INSTRUCTIONS: Please complete all sections of this form either electronically or in ink. All sections requiring a signature or initials must be signed in ink.

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

for PHYSICIANS

The following must accompany the application:

_____ Signed, dated and fully completed application
_____ Curriculum vitae

_____ "Policy History Reports", "Claim History Reports", or "Loss Runs" covering the past ten years. These may be obtained from your current or prior malpractice insurance companies.

_____ Copy of the **declaration page** from your current malpractice insurance policy
_____ Copy of your current license to practice medicine in Pennsylvania
_____ Copy of your current DEA registration
_____ A copy of your letterhead
_____ A copy of any advertisements for your services, if applicable

If 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 or the use of your professional office premises, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval. No coverage exists until a Binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

Send completed application with associated documentation to:

CPP Program
Murray Securus
PO Box 1728 ♦ 39 North Duke
Street Lancaster, PA 17608-1728

If you have any questions regarding the application process or any information contained in this packet, please contact the Program Services Department at (717) 397-9600 ext. 1228.

The policy you are applying for will be issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance guarantee funds are not available for your risk retention group.

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PERSONAL INFORMATION

First Name | MI | Last Name | Suffix

Degree or Title | Date of Birth | Office Phone

Primary office address | Office Fax

City | State | Zip code | E-mail Address

Any other name by which you have been known | **Requested Effective Date of CPPRRG Coverage**

LICENSURE AND CERTIFICATION

Please indicate in which states you were EVER licensed to practice medicine:

State	License Number	Date of License	Current (Yes/No)
Pennsylvania			

Please indicate all board certifications (by a member-board of the American Board of Medical Specialties or Osteopathic Specialties)

Specialty Board	Status (Certified/Eligible)	Certificate Number	Original Certification Date	Expiration Date

PRACTICE INFORMATION

Are you applying for coverage as a:

		If primary care, please mark which specialty:			
	Primary Care Physician →		Family Practice		Internal Medicine
			General Practice		Pediatrics
	Specialist (Please specify) →				
	Non-physician Practitioner (Please specify) →				
If you have one or more sub-specialties, please identify →					

First Date of Practice	**Enter exact date of start of practice:**
Please indicate your first date of practice **IF** you completed a medical residency or fellowship program within the past three years of the date of inception of coverage you are applying for **and** you are in practice for the first time since completion of that program:	

Applicant's Signature (All pages must be signed) | Date

Procedures and practices: (Check the box if applicable during any part of the coverage period, including any retroactive period, if applicable:

	No surgery (see last page for definition)
	Minor surgery (see last page for definition)
	Major surgery (see last page for definition)
	Assist in major surgery on your own patients
	Assist in maj. surgery in patients other than your own
	Administration of general, caudal or spinal anesthesia
	Deep radiation/X-ray therapy (over 120 kv)
	Intestinal surgery for obesity
	Laser surgery
	Colon-rectal surgery: ___ % of surgical practice

	Medical Director at another facility
	Normal obstetrical deliveries
	Supervision on nurse midwives
	Left heart catheterization
	Right heart catheterization
	Interventional radiology
	Caesarian sections
	Abortions
	Endoscopic procedures other than sigmoidoscopy
	Prenatal care: up to ____ weeks
	Remote services (internet or telemedicine)

Practice Organization:

Check which type of practice applies:		**Average hours worked per week**	
	Solo unincorporated	10 hours or less	
	Solo professional corporation	11 to 20 hours	
	Member of limited liability company	21 to 29 hours	
	Member of a professional association	More than 29 hours per week	
	Shareholder or employee in a professional corporation		
	Employee or contractor for a professional corporation, hospital, clinic, etc.		
	Other: _____		

Corporate Coverage:

Do you want coverage for your Professional Corporation or Partnership?	Yes	No
If yes, ONE separate corporation/partnership application is required for each entity.		
If no, is the corporation/partnership insured elsewhere?	Yes	No

Current Office Locations: List all current office or clinic practice locations in this section. Include all locations whether or not CPPRRG, Inc. insurance is desired at that location. If additional space is required to show more than four practice locations, please attach a separate sheet or your brochure.

Name of Location	City and State	County	% of practice

Applicant's Signature (All pages must be signed) _____ Date

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WORK HISTORY

Starting with your current practice, list all employment since completion of post-graduate training.

Name of Location	City and State	From (Date)	To (Date)

HOSPITAL PRIVILEGES

Please provide the following information on your CURRENT hospital privileges

	Hospital Name	City, State	Type of privileges	Specialty or department
1.				
2.				
3.				
4.				

INSURANCE HISTORY

You must attach the declarations page from your current policy	Current Policy	First Prior Policy	Second Prior Policy
Insurance Carrier			
Type of policy (Claims-made or Occurrence)			
Effective Date			
Expiration Date			
Retroactive date (Claims-made only)			

If your current policy is a "Claims-Made" policy, you MUST either purchase prior acts coverage from your new carrier OR obtain a reporting endorsement from your current carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of this coverage.	**I decline or don't need retroactive coverage:**
	Applicant Signature

Applicant's Signature (All pages must be signed) _____ Date _____

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ADDITIONAL UNDERWRITING INFORMATION

Please answer the following questions. Yes responses REQUIRE additional explanation in the area provided. If additional space is needed, please use the area provided on the last page of this application.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other State?

Medical or professional license	Yes	No
DEA or CDS/BNDD registration	Yes	No
Hospital medical staff membership	Yes	No
Clinical privileges or other rights on any hospital medical staff	Yes	No
Employment by any hospital, institution or the military	Yes	No
Professional society memberships	Yes	No
Participation in any private, federal or state health program (i.e., Medicare, Medicaid)	Yes	No
Participation in an HMO, PPO or other managed care organization	Yes	No
Board certification	Yes	No

At any time, have you ever been:		
Convicted of a criminal offense	Yes	No
Convicted of a felony	Yes	No
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of a trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country	Yes	No

Have you ever at any time or are you currently:		
Under indictment for any crime	Yes	No
The subject of an investigation by any private, federal, state or health insurance program or state licensing board	Yes	No
Under investigation by any state licensing board or federal agency	Yes	No
The subject of any adverse action reports to a state or federal databank	Yes	No

Have you either voluntarily or involuntarily:		
Withdrawn your application for medical staff membership at any facility	Yes	No
Withdrawn your request for any clinical privileges at any facility	Yes	No

Health Status:		
Are you able to perform the professional duties of the position with or without reasonable accommodation? (A "Yes" answer to this question does not require additional documentation)	Yes	No
Are you currently using illegal substances or illegally using substances?	Yes	No

Applicant's Signature (All pages must be signed) _____ Date _____

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PROFESSIONAL LIABILITY HISTORY		
Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?	Yes	No
Has any claim or suit for alleged malpractice been brought against you in the past ten years?	Yes	No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?	Yes	No

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING SECTION:

CASE 1

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

CASE 2

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

Applicant's Signature (All pages must be signed) _____ Date _____

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CASE 3

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

CASE 4

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

CASE 5

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

Applicant's Signature (All pages must be signed) _____ Date _____

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CASE 6						
Date of occurrence of event		Date case was filed	Plaintiff's Name		Carrier involved	
Your status in this case			Status of case			
	Primary defendant			Pending		Dismissed/dropped
	Co-defendant			Found for plaintiff		Settled, if settled, state amount:
				Found for defendant	Amount:	
Alleged harm to patient:						
Circumstance of patient's illness:						
Any other pertinent details:						

DEFINITIONS:

MAJOR SURGERY: Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis; any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.
MINOR SURGERY: Any operation not defined as major surgery
NO SURGERY: The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

The undersigned agrees to fully comply with the conditions of membership in CPPRRG and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to and form part of this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such a person to criminal and civil penalties.

Save form

Print Application

Applicant Signature _____ Date _____

The policy you are applying for will be issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance guarantee funds are not available for your risk retention group.