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ASBP EXCLUSIVE PREFERRED PROVIDER - BARIATRIC PHYSICIAN (NEW)

(Professional Liability - Claims Made Coverage)

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: ____________________

(ii) Professional Degree: ____________________

(b) Principal practice address: ____________________
(Street)

____
(City) (State) (Zip)

(c) (i) Phone: ____________ (ii) Fax: ____________

(iii) E-Mail Address: ____________ (iv) Website Address: ____________

(d) (i) Date of Birth (MM/DD/YYYY): ____________ (ii) Place of Birth: ____________

(e) (i) Social Security No.: ____________ (ii) Federal Tax ID Number: ____________

2. Are you a U.S. citizen? .... [ ] Yes [ ] No
If No, what is your status in the U.S. and current citizenship? ____________

3. (a) Type of practice: [ ] solo practitioner (unincorporated) [ ] solo practitioner (incorporated)*
[ ] professional corporation* [ ] professional association*
[ ] limited liability company* [ ] partnership*
[ ] employee of ____________ [ ] independent contractor of ____________
[ ] other ____________
* Specify name of entity: ____________

(b) Do you want coverage for the entity named Item 3(a) above? .... [ ] Yes [ ] No

4. Federal DEA License No. and status: ____________

5. Provide the following information for all hospitals and surgi-centers where you are currently on staff:

Name	City	State	Percentage of Work	Type of Privileges

6. Are you currently a hospital chief of staff or head of any hospital department? .... [ ] Yes [ ] No
If Yes, describe. ____________

7. Do you or the entity firm named in Item 3(a) above own (either wholly or in part), operate or administer any hospital, nursing home, surgicenter, urgent care center other facility where medical services are customarily provided? [ ] Yes [ ] No

If Yes, provide a detailed explanation specifically including the name, location, size, and number of beds. ____________

____

8. Is the Applicant a “Covered Entity” under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .... [ ] Yes [ ] No
(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. ____________

II. EDUCATION AND TRAINING

1. (a) Provide your medical or surgical specialty: ______________________________

   (b) Do you limit your practice to the specialty stated in item (a) above? .... [ ] Yes [ ] No

   (c) Do you have a subspecialty?.. [ ] Yes [ ] No
   If Yes, describe. ______________________________

2. Are you American Board certified? .... [ ] Yes [ ] No
   If Yes, provide the following: Medical specialty in which you are certified: ______________________________
   Date of certification: ______________________________ Any recertification date(s): ______________________________
   If No, do you plan on taking the Board examination? .... [ ] Yes [ ] No

3. Provide the following information:

	Name of Institution	City	State	Date Completed
Medical School				
PGY-1/Internship				
Residency – Specialty: ___________				
Residency – Specialty: ___________				
Fellowship – Specialty: ___________				
Other: ______________________				

4. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates?.. [ ] Yes [ ] No
   If Yes, provide the following: year of certification: _______ describe your medical degree: ______________________

5. Provide a detailed summary of where you have practiced your profession since completing your training:
   ____

6. Are you a member of any professional societies? .... [ ] Yes [ ] No
   If Yes, provide information regarding your membership(s). ______________________________

7. Are you currently a dues paying member of the American Society of Bariatric Physicians? .... [ ] Yes [ ] No
8. Are you a diplomate of the American Society of Bariatric Physicians? .... [ ] Yes [ ] No
9. Do you subscribe to the ASBP Bariatric Practice and Anorectic Usage Guidelines? .... [ ] Yes [ ] No

III. SCOPE OF PRACTICE

1. (a) Do you perform surgery, other than incision of boils & superficial abscesses or suturing skin & superficial fascia? .... [ ] Yes [ ] No

   (b) If Yes, please provide details on a separate page.

2. (a) Do you perform any surgery in your office? .... [ ] Yes [ ] No
   If Yes, answer the following:

   (i) Describe each procedure not already identified above in 1(b) or 2 above: ______________________________
   ____

   (ii) Is your surgical suite certified? .... [ ] Yes [ ] No
   If Yes, provide the name of the certification body. ______________________________

   (b) Do you perform any surgery in other non-hospital facilities? .... [ ] Yes [ ] No
   If Yes, answer the following:

   (i) Describe each procedure not already identified above in 1(b) or 2 above: ______________________________
   ____

   (ii) Name each facility: ______________________________
   ____

3. With the exception of surgery for obesity, does your practice include weight reduction or control by other than diet or exercise? .... [ ] Yes [ ] No

   (a) Percentage of your patients that are weight control patients: _______________

   (b) Do you dispense any drugs? .... [ ] Yes [ ] No
   If Yes, provide the name(s) of the drug(s) dispensed.____________________

   (c) Do you use injections for weight control? .... [ ] Yes [ ] No
   If Yes, provide the name(s) of the drugs injected. ____________________

   (d) Do you use hCG for weight control? .... [ ] Yes [ ] No

4. Do you perform any hospital emergency room care? .... [ ] Yes [ ] No

   If Yes, is this solely a requirement for active admitting privileges? .... [ ] Yes [ ] No

   If No, provide a detailed description including the approximate number of hours per month spent in emergency room care. ____________________

   ____

5. Do you perform consultations outside the state of your primary office address, including but not limited to the use of telecommunications technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? .... [ ] Yes [ ] No
   If Yes, provide the following:

   (a) Identify all states in which such patients reside: ____________________

   (b) What percentage of your total practice is involved in such activities? ____________________

6. (a) Do you use experimental procedures, devices, drugs or therapy in treatment or surgery? .... [ ] Yes [ ] No
   If Yes, do you follow FDA-approved protocols? .... [ ] Yes [ ] No

   If Yes, describe. ____________________

   ____

   (b) Are you a Principal Investigator for any clinical trial? .... [ ] Yes [ ] No

7. (a) Indicate the number of professional employees in your practice for each of the following: (If none, check here [ ])

   ___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists

   ___ Physician's Assistants* ___ Nurses ___ Nurse Practitioners* ___ Nurse Anesthetists*

   ___ Surgeon's Assistants* ___ Nurse Midwives* ___ Psychologists

   ___ Other (describe) ____________________

   *Provide a description of duties, in detail, including extent supervised on a separate page and attach protocols.

   (b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? .... [ ] Yes [ ] No
   If No, provide a detailed explanation on a separate page.

8. (a) Average weekly patient load: ________ (b) Number of patients annually: ________

9. Average number of hours you practice each week: ________

10. Do you supervise anyone other than your own employees? .... [ ] Yes [ ] No
    If Yes, indicate by profession the number of individuals you supervise:

    ___ Physicians other than yourself ___ Podiatrists ___ Chiropractors ___ Optometrists

    ___ Physician's Assistants ___ Nurses ___ Nurse Practitioners ___ Nurse Anesthetists

    ___ Surgeon's Assistants ___ Nurse Midwives ___ Psychologists

    ___ Radiology Technicians ___ Lab Technicians ___ Other (describe) ____________________

    Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. ____________________

    ____

11. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

12. Do you anticipate any changes in your practice in the next year? .... [ ] Yes [ ] No
If Yes, attach a detailed explanation.

IV. AFFILIATIONS

1. Are you in the employ of any individual, firm or corporation other than the employer named in Section I. 3(a) above? .... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. ___________________________

____

2. Are you under contract to any individual, firm or corporation other than the contracting entity named in Section I. 3(a) above? .... [ ] Yes [ ] No
If Yes, provide a detailed explanation including a description of your responsibilities. ___________________________

____

If Yes, does any contract contain a hold harmless agreement? .... [ ] Yes [ ] No
If Yes, attach a copy of the contract.

3. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? .... [ ] Yes [ ] No
If Yes, attach a copy of all advertisements.

4. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients?... [ ] Yes [ ] No
If Yes, attach a copy of the advertisement or applicable website address.

5. Are you engaged in or planning to engage in any "moonlighting" activities? .... [ ] Yes [ ] No
If Yes, do you want coverage for your "moonlighting" activities? .... [ ] Yes [ ] No
If Yes, describe the activities. ____

V. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance?... [ ] Yes [ ] No
If Yes, how many? _________Complete a Supplemental Claim form for each one.

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? .... [ ] Yes [ ] No
If Yes, how many? _________Complete a Supplemental Claim form for each one.

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?.. [ ] Yes [ ] No
If Yes, how many? _________ Complete a Supplemental Claim form for each one.

4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew or revoke your privileges?.. [ ] Yes [ ] No

5. Has your license to practice medicine or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state?......... [ ] Yes [ ] No

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? .... [ ] Yes [ ] No

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? .... [ ] Yes [ ] No

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? .... [ ] Yes [ ] No

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? .... [ ] Yes [ ] No

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY. The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, 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 Optional Extension Period option is exercised in accordance with the terms of the policy. The Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the Company receives notice is on file with the Company and is considered physically attached to and part of the of the policy if issued. The Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Company who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, 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 and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the Company.

Must be signed by the Applicant within 60 days of the proposed effective date.

______________________________	______________________________
Name of Applicant	Title
______________________________	______________________________
Signature of Applicant	Date

Notice to 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 the person to criminal and civil penalties.