MEDICAL ALLIANCE INSURANCE COMPANY

PHYSICIAN

APPLICATION

MEDICAL ALLIANCE INSURANCE COMPANY

Application Check List

Thank you for your interest in Medical Alliance Insurance Company. Please use the following checklist to ensure accuracy and completeness of your application, so that processing will not be delayed. If you have any questions, please contact Medical Alliance Insurance Company's underwriting department.

1. **Please fill out each question. Don't leave any blanks. Mark none or N/A if it does not apply.**
2. **Explain any "yes" answers.**
3. **Attach a copy of your current Illinois Medical License.**
4. **Submit a copy of your current insurance declaration page.**
5. **Sign the Application, and Authorization & Consent form.**
6. **Include a CV if you are requesting prior acts coverage.**

Applications should be returned to:

Association Management Resources
1151 East Warrenville Road
P.O. Box 3015
Naperville, IL 60566
Phone: 630-276-5658
Fax: 630-276-5403

MEDICAL ALLIANCE INSURANCE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY APPLICATION

LIMITS OF LIABILITY ARE $1,000,000/$3,000,000

1. **Physician Name (Last, First, Middle Initial)**

   ______________________________ ___________________________ M.D.______________ D.O.______

   Home Address____

   City____ State_______ Zip Code__________________

   Home Phone (Area Code)__________________________ E-mail Address____________________________

   __________________________ ______/________/_______
   Social Security Number Date of Birth

2. **Illinois Office Address**
   Unless otherwise specified, the office address is where all of your documents and correspondence will be sent. If you are employed by a hospital please do not complete, as correspondence will be forwarded directly to the hospital.

   Office Address____

   City____ State_______ Zip Code__________________

   Office Phone (Area Code)___________________________

   Billing Address: If the same as office address, please check here. O
   This address is where all of your insurance premium invoices and notices will be sent.

   Billing Address____

   City__________________________ State_______ Zip Code_______________________________________

3. **Desired Effective Date**:______/_______/_______ **Retroactive Date:**_______/_______/_______

4. **Medical License Information - Please provide a copy of your Illinois Medical License**

State	Number	Expires	Status
_________	______________________	_____/_____/_____	______________________
_________	______________________	_____/_____/_____	______________________
_________	______________________	_____/_____/_____	______________________
DEA Number	______________________	_____/_____/_____	

MAIC-A001-P
(1/01/09)

5. Medical Education and Professional Experience

Medical Education	Institution	State	Dates Attended	Completed Yes/No
Medical School				
Internship				
Residency				
Residency				
Fellowship				

List your professional experience since completion of formal training

City, State, Country   From   To   Practice Activity

________________________ ________ ________ ____

________________________ ________ ________ ____

________________________ ________ ________ ____

________________________ ________ ________ ____

6. Medical Specialty and Board Certification Information

a) Medical Specialty____

Subspecialty___________________________________ % of time devoted to Subspecialty______________________

b) Are you Board Certified? Yes _______ No _______

IF YES:

What specialty or specialties____

Are there any gaps in your certification, if yes, please explain. Yes _______ No _______

____

____

IF NO:

Please specify why you are not board certified______________________________________

____

____

____

7. Practice Activities

a) Average weekly practice time in hours per week___________

Average weekly practice time includes clinical patient care, completion of medical records, in hospital on-call time, in hospital activities and consultations.

b) Average number of patients per week ___________

c) Type of Practice

1. Are you applying for coverage as an employee of a hospital? Yes_____ No________
   If yes, what hospital.

   ____

2. Are you applying for coverage as an independent practitioner? Yes_____ No________
   Indicate your solo corporation name, if applicable.

   ____

3. Are you part of a group practice? Yes_____ No________

   If yes, please list all other physicians who are practicing in your office or with your group:

   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________

   Are they also applying for MAIC coverage? Yes_____ No________

   Are you seeking coverage for the medical corporation? Yes_____ No________

   If yes, what is the name of the corporation____

   What is the corporation's Federal Tax Identification number____________________________

8. Practice Information

a) Do you practice in any of the following locations? If yes, please specify your average weekly practice time at the location and whether you are applying for coverage for that activity.

	Average Weekly Practice Time	Coverage Desired	
Nursing Home	____________	Yes_____	No________
Jail/Prison or Correctional Facility	____________	Yes_____	No________
Federal Government	____________	Yes_____	No________
Surgicenter, Emergency Service Facility or similar Outpatient Facility	____________	Yes_____	No________
Birthing Center	____________	Yes_____	No________

b) Has your practice (specialty, procedures, location) changed significantly during the period for which you have requested retroactive coverage?

Yes_____ No________

If yes, please explain____

____

____

____

c) Primary Office Location____

Address____

City______________________ State_____ Zip_________ Phone___________________

d) Secondary Location: ____

Address____

City______________________ State_____ Zip_________ Phone___________________

e) County in which 51% or more of your office practice will take place ______________________

9. Current Hospital Privileges

Hospital Name	City, State	Category of Privileges*	Estimated % of Hospital Practice

* Category of privileges includes full, restricted, courtesy or other.

If you have restricted privileges at a facility, please explain. ______________________________

10. Employed Clinical Personnel

Type	Number	Indicate if Shared or Separate Limits are desired
Certified Nurse Midwife	________	Separate Only
Certified Registered Nurse Anesthetist	________	Separate Only
Nurse Practitioner	________	________________
Physician Assistant	________	________________
Psychologist	________	________________
Psychotherapist	________	________________
Surgical Assistant	________	________________

List any other employed allied personnel ____

11. **Please indicate your professional liability carriers for the past 10 years as applicable:**

Company	Policy Period	Retro Date	Limits	Claims-made or Occurrence	Annual Premium

12. **PROCEDURES-Check if you perform one or more of the following:**

Minor Risk Procedures

Radiological Procedures

- ❑ Angiography
- ❑ Arteriography
- ❑ Interventional radiology such as embolization, (including extra cranial), percutaneous transluminal angioplasty, percutaneous nephrostomy and drainage procedures
- ❑ Therapeutic radiology, deep (includes radium implants)

Cardiovascular Procedures

- ❑ Arterial, venous, cardiac or other diagnostic catheterization (includes insertion of cardiac pacemaker whether temporary or permanent). This does not apply to Swan-Ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel.
- ❑ Percutaneous angioplasty with or without stent placement
- ❑ Intracoronary streptokinase infusion
- ❑ Pericardiocentesis
- ❑ Myocardial Biopsy

Obstetrical/ Gynecological Procedures

- ❑ Cervical conization and LEEP Procedures
- ❑ Fallopian tube recanalization
- ❑ Diagnostic/therapeutic D&C (does not apply to induced, nonspontaneous abortions)
- ❑ Uncomplicated obstetrical care, whether prenatal (which may include amniocentesis) and postpartum only and/or cephalic vaginal deliveries performed in a hospital which may also include episiotomy, application of low forceps only or obstetric vacuum cup.

  Number of total deliveries you perform annually:_____________

  Number of normal vaginal deliveries you perform annually:____________
  (Uncomplicated pregnancy, may include episiotomy and application of low forceps or vacuum cup)

Ophthalmic Surgery

- ❑ Either extraocular only or extraocular and intraocular (includes surgery for glaucoma, cataract, retinal detachment and strabismus surgery--including YAG laser treatment for membrane opacity, laser trabeculoplasty and laser iridectomy and incision and curettage of chalazion of the eyelid,)

Miscellaneous

- ❑ Assisting in surgery
- ❑ Interstital hyperthermia
- ❑ Ultrasound hyperthermia (superficial only)
- ❑ MRI-Guided focused ultrasound for treatment of uterine fibroids
- ❑ Vascular Access Procedures (primarily used for dialysis) including tunneled catheter insertion, vascular access angiography, vascular access thrombolysis and vascular access thrombectomy.

Other Minor Risk Procedures, please indicate

____

____

____

____

What minor risk procedures do you perform in an office based setting?

____

____

____

____

Major Risk Procedures -- if performing any of the procedures below please indicate number of procedures performed annually.

Procedures	Number Annually
Orthopedic	
❑ Closed reduction in dislocations other than fingers, toes and shoulders.	________
❑ Open reduction of fractures or dislocations	________
❑ Amputation other than digits	________
❑ Any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to fracture	________
❑ Orthopaedic surgery including obtaining an iliac crest bone graft and open procedures on the coccyx but excluding open procedures on the rest of the spine	________
Obstetrical	
❑ Cesarean Sections	________
❑ Midforceps delivery	________
❑ Version & extraction, 2nd Twin	________
❑ Breech extraction	________
❑ Multiple gestation	________
❑ VBAC	________
❑ Abortions, induced non-spontaneous	________
❑ Chorionic Villi Sampling	________

Otorhinolaryngology

- ❑ Elective Plastic Head and Neck Only ______________
- ❑ Elective Plastic Other than Head and Neck ______________
- ❑ Tonsillectomy/Adenoidectomy

Miscellaneous

- ❑ Plastic Surgery-Cosmetic ______________
- ❑ Plastic Surgery-Reconstructive ______________
- ❑ Liposuction ______________
- ❑ Gastroplasty, gastric stapling, gastric partitioning or any like surgical procedure for the treatment of morbid obesity, obesity or weight reduction ______________
- ❑ Temporomandibular Joint Surgery including total replacement Arthroscopy, alloplastic implants or meniscal repair via placation
- ❑ Spinal Surgery, Chemonucleolysis ______________
- ❑ Neurosurgery, Gamma Knife (Leskell Gamma Radiosurgical Unit) ______________
- ❑ Other Major Risk Procedures, please explain:

  ____

  ____

  ____

15. If answer "yes" to any of the following, please explain on comments page

a) Have you signed a contract to supervise any department within a hospital? (NOTE: no coverage is provided for administrative duties) Yes_____ No_____

b) Has your membership in any professional society or association ever been refused, censured, suspended or revoked? Yes_____ No_____

c) Has your license to practice medicine or your narcotics license ever been denied, revoked, suspended or in any way limited? Yes_____ No_____

d) Has any hospital ever restricted, suspended or revoked your privileges or revoked probation for any cause other than incomplete charts? Yes_____ No_____

e) Is there any current action pending to restrict, suspend or revoke your privileges, license to practice medicine or narcotics license? Yes_____ No_____

f) Have your hospital privileges been expanded during the last twelve months to include procedures for which you completed additional required training by the State Licensing Board and/or your board specialty? Yes_____ No_____

g) Have Medicaid authorities brought documented charges against you for alleged inappropriate fees? Yes_____ No_____

h) Have you ever been indicted or charged in a criminal suit? Yes_____ No_____

i) Have you ever been evaluated for, diagnosed or treated with any mental, physical or chronic illness or any other impairment which could inhibit your practice of medicine including alcoholism or substance abuse? Yes_____ No_____

j) Have any complaints been registered/filed against you with your medical association/society, hospital(s) or state licensing authority within the past ten years? Yes_____ No_____

k) Have you ever been denied a medical license or denied certification by a specialty? Yes_____ No_____

l) Have you ever had your malpractice insurance canceled, non-renewed, restricted or special rated, or have you received a letter from your carrier of such intent? Yes_____ No_____

m) Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit? Yes_____ No_____

(If yes, complete the following claims information on the following page)

Claim information (PLEASE PROVIDE FOR ENTIRE TIME IN PRACTICE). If additional space is needed, please make a copy of this page

Patient Name		Date of Occurrence
Insurance carrier covering claim		Date of Treatment
Status (closed, open, incident)	Amt. paid or reserved	Date closed or settled
Additional Defendants		
Allegation		

Patient Name		Date of Occurrence
Insurance carrier covering claim		Date of Treatment
Status (closed, open, incident)	Amt. paid or reserved	Date closed or settled
Additional Defendants		
Allegation		

Patient Name		Date of Occurrence
Insurance carrier covering claim		Date of Treatment
Status (closed, open, incident)	Amt. paid or reserved	Date closed or settled
Additional Defendants		
Allegation		

Comments: Please provide details for any questions with a "yes" response (include question number)

I hereby certify that I have reported all known claims or circumstances which may result in a claim to my previous insurance carrier and have no knowledge of any existing fact or situation which could result in a claim being filed against me.

Consideration of this application does not bind MAIC to provide insurance. All information requested in this application is considered material and important. If MAIC agrees to provide the insurance, the policy will be void if I conceal any important information or mislead or attempt to defraud or lie about any matter contained in this application.

By signing this application, I verify and affirm that the information contained in this application and the attachments which are part of the application are true and correct.

____ ________________________

Signature of applicant Date

Note: You must sign the attached Authorization and Consent Form as part of this application.

AUTHORIZATION AND CONSENT

I hereby authorize Medical Alliance Insurance Company and its agents, Illinois Risk Management Services and Association Management Resources (collectively "The Companies") to investigate and obtain any information bearing upon my moral character, professional reputation, competence or fitness to engage in the activities authorized by my license to practice medicine and I hereby authorize and consent to any hospital, physician, clinic or other healthcare provider releasing to "The Companies" any such information which it is permitted by law to disclose.

I also authorize and consent to any insurance company, self-insured trust, my attorney representing me in any malpractice or negligent action, or any other risk-sharing program providing information to "The Companies" concerning any event, claim, lawsuit or cause of action involving the undersigned.

A photocopy of this authorization shall be accepted as if it were the original.

Dated this _________ day of ______________________ 20 _____.

____

Signature