or put on probation by any governmental health program (e.g. Medicare or Medicaid)?	☐ **Yes** ☐ **No**

→ If you answered YES to any of the above questions, please provide full details on the Supplemental Information Worksheet. In addition, if you answered any question related to your personal health with a YES, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

KNOWN CLAIMS AND MEDICAL INCIDENTS

Have you **EVER** been involved in a malpractice claim or suit with an incident date, report date or close date occurring within the last fifteen (15) years or are you presently involved in malpractice litigation? – **Please submit a separate incident/claim information worksheet for each of these events.**	☐ **Yes** ☐ **No**
Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?	
A. A request for records from a patient and/or attorney related to an adverse outcome?	☐ **Yes** ☐ **No**
B. A letter from a patient and/or attorney regarding your medical treatment of a patient?	☐ **Yes** ☐ **No**
C. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities?	☐ **Yes** ☐ **No**
D. Has your hospital filed any governmental reports regarding a complication related to your treatment of a patient?	☐ **Yes** ☐ **No**
Are you aware of a patient's dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you?	☐ **Yes** ☐ **No**
Have all circumstances that might reasonably lead to an incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐ **Yes** ☐ **No** ☐ **None to Report**
→ If you answered YES to any of the above questions, please provide all of the specifics for each case on a separate Prior Claims Information Worksheet.	

Included with your application materials is a separate No Known Loss Letter. If you have not received one, please contact AMS RRG.

I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier.

_____ ____/____/_____

SIGNATURE **DATE (MM/DD/YY)**

PRIOR CLAIMS INFORMATION WORKSHEET

Please copy this page as necessary to summarize all medical malpractice claims that you have experienced in your complete practice history. This includes all patients requesting payment to avoid a lawsuit, all notices of intent to sue that did not lead to a lawsuit and information on all lawsuits filed whether or not a payment was made.

Name of Patient:							
Name of Insurance Carrier:							
Nature of the Claim: (check all that apply)	☐	**Incident**	☐	**Claim Letter**	☐	**Notice of Intent to Sue**	
	☐	**Lawsuit**	☐	**State Board Investigation**			

Date of Medical Incident:	/ /	**Date Reported to your insurer**	/ /	
Current Status:	☐ **Open**	☐ **Closed → note date**	→ / /	
For Closed Claims				
Amount Paid On Your Behalf:	$	**Amount Paid for all Defendants**	$	
For Open Claims				
Expense Reserves	$	**Indemnity Reserves**	$	

Please provide a detailed account of the events surrounding this claim. This will help us better understand the nature of the claim. In addition, this information will be used to help our physicians reduce their risk of future claims. Please use the Supplemental Information Worksheet as necessary. Again, Please be detailed in your description.

Note: You may be requested to provide additional information such as office records, operative reports, discharge summaries, x-rays, etc. No application may be approved without complete and accurate claim information.

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 EXTENDER CERTIFICATION

Incomplete or incorrect information could result in a retroactive upward premium adjustment or could lead to a denial of liability in the event of a claim. I also understand that any material misrepresentation or omission made by me on this application may render any contract of insurance null and without effect or provide the company with the right to rescind it. I also understand that the coverage for which I am applying shall only protect me for my acts within the scope of my duties on behalf of the employer indicated above

I hereby declare that the statements and responses I have provided in this application are complete and 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 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.

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

Print Applicant Name:	
Applicant Signature:	
Date:	/ /