

# COASTAL INSURANCE RISK RETENTION GROUP, INC.

P.O. Box 211359  
Montgomery, AL 36121-1359

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## MOONLIGHTING PHYSICIAN MEDICAL PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE)

**Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.**

PLEASE TYPE OR PRINT LEGIBLY

### Personal Information

Requested Coverage Effective Date: \_\_\_\_\_ Requested Retro Date: \_\_\_\_\_

1. Full Name of Applicant (include Professional Degree) \_\_\_\_\_
2. Applicant's Date and Place of Birth \_\_\_\_\_
3. Home Address (Street, City, State and Zip Code) \_\_\_\_\_  
Home Phone \_\_\_\_\_
4. Principle Business Address (Street, City, State and Zip Code) \_\_\_\_\_  
Business Phone \_\_\_\_\_
5. E-mail \_\_\_\_\_ Fax No: \_\_\_\_\_ County \_\_\_\_\_
6. Residency Specialty \_\_\_\_\_ Your Moonlighting Specialty \_\_\_\_\_
7. Residency Completion Date: \_\_\_\_\_ Social Security No. \_\_\_\_\_
8. Have you ever: (**explain any yes answers on a separate sheet of paper**)

	YES	NO
a. Been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses?	<input type="checkbox"/>	<input type="checkbox"/>
c. Had any state professional license or license to prescribe or dispense narcotic refused, suspended, revoked, renewal refused, restricted or accepted only on special terms?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had any insurance company or Lloyd's cancel, notify you of intent to cancel, decline, deny, surcharge, refuse to renew, accept on special term or accept professional liability insurance on a consent-to-rate basis?	<input type="checkbox"/>	<input type="checkbox"/>
e. Failed any medical licensing or specialty organization examination or not eligible for Boards?	<input type="checkbox"/>	<input type="checkbox"/>
f. Been named in a claim or suit for professional malpractice of the type that would be addressed by this policy? If Yes, please complete a <b>Supplemental Claim Information Form</b> (attached hereto) for each claim.	<input type="checkbox"/>	<input type="checkbox"/>
g. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including, but not limited to depression and/or chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
h. Had or do you presently have any chronic or life-threatening physical illness or defects?	<input type="checkbox"/>	<input type="checkbox"/>

- i. Had any judgment made against you or any out-of-court settlements made on your behalf?
- j. Are you aware of any acts, errors, omissions, or circumstances which may result in a malpractice claim or suit being brought against you?

**Education and Training**

9. Indicate your educational background (or attach a copy of your Curriculum Vitae if such information is included)
- a. Undergraduate School \_\_\_\_\_ Year Completed \_\_\_\_\_
  - b. Graduate School \_\_\_\_\_ Year Completed \_\_\_\_\_
  - c. Medical School \_\_\_\_\_ Location \_\_\_\_\_ Year Completed \_\_\_\_\_
  - d. Internship at \_\_\_\_\_ Location \_\_\_\_\_ Year Completed \_\_\_\_\_
  - e. Residency at \_\_\_\_\_ Location \_\_\_\_\_ Year Completed \_\_\_\_\_  
 \_\_\_\_\_ Location \_\_\_\_\_ Year Completed \_\_\_\_\_
  - f. Fellowship or advanced training \_\_\_\_\_ Year Completed \_\_\_\_\_

g. Please explain any gaps in above chronological sequence \_\_\_\_\_  
 \_\_\_\_\_

10. Name of Residency Program Director \_\_\_\_\_ Phone \_\_\_\_\_

11. If you are a foreign medical graduate, are you certified by ECFMG?  Yes  No

12. List your Alabama State License number \_\_\_\_\_ Federal D.E. A. number \_\_\_\_\_

13. Have you previously had professional liability insurance coverage other than what is provided to you for your residency program?

Company \_\_\_\_\_ Year \_\_\_\_\_ Claims Made  Occurrence   
 Company \_\_\_\_\_ Year \_\_\_\_\_ Claims Made  Occurrence

14. Location and name of facility where you plan to moonlight: \_\_\_\_\_

**Limit of Liability**

a. Individual Professional Limit of Liability Requested.  \$1,000,000 each claim / \$3,000,000 aggregate

**Applicant must sign at bottom of pages 2,3 and 4**

Signing this application does not bind Coastal Insurance Risk Retention Group, Inc. to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information, or attempt to defraud or attempt to defraud or lie to Coastal Insurance Risk Retention Group, Inc. about any matter contained in this application, then coverage provided by virtue of this application is void.

Date: \_\_\_\_\_

(X) \_\_\_\_\_  
 (Applicant)

(X) \_\_\_\_\_  
 (Witness)

# COASTAL INSURANCE RISK RETENTION GROUP, INC.

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, have provided Coastal Insurance Risk Retention Group, Inc. (Coastal) information in their insurance application in order for Coastal to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including, but not limited to, prior liability carriers, hospitals and their officers, directors, medical staff, and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide Coastal with any information, whether written or otherwise, which may be material to evaluating my application for insurance with Coastal. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Coastal.

I consent for Coastal to use photocopies of this "Authorization for Release of Information" to present to those persons or entities supplying information as provided herein. Each photocopy is to be considered an original copy.

Date: \_\_\_\_\_

(X) \_\_\_\_\_  
(Applicant)

(X) \_\_\_\_\_  
(Witness)

**COASTAL INSURANCE RISK RETENTION GROUP, INC.**

**SUPPLEMENTAL CLAIM INFORMATION**

**INSTRUCTIONS TO THE APPLICANT**

- A. This form should be completed by the applicant whose signature appears on the Coastal Insurance Risk Retention Group, Inc. Professional Liability Insurance Application.
- B. One of these forms should be completed for each claim or incident in which the applicant has been involved. If additional forms are needed, applicant may photocopy this form for use in reporting other claims.
- C. If space is insufficient to fully provide answers to the questions below, use reverse of this form or separate sheet.
- D. Answer all questions completely. Complete information is necessary for the equitable and careful evaluation of your application.

- 1. Full Name of the Applicant \_\_\_\_\_
- 2. Full Name of the Individual(s) of your firm involved in this claim \_\_\_\_\_
- 3. Full Name of the Claimant \_\_\_\_\_ 4. Age: \_\_\_\_\_ 5. Sex: \_\_\_\_\_
- 6. Indicate whether this was a:  Claim  Incident  or Suit
- 7. Date of Alleged Error \_\_\_\_\_ 8. Date of Claim \_\_\_\_\_
- 9. Additional Defendants \_\_\_\_\_
- 10. What is the name of the insurer involved in this claim? \_\_\_\_\_
- 11. What is the insurer's claim number assigned to this claim (if known)? \_\_\_\_\_
- 12. Description of the claim (please provide enough information to allow for evaluation and use the reverse side of this sheet if necessary)  
Alleged act, error or omission upon which the claimant bases claim: \_\_\_\_\_  
Description of the type and extent of injury or damage allegedly sustained: \_\_\_\_\_  
Description of the type and extent of injury or damage allegedly sustained: \_\_\_\_\_

If claim is closed, answer questions 13 and 14. If claim is pending (open), answer questions 15 through 21.

- 13. If closed, what was the total loss paid including a deductible that may have applied? \_\_\_\_\_
- 14. If closed, was this amount paid subsequent to a:  Court judgment or  Out of court settlement
- 15. If pending (open), what is claimant's settlement demand? \$ \_\_\_\_\_
- 16. If pending (open), what is defendant's settlement offer? \$ \_\_\_\_\_
- 17. If pending (open), what is insurer's loss reserve? \$ \_\_\_\_\_
- 18. If pending (open), what deductible (if any) applies? \$ \_\_\_\_\_
- 19. If pending (open), is this claim in suit?  Yes  No \$ \_\_\_\_\_
- 20. If claim is in suit, what amount (if any) was asked for in the summons? \$ \_\_\_\_\_
- 21. If pending (open), who is defense counsel (please include address and phone number if known or available)? \_\_\_\_\_

I hereby understand that information submitted herein becomes a part of and is incorporated with my Professional Liability Application and is subject to the same conditions.

Date: \_\_\_\_\_ (X) \_\_\_\_\_  
(Applicant)  
(X) \_\_\_\_\_  
(Witness)

## **Additional Physician Information**

**Please provide this information with the Application:**

- **CV**
- **Insurance History and Loss History (past 10 years) each carrier**
- **Letters or Evaluations from (3) professional references**
- **Medical License**

**For ER doctors only:**

- **Certificates ACLS, PALS, ATLS**