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PODIATRISTS PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. If you have Curriculum Vitae (C.V.), please attach to application and check here [ ].

1. APPLICANT INFORMATION

a. (i) Full Name of Applicant: _____ Date of Birth: _____

(ii) Home Address: _____ Phone: ( ) _____

b. (i) Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

Phone: ( ) _____

(ii) Other Offices: _____ Phone: ( ) _____

_____ Phone: ( ) _____

c. Limits of Liability desired: ☐ 100,000/300,000 ☐ 250,000/750,000 ☐ 500,000/1,500,000 ☐ 1,000,000/3,000,000

d. Federal DEA Number: _____

e. Your practice is: [ ] Solo Practitioner (unincorporated) [ ] Solo Practitioner (incorporated) [ ] Partnership [ ] Member of a group corp. [ ] Other (describe_____

f. If your practice is a partnership, group corporation, or association, or employ any physicians, please complete the following:

(i) Please list the names of ALL other partners, stockholders, associates and employed physicians; and indicate the status of each:

(a) _____ (d) _____

(b) _____ (e) _____

(c) _____ (f) _____

g. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [ ] Yes [ ] No
If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available.. This is the only Business Associate Agreement we will recognize.

2. PRACTICE

a. Please list all states where you are licensed to practice:

State: _____ License Number: _____

State: _____ License Number: _____

State: _____ License Number: _____

b. Do you practice: [ ] Full-time [ ] Part-time _____ hours per week

c. Please list all locations where you have practiced in the last ten years:

Name of Facility: _____ Address: _____ Year(s): _____

Name of Facility: _____ Address: _____ Year(s): _____

Name of Facility: _____ Address: _____ Year(s): _____

d. (i) Average patient load: _____ Pts. Weekly _____ Total pts. Annually

(ii) Please indicate the number of days you work per week: _____

(iii) Please indicate the number of practice hours per day: _____ per week: _____

e. Please provide a list of all professional health care personnel employed by or under contract with you or your entity. (If insured, please furnish the name of the insurance carrier and the policy number.)

Name Job Category Professional Liability Insurance

_____

_____

_____

f. Please list hospitals/surgery centers at which you are currently a staff member and show % of work at each location. Also submit copies of staff privileges. (If you request a Certificate of Insurance to be sent, please circle the number of the hospital/surgery center.)

1) _____ _____%

2) _____ _____%

3) _____ _____%

4) _____ _____%

g. Are you affiliated in any capacity with any of the following:

(i) Any healthcare facility having bed and board accommodations? ..... [ ] Yes [ ] No

(ii) Any clinic, foundation, blood bank or laboratory? ..... [ ] Yes [ ] No

(iii) Any health maintenance organization (HMO), preferred provider organization (PPO), individual physicians' association, and/or any pre-paid health plan, etc.? ..... [ ] Yes [ ] No

PLEASE PROVIDE THE FOLLOWING FOR ANY "YES" ANSWERS:

1) Please give the full legal name and location of the facility as well as the department in which you serve: _____

_____

2) Does the above facility provide insurance coverage for this work? ..... [ ] Yes [ ] No

3) Please indicate your affiliation:

_____ Owner (whole or part) _____ Committee Member

_____ Executive Officer (e.g., Board Member) _____ Director – Dept. of Ancillary Services

_____ Physician with teaching responsibilities _____ Administrator

_____ Other (please describe): _____

4) How are you compensated for your services? [ ] Salary [ ] Percentage [ ] Fee for Service [ ] Honorary or non-paid

5) What type of contractual agreement do you have? [ ] Oral [ ] Written

6) Please indicate the number of practice hours per day: _____ per week:

h. Do you practice any of the following:

Sports Medicine ..... [ ] Yes [ ] No

Minimal Incision Surgery ..... [ ] Yes [ ] No

Emergency Room work ..... [ ] Yes [ ] No

Laser Surgery ..... [ ] Yes [ ] No

(i) For what type of treatment do you use the laser? _____

(ii) How many times per week do you perform laser surgery? _____

(iii) Please indicate the type of training you received in laser surgery. Please check all that apply:

[ ] Seminar [ ] Course [ ] Hands On [ ] Preceptorship [ ]Other

Please specify the name(s) of program(s): _____

3. PROCEDURES

a. Please complete the following list of procedures performed, adding any others in the space provided below.

Instructions: In column 1, please check each procedure performed.
In column 2, please list the number of times the procedure has been performed within the past two years.
In column 3, please use "O" or "H" to indicate whether in an office or hospital.
In column 4, please indicate the number of office procedures that would be considered "minimal incision surgery."

Name of Procedure	1	2	3	4
Fulguration of verrucae	[ ]	____	____	____
Curettage of verrucae	[ ]	____	____	____
Excision of verrucae	[ ]	____	____	____
Avulsion of toenail	[ ]	____	____	____
Onychoplasty	[ ]	____	____	____
Onychotripsy	[ ]	____	____	____
Subungual exostosectomy	[ ]	____	____	____
I & D of superficial abscess	[ ]	____	____	____
Plantar lesion - skin	[ ]	____	____	____
Tendotomy - digital tendon (exterior flexor)	[ ]	____	____	____
Capsulotomy - forefoot	[ ]	____	____	____
Arthroplasty	[ ]	____	____	____
Phalangectomy	[ ]	____	____	____
Closed reduction (digital)	[ ]	____	____	____
Open reduction (digital)	[ ]	____	____	____
Tendon Lengthening - digital	[ ]	____	____	____
Soft tissue tumors - rear foot	[ ]	____	____	____
Osteoclasis	[ ]	____	____	____
Foreign bodies - forefoot	[ ]	____	____	____
Excision of accessory ossicles	[ ]	____	____	____
Metahead resection (partial or complete)	[ ]	____	____	____
Excision of sesamoids (1st MP)	[ ]	____	____	____
Resection of metatarsal exostosis	[ ]	____	____	____
Closed reduction (metatarsal)	[ ]	____	____	____
Terminal Syme (lesser digitals)	[ ]	____	____	____
Excision of nevi	[ ]	____	____	____
Soft tissue tumors - forefoot	[ ]	____	____	____
Terminal syme (hallux)	[ ]	____	____	____
Hemangioma - excision of	[ ]	____	____	____
Plastic repair of skin - rear foot	[ ]	____	____	____
Repair of ruptured ligament-forefoot	[ ]	____	____	____
Planter fasciotomy and heel spurs	[ ]	____	____	____
Excision of plantar fibromatosis	[ ]	____	____	____
1st metahead resection (partial or complete)	[ ]	____	____	____
Hallux valgus repair (1st MP only)	[ ]	____	____	____
Partial resection of hypertrophied tarsal bone	[ ]	____	____	____
Heel spur resection	[ ]	____	____	____
Digital Fusions IP joints	[ ]	____	____	____
Use of K Wire-staples-implants-wire for fixation	[ ]	____	____	____
Joint or other implants or prostheses made of materials capable of degradation, erosion, fragmentation, and/or the provocation of inflammatory tissue reactions?	[ ]	____	____	____

Name of Procedure	1	2	3	4
Osteotomies with fusion-digits-Metatarsal heads	[ ]	____	____	____
Implants	[ ]	____	____	____
Aneurysm	[ ]	____	____	____
Tendon transfer (digital)	[ ]	____	____	____
Tendon transfer (other)	[ ]	____	____	____
Tendo Achilles lengthening	[ ]	____	____	____
Repair of ruptured tendon	[ ]	____	____	____
Tenodesis	[ ]	____	____	____
Tendon transplant	[ ]	____	____	____
Capsulotomy - rear foot	[ ]	____	____	____
Repair of syndactylism	[ ]	____	____	____
Repair of polydactylism	[ ]	____	____	____
Amputation	[ ]	____	____	____
Panmetahead resection	[ ]	____	____	____
Excision of metatarsal	[ ]	____	____	____
Excision of trigonum	[ ]	____	____	____
Excision of tarsal bone	[ ]	____	____	____
Closed reduction - rear foot	[ ]	____	____	____
Open reduction - other	[ ]	____	____	____
Metatarsal tarsal fusions (MP-MT joints)	[ ]	____	____	____
Arthrodesis of tarsus	[ ]	____	____	____
Skin graft	[ ]	____	____	____
Repair of osteomyelitis	[ ]	____	____	____
Bone cysts and tumors	[ ]	____	____	____
Cavus foot correction	[ ]	____	____	____
Flatfoot correction	[ ]	____	____	____
Metatarsal adductus correction	[ ]	____	____	____
Reconstruction of anomaly	[ ]	____	____	____
Ankle Arthroscopy	[ ]	____	____	____
ORIF Ankle Fracture	[ ]	____	____	____
Tarsal tunnel decompression	[ ]	____	____	____
Ankle Arthrodesis	[ ]	____	____	____
A-O fixation	[ ]	____	____	____
Ankle Stabilization	[ ]	____	____	____
Perform surgery on ankle Joint and lower leg?	[ ]	____	____	____
Perform surgery on tendoachilles?	[ ]	____	____	____
Do you provide post-operative care?	[ ]	____	____	____
Do you provide routine foot care in patients of any age that satisfy Medicare high-Risk criteria?	[ ]	____	____	____
Other procedures performed: _____	[ ]	____	____	____

b. Do you administer anesthesia

(i) Intravenous? ..... [ ] Yes [ ] No

(ii) Local? ..... [ ] Yes [ ] No

(iii) Nitrous Oxide? ..... [ ] Yes [ ] No

(iv) Other (describe) _____

4. HISTORY

a. Attach a detailed explanation with dates for any "Yes" answers:

(i) Have you ever been convicted of a felony? ..... [ ] Yes [ ] No

(ii) Have you ever had professional liability insurance declined, canceled, issued on special terms or non-renewed? ..... [ ] Yes [ ] No

(iii) Have you ever been investigated by a State Board of Medical Examiners, Narcotics Board, or other licensing or governmental regulatory agency? ..... [ ] Yes [ ] No

(iv) Has your membership in any professional society or association ever been refused, censured, suspended or revoked? ..... [ ] Yes [ ] No

(v) Have you ever had privileges at a hospital or surgery center reduced, revoked, restricted or suspended? ..... [ ] Yes [ ] No

(vi) Have you now or ever had any chronic disability or had an interruption of your practice due to disability? ..... [ ] Yes [ ] No

(vii) Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties? ..... [ ] Yes [ ] No

(viii) Have you ever been involved in a drug or alcohol diversion or rehabilitation program? ..... [ ] Yes [ ] No

(ix) Have you ever been suspended by any governmental health program (e.g., Medicare)? ..... [ ] Yes [ ] No

b. Please list malpractice coverage for the past ten years:

Name of Insurer	Dates Covered From - To	Claims Open	Claims Closed	Claims Total
1) _____	_____	_____		
2) _____	_____	_____		
3) _____	_____	_____		
4) _____	_____	_____		
5) _____	_____	_____		

c. If prior professional liability insurance was on a claims made basis, please indicate the retroactive exclusion date of coverage _____

5. CLAIMS

a. Has any physician, patient or insurance plan ever filed a complaint against you with any Medical Association/Society or Foundation, Consumer Protection Agency, Chamber of Commerce or Better Business Bureau? ..... [ ] Yes [ ] No
If yes, please complete a Claims Information form for each case.

b. Are you aware of any facts or circumstances which may give rise to a claim or suit? ..... [ ] Yes [ ] No
If yes, please complete a Claims Information form for each case.

c. Have you ever been involved in a malpractice claim or suit, either directly or indirectly, or are you presently involved in malpractice litigation? ..... [ ] Yes [ ] No
If yes, please complete a Claims Information form for each case.

6. COVERAGE

a. Non-surgical, Podiatry, Category 1 [ ] Yes [ ] No

Limitation Provision One - coverage DOES NOT APPLY (except in an emergency requiring immediate and unexpected intervention) to injury arising out of any professional service listed below:

(i) The administration of anesthesia other than topical or by means of local infiltration;

(ii) The reduction of any fracture;

(iii) The performance of any procedure involving the cutting or penetration beneath the subcutaneous tissue layer, i.e., muscle, tendon, nerve, ligament, joint or bone;

(iv) The use of lasers; and

(v) The administration of nitrous oxide-oxygen inhalation analgesia. Coverage DOES NOT APPLY to injury arising out of any professional services listed below:

1. Incision and/or drainage of sebaceous cysts, abscesses, or hematoma;
2. Curettage of verrucae;
3. Incision and removal of foreign body from the superficial or subcutaneous tissue;
4. Debridement of infected skin, abrasions or keratotic lesions;
5. Debridement, excision or avulsion of nail plate, excluding permanent removal except those procedures which involve the use of electrical or chemical cautery;
6. Needle penetration of the skin and blood vessels;
7. Treatment of burns except the local treatment of third degree burns;
8. Closed manipulative reductions of fractures of metatarsals and phalanges; and
9. Assisting in the performance of any podiatric surgical procedure.

b. Intermediate Surgery [ ] Yes [ ] No

Limitation Provision Two - Coverage DOES NOT APPLY (except in an emergency requiring immediate and unexpected intervention) to injury arising out of any professional service listed below:

(i) Treatment or reduction of compound fractures of the calcaneus or talus;

(ii) Triple arthrodesis;

(iii) Surgical procedures of the ankle joint which includes those parts of the tibia, fibula, the malleoli and their related structures;

(iv) Surgical treatment of the muscles and tendons at the level of the ankle joint and in the leg; and

(v) The administration of general anesthesia.

Coverage DOES APPLY to injury arising out of any professional services covered in Limitation Provision One:

1. All podiatric surgical procedures performed on the human foot except those excluded above; and
2. Assisting in the performance of any podiatric surgical procedure.

c. Advanced Surgery [ ] Yes [ ] No

Limitation Provision Three - Coverage DOES NOT APPLY (except in an emergency requiring immediate and unexpected intervention) to injury arising out of any professional service listed below:

(i) The administration of general anesthesia.

Coverage DOES APPLY to injury arising out of all podiatric surgical procedures performed on the human foot and all of the services covered in Limitation Provisions One and Two.

d. (i) Do you perform surgery in your office? ..... [ ] Yes [ ] No

(ii) Do you perform surgery in a hospital? ..... [ ] Yes [ ] No

(iii) Do you perform surgery in any other non-hospital facility? ..... [ ] Yes [ ] No

(iv) Do you only perform non-surgical procedures or minor surgical procedures that are within the subcutaneous tissue only and that do not require sutures? ..... [ ] Yes [ ] No

(v) Do you assist in surgical procedures outside the scope of podiatric medicine? ..... [ ] Yes [ ] No (If Yes, please explain.)

(vi) Do you have a certificate to perform ankle surgery? (If Yes, please attach copy.) ..... [ ] Yes [ ] No

7. PROFESSIONAL ORGANIZATIONS

American Podiatric Medical Association	APMA	[ ] Yes [ ] No
American College of Foot Surgeons	ACFS	[ ] Yes [ ] No
Academy of Ambulatory Foot Surgeons	AAFS	[ ] Yes [ ] No

8. EDUCATION

a. List all the colleges and professional schools you attended:

Name	Yrs. Attended	Date of Grad.	Degree

b. Post graduate education:

(i) Internship: [ ] Yes [ ] No

Hospital: _____

Location: _____
(City) (State) (County)

Dates of Training: _____

(ii) Residency/Fellowship/Preceptorship: [ ] Yes [ ] No

Hospital: _____

Location: _____
(City) (State) (County)

Dates of Training: _____

(iii) Additional medical/specialty training:

Type of Training	Dates
_____	_____
_____	_____

c. Board Certification: [ ] Yes [ ] No

If Yes, please indicate the name of the Board and the year certified: _____

9. ADDITIONAL INFORMATION

a. Please attach three (3) of your most recent advertisements.

b. Please enclose copies of all your ads (e.g., Yellow Pages, etc.)

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

_____ _____
Name of Applicant Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.