Physicians and Surgeons Application for Professional Liability Insurance

Refer to www.lammico.com for a downloadable version of this application.

It is recommended that you submit your application at least 45 days in advance of your desired effective date in order to ensure a timely review of your application. Please read the following instructions in order to expedite the review of your application:

(1) Answer all questions or mark "N/A" where appropriate.
(2) Complete the attached Claim Addendum if a claim or suit has been filed against you.
(3) Submit a claim/loss history report from your previous carrier(s) – 10 years if applicable.
(4) Provide a copy of your current professional liability policy or declarations page.
(5) Provide a copy of your Curriculum Vitae.
(6) Sign and date your application on page seven.

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (3) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

Once your application is received and reviewed, a member of the LAMMICO Board of Directors may interview you. Following your interview and subsequent underwriting review, you will be advised as to the status of your application.

When completed, please return this application to:

Louisiana Medical Mutual Insurance Company
One Galleria Blvd, Suite 700
Metairie, LA 70001
FAX: 504/841-5205 or 504/841-5300

If you have questions, please call the Underwriting Department at 504/831-3756 or 800/452-2120. Thank you for your interest in LAMMICO. We look forward to serving your medical professional liability insurance needs.

Building Enduring Partnerships

Louisiana Medical Mutual Insurance Company
One Galleria Blvd., Suite 700 • Metairie, LA 70001 • www.lammico.com
504/831-3756 • 800/452-2120 • FAX: 504/841-5300 or 504/841-5205

Physicians and Surgeons Professional Liability Application

Under the "**claims-made**" policy, coverage is limited to claims arising from the performance of professional services subsequent to the retroactive date stated in the declarations and first made against the company while the policy is in force. Under an "**occurrence**" policy, coverage is provided for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is reported.

Personal Information

Application # (LAMMICO use only) ☐☐☐☐☐☐☐

Full Name (Last, First, Middle Initial)			UPIN#
Primary Practice Address (include city, state, zip)			Years at this location
Mailing Address (include city, state, zip)			Other Locations (if any)
Home Address (include city, state, zip)			
Medical Group Name (if any)	Social Security No.	Date of Birth	Parish Medical Society
Office Phone	Fax Number	Home Phone	E-mail Address
Desired Effective Date			

(LAMMICO use only)

Retroactive Date ______
Parish Code ______ Tax Code ______
Specialty/Class ______
Discount Code ______ Discount ______%
Limits/Option ______ Group Code ______
Start of Practice Date ______

Professional Liability Limits Desired (Check one box)

Occurrence	Claims Made	Straight Through Coverage*
n/a	☐	$500,000 each medical incident/$500,000 aggregate
n/a	☐	$1,000,000 each medical incident/$1,000,000 aggregate
n/a	☐	$1,000,000 each medical incident/$3,000,000 aggregate
n/a	☐	$2,000,000 each medical incident/$2,000,000 aggregate
		Basic Limits Coverage
☐	☐	$100,000 each medical incident/$300,000 aggregate **with** PCF
☐	☐	$100,000 each medical incident/$300,000 aggregate **without** PCF

*Louisiana Patients' Compensation Fund participation is mandatory if you purchase limits greater than $100,000/$300,000

Underwriting and Rating Information

1.a. Are you a member of the Louisiana State Medical Society (LSMS)? ☐ Yes ☐ No

2.a. Do you have a current license to practice medicine in LA? ☐ Yes ☐ No LA License No.: ______

2.b. State and Federal Narcotics License Numbers: ______

2.c. Do you have any restrictions? (if *yes*, explain) ☐ Yes ☐ No ______

3. List other states where licensed and license #s: ______

4.

Undergraduate School, Location	Degree	Year
Medical School, Location	Degree	Year
Served Internship at (PG I)	Specialty	Year(s)
Served Residency at (PG II - ?)	Specialty	Year(s)
Fellowship or Postgraduate Training, Location	Specialty	Year(s)

5. Date you began practicing: ______________________

6. If a foreign medical school graduate, have you obtained an ECFMG Certificate or a Fifth Pathway Certificate? ☐ Yes ☐ No

6a. Indicate which certification was obtained and year certified: ☐ ECFMG ☐ Fifth Pathway Year Certified: ________

7. Are you certified by an approved specialty board? (If *yes*, which?) ☐ Yes ☐ No ______________________

8. How many continuing medical education credits did you achieve last year? ______________________

9. If you are coming to Louisiana from another state or country, why? ______________________

____

10. What is your medical specialty? ______________________

Indicate percentage of time devoted to the following medical and/or surgical activities: (total should equal 100%)

%		%		%		%	
____	Aesthetic Medicine	____	General Practice	____	Neurology	____	Pain Management
____	Allergy	____	General Practice - Surgery	____	Neuro-radiology	____	Pathology
____	Anesthesiology	____	General Preventive Medicine	____	Neurosurgery	____	Pediatrics
____	Bariatric Medicine	____	General Surgery	____	Nuclear Medicine	____	Pharmacology-Clinical
____	Bariatric Surgery	____	Geriatrics	____	Nutrition	____	Physiatry - Phys. Med
____	Cardiac Surgery	____	Geriatrics/Institutional	____	Obstetrics	____	Psychiatry
____	Cardiovascular Diseases	____	Gynecology	____	Obstetrics/Gynecology	____	Psychoanalysis
____	Cardiovascular Surgery	____	Gynecology - Surgery	____	Occupational Medicine	____	Plastic Surgery
____	Colon & Rectal Surgery	____	Hand Surgery	____	Oncology-Medical	____	Pulmonary Diseases
____	Dermatology	____	Hematology	____	Oncology-Surgery	____	Radiology-Diagnostic
____	Emergency Medicine	____	Hospitalist	____	Ophthalmology	____	Radiology-Therapeutic
____	Endocrinology	____	Infectious Diseases	____	Ophthalmology-Surgery	____	Rheumatology
____	Family Practice	____	Intensive Care Medicine	____	Orthopedic – Office Only	____	Thoracic Surgery
____	Family Practice-Incl. OB	____	Internal Medicine	____	Orthopedic Surgery	____	Traumatic Surgery
____	Family Practice-Surgery	____	Laborist	____	Otorhinolaryngology	____	Urgent Care Medicine
____	Forensic Medicine	____	Neonatology	____	Otorhinolaryngology/Plastic	____	Urological Surgery
____	Gastroenterology	____	Nephrology	____	Otorhinolaryngology/Surgery	____	Urology/Gynecology
						____	Vascular Surgery

Additional Specialties ______________________

List any non-standard procedures you perform within or outside of your specialty ______________________

11. Medical or Surgical Procedures (Please indicate whether you perform any of the following):

☐ **Anesthesia** ☐ General ☐ Spinal ☐ Epidural

☐ **Assisting in major surgical procedures**

Minor Surgery & Procedures—Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes but is not limited to the following list. Check all applicable:

- ☐ **No procedures—only consulting or diagnostic**
- ☐ Incisions of boils and superficial abscesses
- ☐ Suturing of skin and superficial fascia
- ☐ Acupuncture—other than acupuncture anesthesia
- ☐ Angiography
- ☐ Angioplasty
  - ☐ Coronary
  - ☐ Peripheral
- ☐ Bone fractures: closed treatment
- ☐ Cancer chemotherapy
- ☐ Cryosurgery
  - ☐ On benign dermatological lesions
  - ☐ Other ______________________
- ☐ Dermabrasion
- ☐ Diagnostic sonography
- ☐ Discograms
- ☐ Electroshock therapy (psychiatric)
- ☐ Fiberoptic bronchoscopy
- ☐ Hair transplant
- ☐ Interventional endoscopy—specify type: ____________

- [ ] Catheterization
  - [ ] Cardiac
  - [ ] Transarterial
  - [ ] Occasional insertion of pulmonary wedge, recording catheters, or temporary pacemakers
  - [ ] Transvenous
  - [ ] Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency or for transport)
- [ ] Cervical conization—specify type: ____________________
- [ ] Circumcision
- [ ] Colonoscopy
- [ ] Cosmetic injections—specify type: ____________________
- [ ] Cosmetic/reconstructive skin flaps and skin grafts
- [ ] Laser therapy—specify type: ____________________
- [ ] Myelography
- [ ] Needle biopsy
  - [ ] Lung, liver, kidney, or prostate
  - [ ] Other—specify type: ____________________
- [ ] Nerve blocks, therapeutic—specify type in "Remarks"
- [ ] Pain management—specify type in "Remarks"
- [ ] Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- [ ] Radiopaque contrast material injections into veins, blood vessels, lymphatic, sinus tracts, and fistulae
- [ ] Radiopaque contrast material injections into arteries
- [ ] Radiation therapy
- [ ] Vasectomy
- [ ] Other ____________________

Major Surgery—Includes operation procedures in or upon any body cavity including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct hazard to life. It also includes but is not limited to the following list. Check all applicable:

- [ ] Amputations
- [ ] Bariatric/Obesity surgery—specify type: ____________________
- [ ] Bone fractures — [ ] Operative treatment [ ] Closed manipulation-general or regional anesthesia
- [ ] Fertility or reproductive surgery
- [ ] Gynecological procedures — [ ] Dilation and currettements other than emergency
- [ ] Laparoscopic Cholecystectomy
- [ ] Laparoscopy — [ ] Diagnostic [ ] Sterilization [ ] Therapeutic
- [ ] Liposuction—specify type, and if performed under general or local anesthesia: ____________________
- [ ] Minimal invasive endoscopic surgery—specify type: ____________________
- [ ] Obstetrical procedures
  - [ ] Abortions
    - [ ] Elective
    - [ ] Therapeutic
  - [ ] Cesarean sections
  - [ ] Forceps delivery other than outlet forceps
  - [ ] Home delivery
  - [ ] Vaginal delivery
  - [ ] Other ____________________
- [ ] Penile implants
- [ ] Percutaneous disc surgery
- [ ] Plastic surgery
  - [ ] Cosmetic—specify type: ____________________ [ ] Breast augment/reduction
  - [ ] Reconstructive—specify type: ____________________
  - [ ] Facial—specify type: ____________________
- [ ] Radial keratotomy
- [ ] Spine surgery
  - [ ] **Primary**
    - [ ] Cervical
    - [ ] Thoracic
    - [ ] Lumbar
    - [ ] Spinal instrumentation
  - [ ] **Reoperative**
    - [ ] Cervical
    - [ ] Thoracic
    - [ ] Lumbar
    - [ ] Spinal instrumentation
- [ ] Tonsillectomies and/or adenoidectomies
- [ ] Other—specify type: ____________________

12. Medical or Surgical Procedures cont'd (Please indicate whether you perform any of the following):

(a) What percentage of your overall practice is devoted to treatment of chronic pain by prescribing controlled substances? ____________%

If *yes*, please answer the following:

Is the clinic licensed to operate as a pain management clinic? ☐ Yes ☐ No

If *yes*, please attach a copy of the license.

If *no*, please explain.

Physical address of the pain management clinic: ____________________

List the owner(s) of the pain management clinic: ____________________

How many hours/week do you work in a pain management clinic? ____________________

How many patients do you see weekly in a pain management clinic? ____________________

What percentage of your patients in the pain management clinic, are prescribed controlled substances? ____________________

Please describe your training, qualifications and/or board certifications in Pain Management in "Remarks".

(b) Do you provide care for federal/state prison or other correctional institution inmates? ☐ Yes ☐ No

If *yes*, please list institution(s) in "Remarks".

If *yes*, what percentage of your practice does this involve? __________ %

Does the institution(s) cover you for this exposure? ☐ Yes ☐ No

(If *no*, please forward copy of your contract with the institution so LAMMICO can determine if coverage can be provided.)

(c) Do you provide care for nursing home or long-term care facility patients? ☐ Yes ☐ No

If *yes*, what percentage of your practice does this involve? __________ %

(d) Do you provide care for any sports team or other athletic organization? ☐ Yes ☐ No

If *yes*, what percentage of your practice does this involve? __________ %

Does the team cover you for this exposure? ☐ Yes ☐ No

Do you travel outside of Louisiana as part of your duties for the team?If *yes*, please explain in "Remarks". ☐ Yes ☐ No

(e) If you practice as a Radiologist, do you interpret mammograms? ☐ Yes ☐ No

If *yes*, what percentage of your practice does this involve? __________ %

If *yes*, are they double-read by another radiologist? ☐ Yes ☐ No

(f) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? ☐ Yes ☐ No

If *yes*, please describe in "Remarks".

Do you follow FDA-approved protocols? If *no*, please describe in "Remarks". ☐ Yes ☐ No

(g) Do you practice as a pulmonologist? ☐ Yes ☐ No

If *yes*, do you also practice as an intensivist? ☐ Yes ☐ No

If *yes*, what percentage of your practice does this involve? ________ %

(h) Do you perform any coroner duties? If *yes*, please explain in "Remarks". ☐ Yes ☐ No

(i) Does your practice include cosmetic/aesthetic procedures? ☐ Yes ☐ No

If *yes*, please describe in "Remarks".

(j) Do you provide laser/pulsed light procedures for cosmetic purpose? ☐ Yes ☐ No

If *yes*, please describe in "Remarks".

If *yes*, are these procedures performed under your direct on-site supervision? ☐ Yes ☐ No

13. Type of practice:

☐ Solo ☐ Partnership ☐ Corporation ☐ Employee ☐ Other: __________________

(a) Give names of all medical partnerships, professional medical corporations, or other business entities:

____

____

____

(b) Name each partner/shareholder who is insured by LAMMICO

(c) Name each partner/shareholder who is not insured by LAMMICO ______________________

____

(d) Is a medical corporation, partnership, or other entity to be added as an additional insured on your policy? ☐ Yes ☐ No

If *yes*, provide a copy of the Articles of Incorporation or Partnership Agreement for each entity that is to be covered.

(e) If employed, name of employer: ______________________

(f) Are you in the employ of or under contract to any governmental entity? ☐ Yes ☐ No

If *yes*, provide a detailed explanation including a description of your responsibilities in "Remarks".

(g) Are you under contract to provide professional services to any individual, firm, corporation or athletic organization other than your own? ☐ Yes ☐ No

If *yes*, please explain the details of your responsibilities in "Remarks" .

14. Do you serve as a Medical Director? If *yes*, please explain in "Remarks". ☐ Yes ☐ No

15a. What call arrangements have you made and what are the qualifications of the person(s) taking your calls?

____

15b. Do you verify whether or not the person taking your calls purchases professional liability insurance? ☐ Yes ☐ No

16. (a) Do you (or does your partnership/association/corporation/joint venture) employ or contract with any of the following:

Licensed Physician Assistants	☐ Yes	Indicate # ________	☐ No
Licensed Surgeon Assistants	☐ Yes	Indicate # ________	☐ No
Licensed Nurse Practitioners (not LPNs)	☐ Yes	Indicate # ________	☐ No
Certified Registered Nurse Anesthetists (CRNAs)	☐ Yes	Indicate # ________	☐ No
Nurse midwives	☐ Yes	Indicate # ________	☐ No
Other—please list in "Remarks"	☐ Yes	Indicate # ________	☐ No

Please provide a copy of all Collaborative Practice Agreements with APRNs you supervise.

NOTE: If you answered *yes* to any part of question 16(a), please list all names in the "Remarks" section. If you want to apply for insurance for these medical professionals through LAMMICO, please indicate in the "Remarks" section.

(b) Are the providers listed above currently covered by LAMMICO? ☐ Yes ☐ No
If covered elsewhere, please provide certificates of insurance.

(c) Are the providers listed above qualified with the Louisiana Patients' Compensation Fund? ☐ Yes ☐ No

(d) Are the providers listed above independent contractors? ☐ Yes ☐ No
If *yes*, please list names and provide certificates of insurance.

(e) Do you supervise any individuals other than your employees? ☐ Yes ☐ No

17. Describe your practice mix, i.e., surgical to non-surgical, city or rural, welfare or private pay, etc.:

____

18. Do you market, advertise, or practice medicine outside Louisiana? ☐ Yes ☐ No
If *yes*, explain: ______________________

19. Do you perform consultations outside Louisiana, including but not limited to the use of communications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ☐ Yes ☐ No

If *yes*, identify all states in which such patients reside: ______________________

If *yes*, what percentage of your practice is involved in such activities? ________ %

20. Do you read, interpret or diagnose films, slides or specimens taken from patients residing in states other than your primary practice address? ☐ Yes ☐ No

If *yes*, identify all states in which such patients reside: ______________________

21. Do you work in an emergency room on a scheduled basis? (if *yes*, please answer a and b below) ☐ Yes ☐ No

(a) Indicate number of hours per month devoted to hospital emergency room care: ____________ Hours per month

(b) Is this emergency room care: On your own patients only? ☐ Yes ☐ No

Required for staff privileges ☐ Yes ☐ No

Other—please describe: ______________________________

(c) Are you requesting LAMMICO to cover you for ER work? ☐ Yes ☐ No

22. Do you perform major surgery in a freestanding facility (other than a hospital)? ☐ Yes ☐ No
If *yes*, please provide details in "Remarks".

23. Do you dispense drugs (other than free samples) in your office? ☐ Yes ☐ No If *yes*, state your Louisiana State Dispensing number ________________ and outline your training, record keeping under "Remarks" section.

24. Do you anticipate changes in your practice in the next 12 months? ☐ Yes ☐ No
If *yes*, please describe.

____

____

25. Has there been any change in your practice or specialty in the past ten years? ☐ Yes ☐ No
If *yes*, please describe.

____

____

26. Are you applying for insurance to cover only part-time practice or moonlighting activities? ☐ Yes ☐ No
(If *yes*, please explain in the "Remarks" section of this application) Number of hours per month? ______

NOTE: If you answer *yes* to any of the following questions, please give detailed information in the "Remarks" section of this application. (Attach additional sheets if necessary.)

27. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? ☐ Yes ☐ No

28. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? ☐ Yes ☐ No

29. Has your license to practice medicine or narcotics license ever been revoked, voluntarily suspended, or subjected to probation/restrictions or are you aware of any circumstances that might lead to such? ☐ Yes ☐ No

30. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? ☐ Yes ☐ No

31. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No

32. Have you volunteered to or been asked to participate in a physician's health (impaired) program? ☐ Yes ☐ No

33. Have Preceptor(s) or assisting physicians ever been assigned to your practice by a state licensing committee? ☐ Yes ☐ No

34. Have you now or have you ever had a chronic illness or physical limitation that impairs or could tend to impair your ability to practice medicine? ☐ Yes ☐ No

35. Have you been charged with or convicted of a crime (other than a motor vehicle violation)? ☐ Yes ☐ No

36. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? ☐ Yes ☐ No

37. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy? ☐ Yes ☐ No

38. Has any insurance carrier ever declined to offer professional liability insurance to you? ☐ Yes ☐ No

39. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No

40. Are you aware of any circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No

NOTE: If you answered yes to question 39 or 40, please provide the following information to complete and expedite our underwriting review:

(1) For each claim, complete the attached CLAIM ADDENDUM.
(2) A copy of the petition filed against you, if available.
(3) If you think it will help in the evaluation of the claim, include a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim.

<u>**We may ask for additional information as needed. Please be as thorough as possible in order to expedite the review of your application.**</u>

41. List names of all professional liability insurance carriers that you have been insured with for the last 10 years, dates of coverage and reasons for change: ______________________________

____

42. Why did you choose LAMMICO? ______________________________

43. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes?

____

44. What is your existing form of insurance? ☐ Claims-made ☐ Occurrence ☐ None Carried

45. a. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement ("tail" coverage)? ☐ Yes ☐ No

b. If no, are you applying for prior acts coverage from LAMMICO? ☐ Yes ☐ No

If no, I realize that not purchasing the "tail" from my current carrier can result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy I am purchasing from LAMMICO will not provide prior acts coverage.

Initial here _____________

(**LAMMICO will give consideration for prior acts only to those physicians who have practiced medicine exclusively in Louisiana**. If you qualify, please submit a copy of your current policy showing the retroactive date and a current certificate of enrollment from the Louisiana Patients' Compensation Fund.)

46. Retroactive date used by your existing carrier: ______________________________

NOTE: To prevent possible gaps in your claims-made coverage, either a reporting endorsement ("tail") or prior acts coverage must be purchased.

Question No.	Remarks (Attach additional sheets, if necessary)

Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I understand that the statements and answers will be relied upon by Louisiana Medical Mutual Insurance Company (LAMMICO) and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize release of my name, business address, policy and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

______________________________ ______________________________

Applicant Signature Date

LAMMICO is required by LA Revised Statue 40:1424, to include the following on this application:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.

Certificates Of Insurance

List hospitals where you hold or are applying for staff privileges. Place an ***X*** in the box in front of each hospital requiring a certificate of insurance. Also list other entities (i.e., credentialing organizations, managed care entities, etc.) requiring certificates of insurance.

		Institution Code (LAMMICO use only)
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CLAIM/SUIT/COMPLAINT INFORMATION ADDENDUM

IF ADDITIONAL SPACE IS REQUIRED PLEASE PHOTOCOPY THIS FORM AS NEEDED. PLEASE TYPE OR PRINT IN BLACK INK.
NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

Name of applicant ____________________

Patient's initials ____________________ Age ________ Sex ________ Date of incident ____________________
Month/Day/Year

Insurance company defending your claim ____________________ Policy no. ____________________

Location of incident ____________________ City ____________________ State ____________________
(Hospital, Office, etc.)

Procedures performed ____________________

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.). If you already have a written narrative, please attach it to this form.
Please attach a second sheet of paper if additional space is required.

____
____
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Co-defendants: ____________________

Present Status:

Medical review panel date ________ Panel Opinion: Favorable ☐ Unfavorable ☐ Issue of fact ☐

Suit filed: Yes ☐ No ☐ If Yes: Month ____________ Year ____________

Court Trial: Yes ☐ No ☐ Verdict: Defense verdict ☐ Plaintiff verdict ☐ Amount $ ____________

Settlement out of court: Yes ☐ No ☐ If Yes: Month ____________ Year ____________ Amount $ ____________

Claim settled without indemnity payment on your behalf ☐ Claim is pending ☐ Claim dismissed or withdrawn ☐

Amount in reserve by insurance company $ ____________________
Total amount paid to claimant on your behalf $ ____________________
Total amount paid to claimant for all defendants $ ____________________

The Applicant understands that the information submitted herein becomes part of the Professional Liability Application for insurance and declares that no material facts have been suppressed or misstated.

____________________ Applicant Signature in full

____________________ Date