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 Risk Retention Group 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

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 your risk retention group."

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

II. EDUCATIONAL INFORMATION

14. Podiatric Medical School:		15. Year Graduated:	
16. Degree:		17. Date you began practice: (after license & residency)	

18. I completed an Internship ☐ / Residency ☐ / Preceptorship ☐	# of Years:	Year Completed:	Name of Hospital where completed:

19. Memberships, Licenses, and Affiliations:

a) Are you Board Certified / Eligible? ☐ Yes ☐ No Completion Date: _____

b) Please check the professional organizations to which you belong:

- ☐ Am. College of Foot & Ankle Orthopedics & Medicine (ACF)
- ☐ Am. Board of Podiatric Surgery (ABPS)
- ☐ Am. Podiatric Medical Association (APMA)
- ☐ Academy of Ambulatory Foot Surgery (AAFS)
- ☐ Am. College of Foot Surgeons (ACFS)
- ☐ Other: _____

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

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

22. 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

23. Do you practice as:

☐ Solo Unincorporated ☐ Solo Incorporated ☐ Partner in a Partnership ☐ Independent Contractor

☐ Employed Podiatrist in a Corporation not Owned by You ☐ Other _____

24. 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): _____

25. 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: _____%

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

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

27. 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.

28. 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)

29. 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
	☐ Employee ☐ Independent Contractor
	☐ Employee ☐ Independent Contractor

30. 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

31. 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.

32. 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	_____	Arthoereisis	_____

Other (describe): _____

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

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

V. COVERAGE INFORMATION

35. 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.*

36. Proposed Effective Date: _____ 37. 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****

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

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $500,000/$1,500,000

☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ Other $ _____

VI. PRACTICE HISTORY – PLESE EXPLAIN ALL YES ANSWERS (BELOW) IN THE REMARKS SECTION

39. Has any insurer, to whom you applied for medical professional liability or related coverage, canceled, declined, rescinded or modified coverage, or refused renewal, excluding insurance company withdrawal? ☐ Yes ☐ No
(e.g. reduced limits, assigned a deductible, restricted coverage, surcharged rates)
Missouri applicants DO NOT answer this question

40. Has anyone ever filed a complaint of any kind against you with your medical society or association? ☐ Yes ☐ No

41. Has any hospital or other institution reduced, revoked, restricted or suspended your privileges? ☐ Yes ☐ No

42. Have you voluntarily withdrawn or resigned from any hospital privileges in lieu of disciplinary action? ☐ Yes ☐ No

43. Have you ever been under punitive or disciplinary observation, preceptorship, or sponsorship in a hospital? ☐ Yes ☐ No

44. Has any governmental or licensing agency ever investigated, suspended, revoked, placed on probation, or taken any other action against either your narcotics license or your license(s) to practice podiatry? ☐ Yes ☐ No

It is not the intent of the Coverys/PPIC policy to cover known patient injuries. If you are requesting Prior Acts coverage for your professional liability exposure, we must have confirmation that you have informed your current Professional Liability carrier of any incidents or circumstances that could lead to a claim that may be made against you.

Your signature on the application form indicates that you have complied with the above provisions.

45. Have you ever been notified of your involvement in a malpractice claim, suit, or "incident" either directly or indirectly? ☐ Yes ☐ No

46. Are you aware of any incident that could lead to a malpractice claim? ☐ Yes ☐ No

47. Do you have or have you had any physical disability or injury, personal health problems, including alcoholism, narcotics addition or mental illness which affects your ability to practice podiatry? ☐ Yes ☐ No

48. Have you ever had a complaint or claim brought against you for sexual misconduct? ☐ Yes ☐ No

VII. REMARKS SECTION

VIII. FRAUD STATEMENT

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

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: ☐ Incident ☐ Claim

4. Name of Insurance Company:

5. Date Reported to Insurance Company:

6. Date of Incident/Claim:

7. Status of incident/claim:

☐ Suit threatened, no action taken	☐ Court outcome in **YOUR** favor	**Unresolved/Open**
☐ Suit filed but dropped by claimant	☐ Court outcome in **PLAINTIFF** favor	☐ Awaiting mediation
☐ Summary judgment in your favor	☐ Directed Verdict	☐ Awaiting court action

If closed, ☐ Settled ☐ Trial If settled, did you want to settle? ☐ Yes ☐ 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? ☐ 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

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:

   - ☐ Autoclave
   - ☐ Full Face Mask Resuscitator
   - ☐ Endotracheal Tubes (adult/child size
   - ☐ Laryngoscope
   - ☐ Direct Current Defibrillator
   - ☐ Tracheostomy/Coniotomy Equipment
   - ☐ Sphygmomanometer/Stethoscope
   - ☐ Electrocardiographic monitoring Equipment
   - ☐ Pulse Oximeter
   - ☐ CO2 Monitor
   - ☐ Internal/External Temperature Monitor
   - ☐ Portable Suction
   - ☐ Capnography
   - ☐ Auxiliary Lighting
   - ☐ Emergency Pharmaceutical Kit
   - ☐ 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