



**INDIVIDUAL PODIATRISTS
APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE**

IMPORTANT INSTRUCTIONS - PLEASE READ CAREFULLY

1. **PLEASE MAKE SURE ALL QUESTIONS ARE ANSWERED IN FULL.**
Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.
2. **IF YOU HAVE HAD CLAIMS OR SUITS FILED AGAINST YOU OR HAVE REPORTED INCIDENTS TO YOUR CURRENT INSURANCE COMPANY,** please make certain you have completed the claim information report on page 8 for each claim, suit, or incident.
3. **SIGNATURES ARE REQUIRED.** The policy application and claim information report form must be signed (Pages 7 and 8).
4. **PLEASE ATTACH A COPY OF YOUR CURRENT DECLARATIONS PAGE SHOWING RETROACTIVE DATE.**

We are aware of the urgent concern of many health care providers regarding their insurance renewal date. **However, applicants must meet the underwriting standards of Preferred Professional Insurance Company® before coverage will be provided.** Qualified applicants who meet our underwriting standards can receive an effective date as early as the date submitted to us, if so requested.

FOR ASSISTANCE, PROVIDERS MAY CALL OUR OFFICE

Toll: (800) 397-9697, ext. 2629
Main: (719) 528-8200

Direct: (719) 219-2629
FAX: (719) 528-8323

RPS Healthcare
1975 Research Pkwy, Suite 230
Colorado Springs, Colorado 80920

**INDIVIDUAL PODIATRISTS
APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE**

**CLAIMS MADE BASIS
(Please type or print)**

I. GENERAL INFORMATION

1. Name:	Last	Middle Initial	First
2. DBA:			3. Website:
4. Date of Birth:			5. Social Security #:
6. Phone:		7. Fax:	8. Email:
9. Primary Practice Address:	Street		
	City	County	State Zip
10. Contact Person:			11. Title:
12. Contact Email:			
13. Billing Address: (If different than above)	Street		
	City	County	State Zip

Kansas applicants only

14. Home Address:	Street		
	City	County	State Zip
15. Home Phone:			

II. EDUCATIONAL INFORMATION

16. Podiatric Medical School:			17. Year Graduated:	
18. Degree:			19. Date you began practice: (after license & residency)	
20. I completed an Internship Residency Preceptorship	<input type="checkbox"/> or <input type="checkbox"/>	# of Years:	Year Completed:	Name of Hospital where completed:
21. Memberships, Licenses, and Affiliations:				
a) Are you Board Certified / Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No Completion Date: _____				
b) Please check the professional organizations to which you belong:				
<input type="checkbox"/> Am. College of Foot & Ankle Orthopedics & Medicine (ACF)		<input type="checkbox"/> Am. Board of Podiatric Surgery (ABPS)		
<input type="checkbox"/> Am. Podiatric Medical Association (APMA)		<input type="checkbox"/> Academy of Ambulatory Foot Surgery (AAFS)		
<input type="checkbox"/> Am. College of Foot Surgeons (ACFS)		<input type="checkbox"/> Other: _____		

22. Podiatric/Medical License Number(s)	State	Expiration Date(s)

23. Narcotic/Drug License Number(s)	State(s)	Expiration Date(s)

24. Have you participated in any risk management forums during the past year? Yes No

If YES, provide information below for possible credit.

Date: _____ Co. Sponsor: _____ Name of Seminar/Self Study: _____

Type of Risk Management: Self Study ½ Day Seminar Full Day Seminar ELM Other _____

III. PRACTICE LOCATIONS

25. Do you practice as:

- Solo Unincorporated Solo Incorporated Partner in a Partnership Independent Contractor
 Employed Podiatrist in a Corporation not Owned by You Other _____

26. Do you have ownership interest in any Professional Corporation (PC), Professional Association (PA) or Limited Liability Corp (LLC)?

Yes No PC/PA/LLC Name: _____ Tax ID: _____

Would you like to add this entity as: Separate Limit Liability **If Yes, complete and submit Corporation Application**
 Shared Limit of Liability

If Yes, give legal name of corporation(s): _____

Practice website address (URL): _____

27. In what state do you do the majority of your practice? _____

a) Do you practice in any other state? Yes No

If Yes, name of state(s): _____ Percent of Practice: _____ %

28. Have you moved your practice within the last two years? Yes No

If Yes, please provide the previous address of your practice. _____

29. List all locations (or name of hospital) where you currently practice or have practiced in the last ten years (beginning with current practice):

Practice Location (or name of Hospital)	City	State	Dates	# of Admissions (consultations or procedures)	Percentage (if current practice)
					%
					%
					%
					%

- Note:** Certificates of insurance are provided to all hospitals, at which you indicate privileges are held. If you do not wish to have a certificate sent to a particular hospital, please indicate.

30. Average number of hours you practice per week: _____

- Note:** Hours practiced include consulting, paperwork, lab time, and hospital hours.

Have your hours changed in the past five years? Yes No If Yes, what were your previous hours? _____

III. PRACTICE LOCATIONS (CONT)

31. If you are employed by others, or perform services on behalf of others as an independent contractor, list the names of those other persons or entities : _____

	Employment Status	
	<input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee	<input type="checkbox"/> Independent Contractor

32. Is your practice office or hospital based? (Please select one) Office Hospital
If Office based, what percentage of your practice is conducted in your office? _____%

IV. CURRENT PRACTICE

33. What percent of your total practice involves:

A. Local Anesthesia: _____%

B. General Anesthesia: _____%

*Includes IV Conscious Sedation

Practices using General Anesthesia must complete and sign the anesthesia supplement on page 9.

34. How many of the following surgeries do you perform a year?

Joint or other Implants or Prosthesis	_____	Ankle/Joint/Lower Leg Surgery	_____	Tendon Transfer Surgery	_____
Achilles Tendon Surgery	_____	Laser Surgery	_____	Minimal Incision Foot Surgery	_____
Bunion Surgery — Non-Osteotomy	_____	Bunion Surgery — Osteotomy	_____	Hammertoe Surgery	_____
Cryosurgery/Chemosurgery	_____	Amputation	_____	Arthroereisis	_____

Other (describe): _____

35. What percent of your patient load involves diabetic patients? 0-15% 16-30% 31-50% 51-70% 71-100%

36. Do you obtain: Written informed consent OR Verbal informed surgical consent from your patients

V. COVERAGE INFORMATION

37. Are you currently insured?

Yes Insurance Company: _____ Expiration Date: _____
Years with company: _____ Limits of Liability: _____

No *If you are currently not insured and are not in your first year of practice, please attach a summary that includes, 1) the last date of coverage and insurance company; 2) reason why you are currently not insured; and 3) why you need to secure coverage now.*

38. Proposed Effective Date: _____ 39. Retroactive Date: _____

Please Note: If you are currently not insured, the proposed effective date cannot be backdated and retroactive coverage is not available.

****Attach copy of Declarations Page from your current professional liability insurance company showing retroactive date****

40. Limits of Liability Desired (per claim/aggregate) **Note:** Some limits are not available in certain states.

<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$250,000/\$750,000	<input type="checkbox"/> \$500,000/\$1,500,000
<input type="checkbox"/> \$1,000,000/\$1,000,000	<input type="checkbox"/> \$1,000,000/\$3,000,000	<input type="checkbox"/> \$2,000,000/\$4,000,000	<input type="checkbox"/> Other \$ _____

VIII. FRAUD STATEMENTS / WARNINGS

NOTICE TO ALABAMA APPLICANTS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines, or confinement in prison, or any combination thereof.

NOTICE TO ARKANSAS, LOUISIANA, MARYLAND, RHODE ISLAND & WEST VIRGINIA APPLICANTS

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

*Applies in Maryland only

NOTICE TO COLORADO APPLICANTS

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA and OKLAHOMA APPLICANTS

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in Florida only

NOTICE TO KANSAS APPLICANTS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

NOTICE TO KENTUCKY and NEW YORK APPLICANTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in New York only

NOTICE TO MAINE, TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in Maine only

NOTICE TO NEW MEXICO APPLICANTS:

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 for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW JERSEY APPLICANTS

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO OHIO APPLICANTS:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO PENNSYLVANIA APPLICANTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO ALL OTHER APPLICANTS:

Any person who knowingly and with intent to defraud any Insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DECLARATION AND CERTIFICATION:

BY SIGNING THIS APPLICATION, THE APPLICANT REPRESENTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant

Signature of Broker/Agent

Title

Date

Date

Signed by Licensed Resident Agent

(Where Required By Law)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

PODIATRIC CLAIM OR INCIDENT REPORT SUPPLEMENT

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked, Not Applicable (N/A) and each sheet must be signed.

1. Name:	First	Middle Initial	Last
2. Claimant Name: _____			
3. Type of Claim: <input type="checkbox"/> Incident <input type="checkbox"/> Claim			
4. Name of Insurance Company: _____			
5. Date Reported to Insurance Company: _____			
6. Date of Incident/Claim: _____			
7. Status of incident/claim:			
	<input type="checkbox"/> Suit threatened, no action taken	<input type="checkbox"/> Court outcome in YOUR favor	Unresolved/Open
	<input type="checkbox"/> Suit filed but dropped by claimant	<input type="checkbox"/> Court outcome in PLAINTIFF favor	<input type="checkbox"/> Awaiting mediation
	<input type="checkbox"/> Summary judgment in your favor	<input type="checkbox"/> Directed Verdict	<input type="checkbox"/> Awaiting court action
	If closed, <input type="checkbox"/> Settled <input type="checkbox"/> Trial	If settled, did you want to settle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date Closed:	_____	
	Expense Paid:	_____ \$	
	Indemnity Paid:	_____ \$	
	If open,		
	Reserve Amount:	_____ \$	
8. Allegations/Circumstances: _____			
9. Treatment Provided: _____			
10. Present condition of claimant: _____			
11. Additional Defendants: _____			
12. What action(s) have you taken to prevent recurrence of this type of claim? _____			
13. Did you in any way alter, embellish, delete, change or destroy any medical records or were allegations made that you did? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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

Signature of Applicant _____
Date

Printed Name

PODIATRIC ANESTHESIA SUPPLEMENT

I. APPLICANT INFORMATION

1. Name: _____
First Middle Initial Last

II. PRACTICE ACTIVITIES

2. General Anesthesia

- Please indicate who administers general anesthesia:

I do MD/DO Anesthesiologist Nurse Anesthetist/CRNA

Other (please explain): _____

- Where is general anesthesia performed?

In office Hospital Licensed Surgical Center

Other (please explain): _____

3. How often do you treat patients under general anesthesia: _____

4. If general anesthesia is performed at a location other than a hospital, how often do you and your staff participate in simulated emergency training?

Every 3 months Every 6 months Every 12 months

Other (please explain): _____

5. Are you or the individual administering the general anesthesia certified in one or more of the following?..... Yes No

If yes, please indicate:

CPR ACLS ATLS PALS

6. Do you use the following equipment?..... Yes No

If yes, please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Autoclave | <input type="checkbox"/> Pulse Oximeter |
| <input type="checkbox"/> Full Face Mask Resuscitator | <input type="checkbox"/> CO2 Monitor |
| <input type="checkbox"/> Endotracheal Tubes (adult/child size) | <input type="checkbox"/> Internal/External Temperature Monitor |
| <input type="checkbox"/> Laryngoscope | <input type="checkbox"/> Portable Suction |
| <input type="checkbox"/> Direct Current Defibrillator | <input type="checkbox"/> Capnography |
| <input type="checkbox"/> Tracheostomy/Coniotomy Equipment | <input type="checkbox"/> Auxiliary Lighting |
| <input type="checkbox"/> Sphygmomanometer/Stethoscope | <input type="checkbox"/> Emergency Pharmaceutical Kit |
| <input type="checkbox"/> Electrocardiographic monitoring Equipment | <input type="checkbox"/> Fail safe mechanisms on anesthesia machines |

7. Do all anesthesia providers who are providing anesthesia services to your patients:

Have a minimum of two years of anesthesia residency training? Yes No

Have professional liability insurance limits equal to or greater than your policy limits? Yes No

If anesthesia is being provided by a CRNA, are they supervised on site by a doctor with a minimum two years or greater residency in anesthesia? Yes No

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

Signature of Applicant

Date

Printed Name