LOUISIANA MISCELLANEOUS HEALTHCARE PROVIDERS

Application for Professional Liability Insurance

In order to allow adequate time for our underwriting review process, we ask that you please submit your application at least 30 days in advance of your requested effective date. Incomplete submissions or lack of required information will delay the underwriting process. After your application has completed the underwriting process, you will be promptly notified.

Please read the following instructions in order to expedite the review of your application:

1. Save this PDF to your local computer
2. Answer all questions or mark "N/A" where appropriate
3. Save and print your document
4. Sign and date your application
5. Complete the attached Claim Addendum if a claim or suit has been filed against you
6. Submit a loss summary report from your previous carrier(s) – 10 years if applicable
7. Provide a copy of your current professional liability policy or declarations page
8. Provide a copy of your Curriculum Vitae
9. Fax the signed application to 504.841.5205 or scan the signed application to email to your Underwriter

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (6) 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.

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.

When completed, please remit this application to:

LAMMICO
One Galleria Blvd., Suite 700
Metairie, LA 70001
FAX: 504.841.5205

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LOUISIANA MISCELLANEOUS HEALTHCARE PROVIDERS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

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.

Please complete this application ONLY for the practice for which you are applying.

A. General Information

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

Full Name (Last, First, Middle Initial)	Suffix ☐ Jr. ☐ Sr. ☐ III ☐ IV	Gender ☐ Male ☐ Female	NPI#
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)		Parish Medical Society	

Medical Group Name (if any)	Social Security No.	Date of Birth	Website Address	Email Address

Office Phone	Fax Number	Home Phone	Cell Phone

B. Coverage Information

Requested Effective Date: _____ / _____ / _____
MM DD YYYY

(LAMMICO Use Only)

Retroactive Date _____
Parish Code _____ Tax Code _____
Specialty/Class _____
Discount Code _____ Discount _____ %
Limit/Option _____ Group Code _____
Start of Practice Date _____

Professional Liability Limits Desired (Check one box)

Occurrence	Claims-Made	Higher Limits Coverage*
☐ N/A	☐	$500,000 each medical incident/$500,000 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
☐ N/A	☐	Higher Limits: Please refer to Company
		Basic Limits Coverage
☐	☐	$100,000 each medical incident/$300,000 aggregate **with** PCF
☐	☐	$100,000 each medical incident/$300,000 aggregate **without** PCF

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

1. 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: _____

2. What is your existing form of insurance? ☐ Claims-Made ☐ Occurrence ☐ None Carried

3.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

3.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 providers 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 Patient's Compensation Fund.) Any claims or any circumstances that might reasonably lead to a claim or suit must be reported to your present carrier prior to the requested effective date of this insurance.

4. Retroactive date used by your existing carrier: _____
(MM/DD/YYYY)

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

C. Practice Information

___Aesthetician (specify type): _____
___EEG/EKG Ultrasound Technician
___Lab Technician (specify type): _____
___Nurse Midwife
___Nurse Practitioner (NP area of specialty): _____
___Occupational Therapist
___Optician
___Optometrist
___Pharmacist
___Physical Therapist
___Certified Reg. Nurse Anesthetist (CRNA)
___Physician Assistant (PA)
___Psychologist
___Registered Nurse (RN)
___Respiratory Therapist
___Social Worker
___Surgical Technician
___X-ray Technician
___Other: _____

1. Briefly explain the type of practice for which you are applying: _____
_____
2. Do you have a signed protocol agreement in place for this practice? ☐ Yes ☐ No
If *no*, please explain: _____
3. For Nurse Practitioners/Midwives:
Do you have a signed Collaborative Practice Agreement with your supervising M.D.? ☐ Yes ☐ No
If *no*, please explain: _____

4. Type of practice: Coverage will only apply to the practice for which you are applying.
☐ Solo ☐ Partnership ☐ Corporation ☐ Employee ☐ Self-Employed ☐ 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: _____
_____

5. Name of employer for this work: _____
6. Is your employer insured with LAMMICO for this work? ☐ Yes ☐ No
7. If your employer is not insured with LAMMICO, please list name of insurer for this work: _____
8. Name of medical group for this work: _____
9. Name of supervising physician (if required) for this work: _____
10. Does your supervising physician practice at the same location? ☐ Yes ☐ No
11. **Is a 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.
12. **Do you want separate limits of liability for the entity?** ☐ Yes ☐ No
13. Are you the owner of the entity? ☐ Yes ☐ No
If *no,* please list owner(s): _____

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D. Education/Training Information

Educational Background: Please include a copy of your CV or resumé:

School of Graduation	Field of Study	Degree	Year of Graduation

Date you began practicing: _____
(MM/DD/YYYY)

E. Underwriting and Rating Information

1. Do you have a current license to practice medicine in LA? ☐ Yes ☐ No LA License No.:_____
2. Do you have any restrictions? (if *yes*, explain) ☐ Yes ☐ No
3. List other states where licensed and license numbers: _____
   _____
4. Do you have prescriptive authority? ☐ Yes ☐ No Date of Prescriptive License: _____
   MM / DD / YYYY
5. Does your practice include cosmetic/aesthetic procedures? If *yes*, please describe in "Remarks". ☐ Yes ☐ No
6. Does your practice involve pain management? If *yes*, please describe in "Remarks". ☐ Yes ☐ No
7. Do you perform surgical procedures? If *yes,* please describe in "Remarks". ☐ Yes ☐ No
8. Are you under contract to provide professional services to any individual, firm, corporation or athletic organization other than your own? If *yes*, please explain the details of your responsibilities in "Remarks". ☐ Yes ☐ No
9. 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".
10. 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? ____%
11. Does the institution(s) cover you for this exposure? ☐ Yes ☐ No
    If *no,* please forward a copy of your contract with the institution so LAMMICO can determine if coverage can be provided.
12. 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? ____%
13. Do you provide care for any sports team or other athletic organization? ☐ Yes ☐ No
    If *yes*, what percentage of your practice does this involve? ____%
14. Does the team cover you for this exposure? ☐ Yes ☐ No
15. Do you travel outside of Louisiana as part of your duties for the team? If *yes*, please describe in "Remarks". ☐ Yes ☐ No
16. Do you market, advertise, or practice medicine outside Louisiana? ☐ Yes ☐ No
    If *yes*, explain: _____
17. 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? ____%
18. Do you anticipate changes in your practice in the next 12 months? ☐ Yes ☐ No
    If *yes*, please describe: _____
    _____
19. Has there been any change in your practice or specialty in the past 10 years? ☐ Yes ☐ No
    If *yes*, please describe: _____
    _____
20. Are you applying for insurance to cover only part-time practice or moonlighting activities? ☐ Yes ☐ No
    If *yes,* please indicate: # of hours_____/per month for these activities.

If *yes*, please describe these activities in the "Remarks" section (include the name of your full time employer)

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.)

F. Additional Information

1. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? ☐ Yes ☐ No
2. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? ☐ Yes ☐ No
3. 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
4. Has your membership in any medical society/association ever been refused, suspended, revoked, voluntarily surrendered or been censured? ☐ Yes ☐ No
5. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No
6. Have you volunteered to or been asked to participate in an impaired provider program? ☐ Yes ☐ No
7. Have Preceptor(s) or assisting providers ever been assigned to your practice by a state licensing committee? ☐ Yes ☐ No
8. 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
9. Have you been charged with or convicted of a crime (other than a minor traffic violation)? ☐ Yes ☐ No
10. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? ☐ Yes ☐ No
11. Has your professional liability insurance ever been cancelled, non-renewed, restricted, surcharged, or has your professional liability insurer ever asked you not to renew your policy? ☐ Yes ☐ No
12. Has any insurance carrier ever declined to offer professional liability insurance to you? ☐ Yes ☐ No
13. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
    If *yes,* has this been reported to your present or prior insurer(s)?
14. Are you aware of any circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No
    If *yes,* has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No

NOTE: If you answered yes to question 13 or 14, 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***

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

15. Why did you choose LAMMICO? _____

G. Remarks/Comments

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 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 Statute 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: _____
(MM/DD/YYYY)

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.

_____
_____
_____
_____
_____
_____
_____

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