Medical Alliance Insurance Company

MEDICAL ALLIANCE INSURANCE COMPANY (MAIC)

PHYSICIAN APPLICATION

MAIC-A001-P
(1/1/2009)

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. ☐
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

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?

IF YES:

What specialty or specialties

Are there any gaps in your certification, if yes, please explain.

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?
   If yes, what hospital.

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

3. Are you part of a group practice?

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

   Are they also applying for MAIC coverage?

   Are you seeking coverage for the medical corporation?

   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		
Jail/Prison or Correctional Facility		
Federal Government		
Surgicenter, Emergency Service Facility or similar Outpatient Facility		
Birthing Center		

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

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)

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

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

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

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

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?

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

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

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?

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?

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

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?

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?

(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		

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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