

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.

**COASTAL INSURANCE RISK RETENTION GROUP, INC.**  
**P.O. Box 211359**  
**Montgomery, AL 36121-1359**

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**APPLICATION FOR PROFESSIONAL  
LIABILITY INSURANCE FOR  
PHYSICIANS AND SURGEONS  
(CLAIMS MADE)**

PLEASE TYPE OR PRINT LEGIBLY

Personal Information

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)\_\_\_\_\_
4. Principle Business Address (Street, City, State and Zip Code)\_\_\_\_\_
- E-mail\_\_\_\_\_ 5. County\_\_\_\_\_
6. Principle Correspondence Address\_\_\_\_\_
7. Social Security No.\_\_\_\_\_ 8. Business Phone\_\_\_\_\_ 9. Home Phone\_\_\_\_\_
10. Your specialty or type of practice for which you are applying for coverage\_\_\_\_\_
11. 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?	<input type="checkbox"/>	<input type="checkbox"/>
12. a. Are you aware of any acts, errors, omissions, or circumstances which may result in a malpractice claim or suit being brought against you, your partners, or members of your P.A. or P.C.?

	<input type="checkbox"/>	<input type="checkbox"/>
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## PRACTICES AND PROCEDURES

13. Check the procedures performed by you:

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Acupuncture</li> <li><input type="checkbox"/> Organ Transplant</li> <li><input type="checkbox"/> Insertion of pacemakers</li> <li><input type="checkbox"/> Injection of radioisotopes</li> <li><input type="checkbox"/> Radiation Therapy, including Radium</li> <li><input type="checkbox"/> Chemotherapy</li> <li><input type="checkbox"/> Silicone Injections</li> <li><input type="checkbox"/> Liposuction</li> <li><input type="checkbox"/> Dilatation &amp; Curretage</li> <li><input type="checkbox"/> Abortions</li> <li><input type="checkbox"/> Caesarean Sections</li> <li><input type="checkbox"/> Hysterectomies</li> <li><input type="checkbox"/> Amniocentesis</li> <li><input type="checkbox"/> Cryosurgery</li> <li><input type="checkbox"/> Experimental Procedures or Research or drug testing. (Including a copy or form used to obtain informed consent) Are procedures FDA approved? _____</li> <li><input type="checkbox"/> Bronchoscopies</li> <li><input type="checkbox"/> Esophagoscopies</li> <li><input type="checkbox"/> Tonsillectomies/Adenoidectomies</li> <li><input type="checkbox"/> Myringotomies</li> <li><input type="checkbox"/> Laser Surgery: Type _____</li> <li><input type="checkbox"/> Diagnostic Laparoscopies</li> <li><input type="checkbox"/> Thoracentesis</li> <li><input type="checkbox"/> Paracentesis</li> <li><input type="checkbox"/> Normal Deliveries</li> <li><input type="checkbox"/> Bariatric Surgery</li> </ul> | <p>Catheterizations</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arterial</li> <li><input type="checkbox"/> Cardiac</li> <li><input type="checkbox"/> Swan-Ganz</li> <li><input type="checkbox"/> Ureteral</li> <li><input type="checkbox"/> Umbilical</li> </ul> <p>X-Ray Procedures</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Noninvasive</li> <li><input type="checkbox"/> Invasive</li> </ul> <p>Reduction of Fractures</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Closed</li> <li><input type="checkbox"/> Open</li> </ul> <p>Sterilization Procedures</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tubal Ligation</li> <li><input type="checkbox"/> Vas Ligation</li> </ul> | <p>Anesthetic Procedures</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> General</li> <li><input type="checkbox"/> Spinal</li> <li><input type="checkbox"/> Regional or Nerve Block</li> </ul> <p>Plastic Surgery</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Reconstructive</li> <li><input type="checkbox"/> Cosmetic</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> Discography</li> <li><input type="checkbox"/> Peripheral Nerve Surgery</li> <li><input type="checkbox"/> Arthroscopies</li> <li><input type="checkbox"/> Dermabrasion/Chemobrasion/Hair Transplants</li> <li><input type="checkbox"/> Dialysis Procedures</li> <li><input type="checkbox"/> Shock Therapy</li> </ul> |
|--|--|---|

14. Pain Management Procedures List:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Do you use x-ray equipment on your premises? \_\_\_\_\_

If yes, are your x-rays overread by a radiologist? \_\_\_\_\_

16. Do you perform any surgical procedures in your professional office or similar non-hospital facility? \_\_\_\_\_

If yes, list procedures \_\_\_\_\_

17. Do you perform laparoscopic surgery?  Yes  No

18. If you administer anesthetics, is there a pre-anesthesia examination and conference with the patient?  Yes  No

Do you use pulse oximetry and capnography with general anesthesia?  Yes  No

19. Do you assist in surgery? On your own patients \_\_\_\_\_ On the patients of others \_\_\_\_\_

20. Do you participate in any activity (e.g. newspaper columns, broadcasts, etc.) whereby professional advice is offered to the public?  Yes  No

If yes, explain \_\_\_\_\_

21. In what states are you registered and licensed to practice? \_\_\_\_\_

Is your license limited?  Yes  No If yes, explain \_\_\_\_\_

22. a. Federal DEA No. \_\_\_\_\_

b. Medical License No. for each state in which you are licensed. \_\_\_\_\_

c. Are all the above licenses current?  Yes  No If No, which are not \_\_\_\_\_

23. List in chronological order all hospitals where you have applied, had privileges or have been denied privileges:

Hospital Name	Hospital Address	Start Date	End Date	% of Patients	Issue Certificate of Insurance?
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO
					YES NO

24. Has there been any change in your practice or specialty in the past 5 years?  Yes  No  
 If yes, explain \_\_\_\_\_
25. Are you credentialed at any hospital for any procedures which are not included in your primary medical specialty?  Yes  No  
 If yes, explain \_\_\_\_\_
26. If you have just completed your residency training or fellowship, name the institution where you trained, the director of your program and the telephone number of the department.  
 Institution \_\_\_\_\_ Program Director \_\_\_\_\_ Telephone \_\_\_\_\_  
 Institution \_\_\_\_\_ Program Director \_\_\_\_\_ Telephone \_\_\_\_\_
27. Are you a member of the staff, or do you practice in an ambulatory care center?  Yes  No
28. Do you normally staff an emergency department?  Yes  No How many hours per month? \_\_\_\_\_
29. If your hospital does not employ full-time emergency physicians, do your staff privileges require you to take emergency call on a regular rotation?  Yes  No If yes, how many hours per month? \_\_\_\_\_
30. a. Do you work part-time outside of your regular practice ("moonlight")?  Yes  No If yes, describe \_\_\_\_\_  
 \_\_\_\_\_  
 b. Is this activity insured by your employer?  Yes  No If yes, name of insurance company \_\_\_\_\_
31. a. Are you employed full-time by the Federal Government **or** are you under contract to any government entity?  Yes  No  
 If yes, explain \_\_\_\_\_  
 b. Do you work in either a federal or state prison?  Yes  No  
 If yes, describe your duties and hours worked \_\_\_\_\_
32. Are you currently in the Military Service?  Yes  No If yes, circle whether Active or Reserve
33. Are you a U.S. citizen?  Yes  No If no, indicate your status and date of entry into the USA \_\_\_\_\_  
 \_\_\_\_\_
34. Are you a foreign medical school graduate?  Yes  No  
 If yes, are you certified by the Educational Council for Foreign Medical School Graduates?  Yes  No
35. In what Medical Associations are you a member in good standing? \_\_\_\_\_  
 \_\_\_\_\_



45. I practice as a:
- Sole Practitioner (Unincorporated)                       Partner in a Group Practice
- Professional Association     Professional Corporation
- Other \_\_\_\_\_
- 
46. a. If you practice as an employee of an organization other than a hospital, list the names of all your partners or members of your professional association with whom you practice who are not insured by Coastal Insurance Risk Retention Group, Inc.
- \_\_\_\_\_
- \_\_\_\_\_
- b. Give the formal corporate, association, partnership or business name \_\_\_\_\_
- c. Attach a copy of your letterhead \_\_\_\_\_
47. Are you in the employ of an individual firm or corporation other than your own?    Yes    No
- If yes, explain, giving details of your responsibilities \_\_\_\_\_
48. I practice medicine     full time                       20 hours per week or less
49. a. If your prior coverage was "claims made" rather than "occurrence", please state your **retroactive date** \_\_\_\_\_
- b. If you are requesting "prior acts" coverage, complete enclosed "LIMITATIONS OF PRIOR ACTS COVERAGE ENDORSEMENT".

## Coverage

50. **Proposed Effective Date of Coverage** \_\_\_\_\_
51. a. Individual Professional Limit of Liability Requested.
- \$1,000,000 each claim / \$3,000,000 aggregate
- b. Do you desire an excess (higher) limit of liability?    Yes    No    If yes, check the amount to be added.
- \$1 million     \$2 million     \$3 million     \$4million
52. a. Do you want a deductible to apply?    Yes    No    If yes, check the deductible amount below. (Figure in parenthesis is the percentage discount to come off of the standard premium.)
- \$5,000 (5.0%)    \$10,000 (8.0%)    \$25,000 (16.0%)
- (Deductible applies only to indemnity; not to legal expenses)
- b. Do you desire to purchase a separate policy for your Partnership, Association or Professional Corporation?    Yes    No
- or do you desire to have shared limits at no extra cost?    Yes    No
- c. I.R.S. Tax Identification Number (if entity coverage applies) \_\_\_\_\_
53. a. Do you desire coverage for professional premises liability?    Yes    No
- b. If yes, list the square footage of your office referenced in question #4 \_\_\_\_\_
- c. If yes, what limit of liability do you request?
- \$300,000 Bodily Injury / \$50,000 Property Damage                       \$500,000 Bodily Injury / \$50,000 Property Damage

54. a. Do you wish to have your professional employees endorsed on this policy?  Yes  No  
 b. If yes, complete the following:

Name	Professional Classification	Date of Employment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant must sign at bottom of pages 6, 7, and 8

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.**  
**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)

# 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)

## **Additional 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**
- **Copy of Current Med Mal Policy Declarations page.**

**For ER doctors only:**

- **Certificates ACLS, PALS, ATLS**