

COASTAL INSURANCE RISK RETENTION GROUP, INC.

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

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 Supplemental Claim Information Form (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**