



**Physicians  
& Surgeons**

# APPLICATION

For Claims Made Professional Liability  
Insurance and Prior Acts Coverage

 **NORCAL**  
Mutual Insurance Company

# COVERAGE HIGHLIGHTS

Feature	Benefit
Physicians Administrative Defense Reimbursement Coverage	Provides defense cost reimbursement and practice interruption expense reimbursement for administrative proceedings and employment-related civil actions
Free Tail Coverage If Retiring at Age 60+ (certain qualifications required)	Reduces your expenses after retirement
Limited Professional Office Premises Liability Coverage	Provides limited coverage for slips and falls and property damage
Prior Acts/Nose Coverage (Over Current Retroactive Date)	Conveniently provides coverage from one insurer
Right to Consent to Settle	Places you in control of whether to settle a claim

**The following benefits are provided in addition to the Limits of Liability of the policy:**

- Defense Costs
- Attendance at Trial: *\$500 maximum per half day*
- Fire and Water Damage Legal Liability: *\$500,000/\$500,000*
- Medical Payments: *\$10,000 per person*
- Pre-judgment and Post-judgment Interest

**Additional Highlights**

Aggressive Claims Handling	Represents your interests and helps protect your reputation
On-Site Clinical and Administrative Assessment	Helps you identify risks and evaluate and improve your practice systems
Award-winning CME Material	Assists you in enhancing patient safety and improving communication
Monthly <i>Claims Rx</i> Newsletter	Helps you stay on top of current administrative and clinical issues
Risk Management 24/7 Phone Consultations	Offers peace of mind and allows you to call NORCAL 24/7 for Risk Management advice

The above information is intended only to highlight the NORCAL policy features and benefits. The conditions of coverage are specifically explained in the NORCAL policy. Please read your policy for complete coverage information.

If you have questions regarding this application or would like a copy of the NORCAL policy, please contact NORCAL's Policyholder Services Unit at (877) 443-7232.

The coverage of any policy, if issued, is limited generally to liability only for those claims that are first made against the insured while the policy is in force. Please review the policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker. Please note that no coverage exists until written verification of coverage by NORCAL Mutual Insurance Company is issued in your name.

## APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- If you are beginning a new practice or changing your current practice, your application must reflect your planned practice situation as of your Requested Effective Date, unless a question requires that you provide information about previous practices.
- The application asks that you provide information regarding hospital affiliations, practice associations, etc. This information is requested to provide us with an understanding of your practice but does not mean that a policy, if issued, would cover such entities or persons.
- If you wish to explain any of your answers, please use the Remarks section on page 21. If you need more space, please attach additional pages.
- Please ensure that you sign and date the application on page 23 for California and Rhode Island applicants or page 24 for Alaska applicants.
- In addition to a completed application, please provide the following items:
  - A copy of your letterhead(s).
  - Loss runs for the previous ten years, or since the date you began practicing medicine, whichever is more recent. The loss runs must be less than 90 days old.
  - A copy of the Declarations Page and any endorsements from your most recent insurance policy, if applicable.
- Please make a copy of the completed application and supporting documents for your records.

## SECTION I IDENTIFYING INFORMATION

1. Is this an application to join a physician or group currently insured with NORCAL?  Yes  No

If yes, please identify the name of the physician and/or group: \_\_\_\_\_

Applicant Name (Last, First Middle)		<input type="checkbox"/> MD <input type="checkbox"/> DO	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	
Primary Practice Address	City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Mailing Address (Location where all mailings except invoices will be sent)	City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Billing Address (Location where invoices will be sent)	City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Home Address	City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -

E-Mail Address

Name and Title of Authorized Representative to Act on Your Behalf (if other than you)	Telephone # ( ) -	Fax # ( ) -
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## SECTION II LICENSES

1. Please complete the following regarding *all* states where you are presently or have been previously licensed to practice medicine in any capacity:

State	License Number	Type	Current Status	If Inactive, Reason for Inactive Status
		<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	
		<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	
		<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	

2. Federal DEA License: Number: \_\_\_\_\_ Status: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

## SECTION III COVERAGE/INSURANCE INFORMATION

**Requested Effective Date** (the date you wish coverage to begin)

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

**NOTE:** NORCAL should receive the application at least thirty days before the Requested Effective Date.

**Risk Management Discount** (check one)

**NOTE:** If you are practicing in a group of five or more physicians, please skip this question.

Solo physicians and physicians practicing in a group of four or fewer physicians may be eligible for a 5% Risk Management Discount.

- I would like to enroll in the 5% Risk Management Discount Program. I pledge to complete at least one approved Risk Management activity each year in order to qualify for the discount. I understand that if I do not complete an approved activity each year, I will lose my discount. NORCAL-approved activities are listed in the CME Catalog published annually by NORCAL. Activities other than those listed in the CME Catalog must be approved by the Risk Management Department.
- I **do not** wish to participate in the 5% Risk Management Discount Program at this time.

**Prior Acts Coverage** (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. **NORCAL does not automatically provide Prior Acts Coverage.**

- I wish to apply for Prior Acts Coverage. (Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 19.):
- I **do not** wish to apply for Prior Acts Coverage. I understand that if I do not obtain Prior Acts Coverage, I will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the Effective Date of my NORCAL policy, if issued.

**Requested Retroactive Date**

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

**NOTE:** The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

**Requested Limits of Liability** (check one)

**NOTE:** If you are joining a group of physicians already insured with NORCAL, your limits of liability must be the same as theirs. If you and your partners or associates are joining NORCAL concurrently, all must apply for the same limits of liability.

**Alaska Physicians**

- \$500,000/\$1,000,000
- \$1,000,000/\$2,000,000
- \$1,000,000/\$3,000,000
- \$2,000,000/\$4,000,000

**California Physicians**

- \$500,000/\$1,500,000
- \$1,000,000/\$3,000,000
- \$2,000,000/\$4,000,000
- \$2,000,000/\$5,000,000

**Rhode Island Physicians**

- \$500,000/\$1,500,000
- \$1,000,000/\$1,000,000
- \$1,000,000/\$3,000,000

**Scope of Coverage** (check one)

- I am requesting coverage for my entire medical practice as described in this application.
- I **do not** need NORCAL coverage for part of my medical practice (e.g., certain procedures or duties, or services rendered at certain locations).

If you do not need NORCAL coverage for a particular part of your practice, please provide a detailed description of that part of your practice, including the start date and number of hours devoted to it, in the Remarks section on page 21. Please also identify the name of the insurance carrier that is providing you with professional liability coverage for that part of your practice, as well as the limits of liability of that coverage.

**NOTE:** In the subsequent sections of this application, be sure to describe your entire practice, even parts for which you are not requesting NORCAL coverage.

**Professional Liability Insurance History**

1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) your insurance, declined to offer you coverage or notified you of its intent to pursue such action?  **Yes**  **No**

If **yes**, please provide a detailed written narrative in the Remarks section on page 21 and copies of all pertinent documentation (e.g., a copy of the nonrenewal or declination notice). At a minimum, the narrative must include the name of the insurance company, the date(s) of the action(s) and a detailed description of the reason(s) for the action(s).

2. Please complete the following regarding all professional liability insurance you have maintained during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (Month/Day/Year)	Policy Type	If Claims Made, Check One
	From:  To:	<input type="checkbox"/> Claims Made  <input type="checkbox"/> Occurrence	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Claims Made  <input type="checkbox"/> Occurrence	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Claims Made  <input type="checkbox"/> Occurrence	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Claims Made  <input type="checkbox"/> Occurrence	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Claims Made  <input type="checkbox"/> Occurrence	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____

3. If any of the insurance coverages identified above was Claims Made Coverage, and you did not purchase Tail Coverage or Prior Acts Coverage, please explain in the Remarks section on page 21.

## SECTION IV PRACTICE LOCATIONS

### Non-Hospital Locations

Please identify all non-hospital locations at which you render professional health care services. Please photocopy this page if additional space is needed.

#### 1. Primary Practice Location

Name of Location/Entity: \_\_\_\_\_

Average number of hours per week that you render professional health care services at this location: \_\_\_\_\_

Date (month and year) you began rendering professional health care services at this location: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: ( ) - Fax #: ( ) -

Location Type (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Outpatient Office           | <input type="checkbox"/> Nursing Home                         |
| <input type="checkbox"/> Office-based Surgical Suite | <input type="checkbox"/> Imaging Center (specify type): _____ |
| <input type="checkbox"/> Ambulatory Surgery Center   | <input type="checkbox"/> Laboratory (specify type): _____     |
| <input type="checkbox"/> Urgent Care Clinic          | <input type="checkbox"/> Other (specify): _____               |

Do you own, rent or lease this premise?  Yes  No

If no, please explain: \_\_\_\_\_

#### 2. Additional Practice Location

Name of Location/Entity: \_\_\_\_\_

Average number of hours per week that you render professional health care services at this location: \_\_\_\_\_

Date (month and year) you began rendering professional health care services at this location: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: ( ) - Fax #: ( ) -

Location Type (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Outpatient Office           | <input type="checkbox"/> Nursing Home                         |
| <input type="checkbox"/> Office-based Surgical Suite | <input type="checkbox"/> Imaging Center (specify type): _____ |
| <input type="checkbox"/> Ambulatory Surgery Center   | <input type="checkbox"/> Laboratory (specify type): _____     |
| <input type="checkbox"/> Urgent Care Clinic          | <input type="checkbox"/> Other (specify): _____               |

Do you own, rent or lease this premise?  Yes  No

If no, please explain: \_\_\_\_\_

#### 3. Do you own or operate any of the following? Yes No

If yes, please check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Blood Bank       | <input type="checkbox"/> Community Clinic |
| <input type="checkbox"/> Dialysis Center           | <input type="checkbox"/> Endoscopy Center | <input type="checkbox"/> Imaging Center   |

- Laboratory
- Urgent Care Clinic

- Office-based Surgical Suite
- Other (specify): \_\_\_\_\_

**If yes:**

- a. Do you allow other physicians to render professional health care services in any of the facilities listed in question 3 above?
  - Yes    No

**If yes,** please identify the facility or facilities and the name(s) of the physicians in the Remarks section on page 21.

- b. Please provide proof of each facility's professional liability insurance (i.e., a current Declarations Page or Certificate of Insurance).

**Note:** If you indicated that you own or operate any of the above facilities, please ensure that each was identified in question 1 or 2 above.

**Hospital Locations**

- 1. Please list all hospitals at which you currently maintain or will be applying for staff privileges:

**NOTE:** You may submit your curriculum vitae (CV) in lieu of completing the table as long as the CV is current and provides all of the information requested in the table.

Name of Facility	Location (City and State)	Type of Privileges
		<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pending
		<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pending
		<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pending
		<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pending

- 2. If you checked "provisional" or "other," please explain in the Remarks section on page 21.
- 3. If you do not have hospital privileges, please identify which means you use to admit your patients should the need arise:

- Another Physician
- Hospitalist
- 911
- None (reason): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

If you indicated a means other than another physician or a hospitalist, who follows the patient while he or she is hospitalized?

\_\_\_\_\_

**Previous Practice Locations**

1. Within the past ten years, have you rendered professional health care services at any location other than the non-hospital or hospital location(s) identified in this section (Section IV)?  Yes  No

If yes, please complete the following:

**NOTE:** Do not list medical/osteopathic schools or postgraduate training programs (see Education and Training, Section VII). You may submit your curriculum vitae (CV) in lieu of completing the following table as long as the CV is current and provides all of the information requested in the table.

Name of Practice/Entity/Facility	Location (City and State)	From (Month/Year)	To (Month/Year)

**SECTION V PRACTICE ASSOCIATIONS**

**NOTE:** Due to the potential for shared liability, NORCAL requires that all health care practitioners practicing in an employer-employee relationship, partnership or medical corporation be insured with NORCAL.

1. Do you maintain an ownership interest (in whole or in part) in any entity or entities related to the practice of medicine?  Yes  No

If yes:

- a. Do any persons or entities other than you maintain an ownership interest in that entity or entities?  Yes  No
- b. Please provide a copy of each entity’s partnership agreement, articles of incorporation, etc.
- c. Please complete the following for each entity:

Name of Entity	Legal Structure	Name(s) of Other Owner(s) and the Percentage of Their Ownership Interest
	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____	

2. Are you employed by any person or entity other than an entity identified in question 1?  Yes  No

If yes:

- a. Please identify the entity or entities: \_\_\_\_\_
- b. Do any of the entities employ any physician(s) other than you?  Yes  No

If yes, please identify the physician(s):

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3. Do you or any entities in which you maintain an ownership interest employ any physician(s)?  Yes  No

If yes, please identify the physician(s):

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4. Do you or any entities in which you maintain an ownership interest independently contract with any physician(s) or entities?  
 Yes  No

If yes, please identify the physician(s) and/or entity or entities:

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5. Do you share office space with any physician(s) other than the physician(s) identified in question 2b or 3?  Yes  No

6. If you answered yes to question 4 or 5, please provide a copy of any contract(s), check all of the following that apply to the association and identify the applicable physician(s):

- |   |                             |
|---|-----------------------------|
| <input type="checkbox"/> Share medical professional personnel         | Name of physician(s): _____ |
| <input type="checkbox"/> Share call                                   | Name of physician(s): _____ |
| <input type="checkbox"/> Share profits and/or overhead expenses       | Name of physician(s): _____ |
| <input type="checkbox"/> Use common letterhead                        | Name of physician(s): _____ |
| <input type="checkbox"/> Use common advertisements                    | Name of physician(s): _____ |
| <input type="checkbox"/> Share billing                                | Name of physician(s): _____ |
| <input type="checkbox"/> See each other's patients on a regular basis | Name of physician(s): _____ |
| <input type="checkbox"/> Other (specify): _____                       | Name of physician(s): _____ |

7. Do you, do any entities in which you maintain an ownership interest, or does your practice use any fictitious name(s) or dba(s)?  
 Yes  No

If yes:

a. Please identify each fictitious name or dba: \_\_\_\_\_  
\_\_\_\_\_

- b. Do any other persons or entities utilize the fictitious name(s) listed in 7a?  Yes  No

If yes, please identify each person and/or entity and the fictitious name(s) used: \_\_\_\_\_  
\_\_\_\_\_

8. Do you or any entities in which you maintain an ownership interest employ, independently contract with or otherwise maintain an association with any health care extenders or ancillary personnel who provide patient care?  Yes  No

If yes, please complete the following:

Designation	Association	Name(s)
Certified Nurse Midwife (A supplemental application is required.)	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Certified Registered Nurse Anesthetist (A supplemental application is required.)	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Nurse Practitioner (A supplemental application is required.)	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Physician Assistant (A supplemental application is required.)	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Podiatrist (A supplemental application is required.)	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Perfusionist (A supplemental application is required.)	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Chiropractor	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Licensed Practical/Vocational Nurse	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Medical Assistant	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Optometrist	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Psychologist	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	

Designation	Association	Name(s)
Registered Nurse	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Registered Nurse First Assistant	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	
Other (specify):	Number Employed: _____ Number Independently Contracted: _____ Other (specify): _____	

9. Do any persons identified in question 8 perform cosmetic procedures?  Yes  No

If yes, please provide the name of each person, the cosmetic procedures he or she performs and proof of his or her training for the applicable procedure(s): \_\_\_\_\_

10. Do any health care extenders or ancillary personnel ever take call on your behalf?  Yes  No

If yes, please explain in the Remarks section on page 21.

11. Do any health care extenders or ancillary personnel whom you employ, independently contract with or supervise ever provide professional health care services when you are not on site?  Yes  No

a. If yes, please complete the following:

Name and Designation of Person	Location(s) Where Services Are Provided	Description of Services Provided	Number of Hours Per Week

b. Please identify who is responsible for supervising the health care extender(s) or ancillary personnel when you are not on site and describe the type of supervision that is provided: \_\_\_\_\_

\_\_\_\_\_

## SECTION VI GENERAL PRACTICE INFORMATION

1. Please indicate the average number of hours that you work per week in your practice. Do not count your hours more than once.

Office: \_\_\_\_\_ On-call hours actually worked: \_\_\_\_\_

Scheduled surgery: \_\_\_\_\_ Other clinical work (specify): \_\_\_\_\_

Hospital rounds: \_\_\_\_\_ Other work (specify): \_\_\_\_\_

2. Please provide the following:

Average number of patients cared for by you per week: \_\_\_\_\_

Average number of hospital admissions by you per week: \_\_\_\_\_

Average number of outpatient surgical procedures performed by you per week: \_\_\_\_\_

Average number of inpatient surgical procedures performed by you per week: \_\_\_\_\_

## SECTION VII EDUCATION AND TRAINING

1. List all schools and postgraduate training programs you have entered, whether or not you graduated or completed your training. You may submit your curriculum vitae (CV) in lieu of providing the information in the table below, as long as the CV is current and provides all of the information requested in the table and you complete questions 2 and 3.

Medical/Osteopathic School	Degree	School	City, State	Country	Dates (from – to)
Internship		Facility	City, State	Country	Dates (from – to)
Residency	Type	Facility	City, State	Country	Dates (from – to)
Residency	Type	Facility	City, State	Country	Dates (from – to)
Fellowship	Type	Facility	City, State	Country	Dates (from – to)
Other Training (specify)	Type	Location	City, State	Country	Dates (from – to)

2. If you are a graduate of a non-U.S. medical school, please attach a copy of your Educational Council for Foreign Medical School Graduates (ECFMG) or Fifth Pathway certificate.

3. Did you successfully complete each training program identified above (or on your attached CV)?  Yes  No

If no, please explain in the Remarks section on page 21.

## SECTION VIII MEDICAL SPECIALTY AND BOARD CERTIFICATION

1. Please identify each medical specialty/field of medicine in which you practice and the percentage of your practice that is devoted to that medical specialty/field of medicine. **NOTE:** The percentage total must equal 100%.

Primary specialty/field of medicine: \_\_\_\_\_ %

Additional specialty/field of medicine: \_\_\_\_\_ %

Additional specialty/field of medicine: \_\_\_\_\_ %

2. Are you currently certified by or eligible for a member board of the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or any other health care organizations?  **Yes**  **No**

If **yes**, please complete the following:

Name of Organization	Name of Board	Status	If Eligible, Date of Expiration If Certified, Date of Expiration
		<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible	
		<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible	
		<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible	

3. If you are not currently certified by a member board of the ABMS or AOA, have you ever taken and not passed the written and/or oral portion of a member board's examination?  **Yes**  **No**

If **yes**, please identify the examination, the portion(s) not passed and the number of times that you have taken the applicable examination in the Remarks section on page 21.

4. Have you ever been denied recertification by a specialty board, or has your eligibility, certification or recertification status changed, other than from eligible to certified?  **Yes**  **No**

If **yes**, please explain in the Remarks section on page 21.

# SECTION IX PRACTICE PROFILE QUESTIONS

## Anesthesia and Chronic Pain Management

1. If you are **not** an anesthesiologist, do you administer any of the following types of anesthesia?

- Spinal/epidural anesthesia  **Yes**  **No**      Moderate (conscious) sedation  **Yes**  **No**  
Deep sedation  **Yes**  **No**      General anesthesia  **Yes**  **No**

**If yes:**

a. Do you maintain hospital privileges for each type of anesthesia identified?  **Yes**  **No**

**If no**, please explain in the Remarks section on page 21.

b. Please explain in the Remarks section on page 21 at what locations and for what procedures you administer the anesthesia, and the designation and qualifications of each person who monitors the patients.

2. Do you provide chronic pain management services?  **Yes**  **No**

**If yes:**

a. What percentage of your practice is devoted exclusively to chronic pain management? \_\_\_\_\_

b. What percentage of your chronic pain management practice is:

Conservative (e.g., physical therapy, chiropractic, acupuncture) \_\_\_\_\_

Medication-controlled \_\_\_\_\_

Other Noninterventional (e.g., biofeedback, relaxation techniques, counseling) \_\_\_\_\_

Interventional/Operative (e.g., implantation of morphine reservoir catheters, placement of radiofrequency lesions in the spinal cord and/or brain) \_\_\_\_\_

## Drugs, Devices and Clinical Studies

1. Do you use, administer, distribute or prescribe any drugs, pharmaceuticals, devices or equipment disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings?  **Yes**  **No**

**If yes:**

a. Please describe: \_\_\_\_\_  
\_\_\_\_\_

b. If the applicable use(s) is/are part of a clinical study, please provide the following information for each clinical study:

- i. A copy of the clinical study's protocol
- ii. Proof of its FDA or IRB approval, if not stamped on the protocol
- iii. A copy of the consent form, if it is not FDA or IRB approved

2. Do you use, administer, distribute or prescribe any FDA-approved drugs, pharmaceuticals, devices or equipment in a manner not approved by the FDA (i.e., off-label use)?  **Yes**  **No**

**If yes**, are all of your off-label uses supported by appropriate precedent for effectiveness and safety (i.e., within the standard of care)?  **Yes**  **No**

**If no:**

a. Identify each drug, pharmaceutical, device and/or equipment, its FDA-approved use and your off-label use in the Remarks section on page 21.

b. Provide a copy of the informed consent form that you use for each such off-label use.

### Obstetrics, Abortions and Infertility

Obstetrics is defined as the care and treatment of pregnancy including, but not limited to, prenatal care, labor, delivery, cesarean section and/or postnatal care.

1. Do you practice obstetrics?  Yes  No

If yes, please check all that apply:

First Trimester Prenatal Care

Deliveries

Second Trimester Prenatal Care

Cesarean Section

Third Trimester Prenatal Care

Other (specify): \_\_\_\_\_

2. If you are not an obstetrician, do you take obstetrical call?  Yes  No

If yes, please explain in the Remarks section on page 21.

3. If you provide prenatal care but do not perform deliveries, please identify in the Remarks section on page 21 your means for ensuring that the patient is transferred to the appropriate physician for continued care.

4. Do you provide professional health care services (not limited to obstetrical care) during delivery (including the immediate labor, puerperium and/or neonatal period) in any facility or any place other than a licensed acute care hospital?  Yes  No

If yes, please explain in the Remarks section on page 21.

5. Do you perform abortions?  Yes  No

If yes, do you perform abortions after 15 weeks post-last menstrual period?  Yes  No

If yes, please identify in the Remarks section on page 21 where and under what circumstances you perform abortions after 15 weeks.

6. Do you perform assisted reproductive technology procedures, or are you involved in the treatment of infertility?  Yes  No

If yes, please explain in the Remarks section on page 21.

### Weight Control Surgery and Treatment

1. Do you perform surgery for obesity or weight control (i.e., bariatric surgery)?  Yes  No

If yes, please contact NORCAL for a supplemental questionnaire in order to apply for such coverage.

2. Does your practice involve weight reduction or control other than diet, exercise or surgery?  Yes  No

If yes:

a. What percentage of your patients are seen exclusively for weight control or reduction? \_\_\_\_\_%

b. Please identify all drugs that you use for weight control in the Remarks section on page 21.

### Telemedicine, E-mail and Advertising

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine."

1. Do you provide telemedicine services?  Yes  No

If **yes**, please contact NORCAL for a supplemental questionnaire.

2. Do you communicate online/via e-mail with patients and/or potential patients?  **Yes**  **No**

If **yes**, complete 2a - c.

a. Please check all that apply to your practice:

- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone or other information systems for whom you have performed a good faith prior in-office examination?
- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone, or other information systems for whom you did **not** perform a good faith prior in-office examination?

b. If you communicate online/via e-mail with patients and/or potential patients with whom you did **not** perform a good faith prior in-office examination, please explain in the Remarks section on page 21.

c. Do any of the patients with whom you communicate online/via e-mail reside in a state other than the one in which your primary office is located?  **Yes**  **No**

If **yes**, please explain and identify each state in the Remarks section on page 21.

3. Do you advertise your medical practice in any way other than listing your name, address and telephone number in the telephone book?  **Yes**  **No**

If **yes**, please submit copies of all of your advertisements (excluding those that appear on your website, if applicable) and/or the script of any voice, film or TV media.

4. Is there a website related to your medical practice?  **Yes**  **No**

If **yes**, what is the website address (if more than one, please identify each): \_\_\_\_\_

## Miscellaneous

1. Do you create and maintain a medical record for each patient under your care?  **Yes**  **No**

2. Do you obtain an informed consent for every procedure or surgery that you perform?  **Yes**  **No**

If you answered no to question 1 or 2, please explain in the Remarks section on page 21.

3. Do you render any professional health care services not considered usual and customary to your medical specialty?  **Yes**  **No**

If **yes**, please explain in the Remarks section on page 21.

4. If you are not a plastic surgeon, dermatologist, ophthalmologist or otolaryngologist, do you perform any cosmetic procedures?  **Yes**  **No**

If **yes**, please identify the procedures: \_\_\_\_\_

5. Do you perform any procedure/surgery or provide anesthesia for any procedure/surgery in any office-based surgery suite in which the patient has been administered spinal/epidural anesthesia, moderate (conscious) sedation, deep sedation or general anesthesia?  **Yes**  **No**

If **yes**, please provide each of the following:

- a. The name of each location and proof of each location's accreditation by the AAAASF, AAAHC or similar type of organization and/or proof of its Medicare certification.
- b. A list of the procedures/surgeries you perform in each facility on patients who have been administered any one of the types of anesthesia identified above.

- c. A list of the type(s) of anesthesia used for each procedure/surgery and, if you are not an anesthesiologist, the designation and qualifications of each person who administers the anesthesia.
- d. Proof of professional liability insurance for each surgical suite (if you are not seeking coverage with NORCAL for the suite).

6. If you are not a radiologist, do you interpret your own x-rays?  Yes  No

**If yes:**

a. What type(s) of x-rays do you interpret? \_\_\_\_\_

b. Does a radiologist over-read the x-rays that you interpret?  Yes  No

**If no**, do you render a formal written report for those x-rays not over-read by a radiologist?  Yes  No

**If no**, please explain in the Remarks section on page 21.

7. Are you or is anyone that you supervise involved in alternative medicine?  Yes  No

**If yes**, please check all that apply:

Acupuncture  Herbal Medicine

Osteopathic Manipulation  Homeopathy

Other (specify): \_\_\_\_\_

8. Do you perform any of the following?  Yes  No

**If yes**, please check all that apply:

Mesotherapy  Silicone Injection

Prolotherapy  Sex-Reassignment/Sex Change Surgery

Chelation Therapy

**If yes**, for what reason(s): \_\_\_\_\_

\_\_\_\_\_

9. Do you perform exercise EKGs in a non-hospital setting?  Yes  No

**If yes:**

a. Do you monitor the patient's blood pressure?  Yes  No

b. Do you monitor the patient's heart rhythm via an EKG monitor?  Yes  No

c. Is the location equipped with a defibrillator and supplemental oxygen source?  Yes  No

If you answered no to a, b or c, please explain in the Remarks section on page 21.

10. Do you render professional health care services in any nonclinical setting(s)?  Yes  No

**If yes**, please explain, including the location(s) and type(s) of professional health care services provided, in the Remarks section on page 21.

11. Do you function as a hospitalist?  Yes  No

**If yes**, please contact NORCAL for a supplemental questionnaire.

12. Do you have any medical director, management or similar responsibilities at or on behalf of an entity or organization not wholly owned by you?  Yes  No

13. Do you provide services for, with or on behalf of the U.S. government or any other governmental or public entity?  Yes  No
14. Do you render services in or on behalf of an emergency room other than as required by hospital bylaws for mandatory call rotation?  
 Yes  No
15. Do you perform medical/legal evaluations (e.g., expert reviews, workers compensation evaluations, etc.)?  Yes  No

**If yes:**

- a. How many evaluations do you perform on average weekly that involve physically evaluating the person? \_\_\_\_\_
- b. How many evaluations do you perform on average weekly that do **not** involve physically evaluating the person? \_\_\_\_\_

16. Do you perform utilization reviews other than as part of your medical group's authorized committee that conducts these reviews?  
 Yes  No  N/A

If you answered yes to questions 12, 13, 14, 15 and/or 16, please do the following:

- a. Ensure that each association was identified in Section V (Practice Associations).
- b. Provide a copy of each contract.
- c. Provide proof of professional liability insurance for the entity or organization if other than a hospital or government entity.
- d. Identify the average number of hours per week that you devote to each exposure in the Remarks section on page 21.
- e. Provide proof of coverage for your administrative duties (if you indicated that you are a medical director).
17. Do you have a faculty appointment or teaching responsibilities that involve patient care?  Yes  No
- a. If yes, please complete the following:

Name of School/Facility	Location (City and State)	Are You an Employee?	Does the School/Facility Provide You Professional Liability Coverage for These Duties?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- b. If the facility provides you with professional liability coverage for the professional health care services rendered as part of your faculty appointment/teaching responsibilities, do you also admit private patients to the facility unrelated to your faculty appointment/teaching responsibilities?  Yes  No  N/A
- c. If the facility does not provide you with professional liability coverage:
- c1. Do any students ever provide patient care in a non-hospital location that you have identified in Section IV (Practice Locations)?  Yes  No
- If yes**, please identify the location and explain, including the average number of hours this occurs weekly, in the Remarks section on page 21.
- c2. Please provide a copy of the contract.

## SECTION X SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed written narrative (including, but not limited to, date of occurrence, reason for occurrence and resolution) and pertinent documentation (e.g., medical board documents, letters from hospital, diversion program, treating physician, etc.).

1. Has your license to practice medicine in any jurisdiction, your DEA registration, or any applicable controlled substance license or registration in any jurisdiction **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way?  Yes  No
2. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you?  Yes  No
3. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions or otherwise investigated or limited in any way for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?  Yes  No
4. Have you **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges with; terminated contractual participation or employment in; or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?  Yes  No
5. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations?  Yes  No
6. Have you **ever** been charged with, been convicted of or admitted to committing a felony?  Yes  No
7. Have you **ever** been accused of sexual misconduct?  Yes  No
8. Have you **ever** had any contact of a sexual nature with a patient or former patient?  Yes  No
9. Do you know if any individual who works on your behalf has a prior history or propensity for sexual misconduct?  Yes  No
10. Have you ever had a problem with, been evaluated for, been diagnosed with, been treated for or are currently being treated for alcohol, narcotic or any other substance addiction, sexual addiction or mental illness?  Yes  No
11. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?  Yes  No

## SECTION XI CLAIMS HISTORY

1. Within the past ten (10) years has a malpractice claim or suit been brought against you, or have you been notified of your involvement in a malpractice claim or suit, either directly or indirectly?  Yes  No
  
2. To your knowledge, within the past ten (10) years has a malpractice claim been brought against any organization (e.g., medical group, hospital, etc.) as a result of your rendering or failing to render professional health care services?  Yes  No
  
3. Are you aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against you, directly or indirectly, even if you believe the claim or suit would be without merit?  Yes  No

**If you answered yes to questions 1, 2 or 3, please complete a Claim Information Form on page 25 for each applicable claim, suit, incident, conduct, etc.**

## SECTION XII PRIOR ACTS COVERAGE

**NOTE:** If you are not applying for Prior Acts Coverage, please skip this section.

**Important:** Prior Acts Coverage is optional and subject to separate underwriting approval.

Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Extended Reporting Period Coverage ("Tail Coverage") from your current carrier.

Please ensure that your answers to the following questions reflect your practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date:
  - a. Have you been associated with any entities or physicians that you have not already identified in Section V (Practice Associations)?  Yes  No
  - b. Have you employed, contracted with or supervised any health care extender(s) or ancillary health care personnel that you have not already identified in Section V (Practice Associations)?  Yes  No
2. If you answered yes to 1a or 1b, please complete the following table regarding each association. Please photocopy this page if additional space is needed:

Name of Entity or Person	Designation	Type of Association (e.g., employee, owner, partner, independent contractor, etc.)	From (Month/Year)	To (Month/Year)

3. Have there been any changes in your practice since the Requested Retroactive Date other than as specified in questions 1 and 2 (e.g., no longer performing deliveries, performing new procedures, etc.)?  Yes  No

If yes, please provide a detailed written narrative in the Remarks section on page 21.

**Scope of Coverage** (Prior Acts Period)

Other than any exposure that you might have identified under Scope of Coverage in Section III (Coverage/Insurance Information), is there any aspect of your practice since the Requested Retroactive Date for which you do not need NORCAL Prior Acts Coverage?  Yes  No

If yes, in the Remarks section on page 21 please provide a detailed description of that practice, including the start and end dates. Please also identify the name of the insurance carrier that provided you with professional liability coverage for that practice.

## SECTION XIII CERTIFICATE OF INSURANCE

Please identify all persons (other than yourself), facilities, etc. to which you would like NORCAL to send evidence of insurance (i.e., a Certificate of Insurance) if coverage is approved and a NORCAL policy is issued:

Name	Address	City, State	Zip Code





## FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

### Warranties and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to me by NORCAL ("The Company").

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that my policy, if issued, can be canceled for failure to pay my premium by the due date stated on the invoice.

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

*I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society (or societies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives from any liability arising from any exchange of information about me that is done in good faith and without malice.*

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Signature

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Date

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Name (Print)

## FOR ALASKA APPLICANTS ONLY

### Representations and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to me by NORCAL.

I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that my policy, if issued, can be canceled for failure to pay my premium by the due date stated on the invoice.

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

*I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society (or societies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives from any liability arising from any exchange of information about me that is done in good faith and without malice.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

## CLAIM INFORMATION FORM

Name of Patient: \_\_\_\_\_ Gender:  Male  Female

Age of Patient (at time of treatment): \_\_\_\_\_

Name of Claimant (if different than patient): \_\_\_\_\_

Your Relationship to Patient (e.g., attending physician, primary surgeon, assistant surgeon, consultant, etc.): \_\_\_\_\_

\_\_\_\_\_

Allegation: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Additional Defendants: \_\_\_\_\_

Date Incident or Claim Was Reported to the Insurance Company: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Disposition or Current Status of the Incident, Claim or Suit:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed      Date Closed (Month/Day/Year): \_\_\_\_\_

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in your favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): \_\_\_\_\_

Amount paid on your behalf (if different): \_\_\_\_\_

Total verdict amount (if different than total loss payment amount): \_\_\_\_\_



