



Please mail the completed and signed application with supporting documentation to:

Yellowstone Insurance Exchange, RRG
 Attn: Eric J. Gardzina, CPHRM
 4301 Hillsboro Pike, Suite 310
 Nashville, Tennessee 37215
 Tel. 866-216-7433
 Fax 866-216-7434

**Yellowstone Insurance Exchange, RRG
 APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
 FOR PHYSICIANS AND SURGEONS (CLAIMS MADE)**

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) _____
4. Principle Business Address (Street, City, State and Zip Code) _____
5. 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. Name of Hospital where you are or will be employed _____
 - a. Are you going to be an employee of a hospital? Yes No
 - b. Date of Employment _____
 - c. What department? _____ How many hours a week will you be on duty? _____
12. List in chronological order all hospitals where you have or had privileges.
 - a. Have you ever been denied privileges? Yes No
 - b. If Yes please explain on a separate attachment.

Hospital Name	Hospital Address	Start Date	End Date	% of Patient Care	Issue Certificate of Insurance?
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>

13. In what states are you registered and licensed to practice? _____
 Is your license limited? Yes No If yes, explain _____
 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 _____
14. Has there been any change in your practice or specialty in the past 5 years Yes No
 If yes, explain _____
15. Are you credentialed at any hospital for any procedures, which are not included in your primary medical specialty? Yes No
 If yes, explain _____
16. Are you a member of the staff, or do you practice in an ambulatory care center Yes No
17. Do you normally staff an emergency department? Yes No How many hours per month? _____
18. 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? _____
19. Do you work part-time outside of your regular practice (“moonlight”) Yes No If yes, describe _____
 Is this activity insured by your employer? Yes No If yes, name of insurance company _____
20. Are you employed full-time by the Federal Government **or** are you under contract to any government entity? Yes No
 If yes, explain _____
21. Do you work in either a federal or state prison? Yes No
 If yes, describe your duties and hours worked _____
22. Are you currently in the Military Service? Yes No If yes, check whether Active or Reserve
23. Are you a U.S. citizen? Yes No If no, indicate your status and date of entry into the USA _____
24. In what Medical Associations are you a member in good standing? _____
25. Have you participated in any continuing medical education within the past twelve (12 months)? Yes No
 If yes, how many category 1 credit hours? _____
26. Do you participate in, or are you a member of an HMO, PPO or similar healthcare system? Yes No
27. Is there a “hold harmless” clause in your contract requiring your professional liability insurance company to indemnify any hospital or institution? Yes No
28. Do you participate in peer review or similar activity with respect to above entities? Yes No
29. Are you U.S. Board Certified? Yes No Specify _____
 Organization extending certification _____
30. Are you Board Eligible? Yes No
31. Are you entering private practice for the first time? Yes No
32. Please use the space below for any comments you feel will help Yellowstone better understand any special circumstances concerning your practice. _____

PRACTICES AND PROCEDURES

32. Check the procedures performed by you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Laparoscopic Cholecystectomy | <input type="checkbox"/> Biopsy (Endoscopic) |
| <input type="checkbox"/> Accupuncture | <input type="checkbox"/> Laparoscopic Laser Surgery | <input type="checkbox"/> Peritoneoscopy |
| <input type="checkbox"/> Therapeutic/Local Anesthetic | <input type="checkbox"/> Laser Surgery | <input type="checkbox"/> Laser Therapy (Endoscopic) |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Pacemakers under General Anesthesia |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Silicone Injections |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Skin Flap/Grafts |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Major Gynecological Surgery | <input type="checkbox"/> Cosmetic _____% of practice |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Myelography | <input type="checkbox"/> Reconstruction _____% of practice |
| <input type="checkbox"/> Assisting in major surgery | <input type="checkbox"/> Needle Biopsy | <input type="checkbox"/> Swan-Ganz Catherization |
| <input type="checkbox"/> Own patients only | <input type="checkbox"/> Nerveblocks | <input type="checkbox"/> Right Heart Catherization (other than CVP lines) |
| <input type="checkbox"/> Own & other than own patients | <input type="checkbox"/> Lumbar Epidural Steroid | <input type="checkbox"/> Left Heart Catherization |
| <input type="checkbox"/> Blepharopigmentation | <input type="checkbox"/> Paraspinal | <input type="checkbox"/> Tubal Ligations |
| <input type="checkbox"/> Blepharoplasty-Brow Lifts | <input type="checkbox"/> Sciatic | <input type="checkbox"/> Vasectomies |
| <input type="checkbox"/> Cosmetic _____% of practice | <input type="checkbox"/> Facet | <input type="checkbox"/> On own patients |
| <input type="checkbox"/> Reconstructive _____% of practice | <input type="checkbox"/> Paravertebral | <input type="checkbox"/> On other than own patients |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Peripheral | <input type="checkbox"/> Vasectomies |
| <input type="checkbox"/> Cosmetic _____% of practice | <input type="checkbox"/> Myofascial | <input type="checkbox"/> On own patients |
| <input type="checkbox"/> Reconstruction _____% of practice | <input type="checkbox"/> Triggerpoint Injection | <input type="checkbox"/> On other than own patients |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Phlebography | <input type="checkbox"/> Weight Control Therapy/Surgery |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Pneumoencephalography | <input type="checkbox"/> _____ % of practice |
| <input type="checkbox"/> Cryosurgery (other than external lesions) | <input type="checkbox"/> Radial/Laser Keratotomy | <input type="checkbox"/> Medication-Weight Control |
| <input type="checkbox"/> ERCP | <input type="checkbox"/> Radiation/X-Ray Therapy | <input type="checkbox"/> Gastric Bubble |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Radiopaque Dye | <input type="checkbox"/> Gastric Stapling |
| <input type="checkbox"/> Phenol Facial Peels | <input type="checkbox"/> Non-Ionic only | <input type="checkbox"/> Other (type) _____ |
| <input type="checkbox"/> Diagnostic Embolization | <input type="checkbox"/> Shock Therapy | <input type="checkbox"/> Prenatal Practice |
| <input type="checkbox"/> General/Spinal/Caudal Anesthesia | <input type="checkbox"/> Sigmoidoscopy | <input type="checkbox"/> See patients during the first & second trimester |
| <input type="checkbox"/> Pulse Oximetry | <input type="checkbox"/> Less than 60 CM | <input type="checkbox"/> See patients to term but do not perform delivery |
| <input type="checkbox"/> End Tidal Co2 Analyzer | <input type="checkbox"/> Greater than 60 CM | <input type="checkbox"/> See patients to term and perform delivery |
| <input type="checkbox"/> Hair Transplants | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Normal Obstetrical Deliveries |
| <input type="checkbox"/> Scalp Excision/Transplantation | <input type="checkbox"/> Polypectomy | <input type="checkbox"/> How many per year? _____ |
| <input type="checkbox"/> Plug Technique/Minigraph | <input type="checkbox"/> Gastrointestinal Endoscopy | <input type="checkbox"/> Cesarean Sections |
| <input type="checkbox"/> Other Medical Techniques | | <input type="checkbox"/> How many per year? |
- Describe: _____

33. Pain Management Procedures List:

34. Indicate the percentage of your surgical practice devoted to the following surgical activities:

- | | | |
|---|--------------------|---|
| _____ % Plastic (Reconstructive only) | _____ % Thoracic | _____ % Orthopedic (Including back) |
| _____ % Plastic (Cosmetic enhancement only) | _____ % Cardiac | _____ % Orthopedic (not including back) |
| _____ % Hand | _____ | _____ % Other (describe) |
| _____ % Traumatic | _____ % Obstetrics | |

35. In the last (10) years,
- Have you discontinued major surgical procedure? Yes No
If "Yes" list procedures and date discontinued _____
 - Have you ever been a representative of a Pedicle Screw Manufacturer? Yes No
If "Yes" please attach an explanation _____
 - Have you performed weight control surgery or prescribed weight control medication? Yes No
 - If "Yes" what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs.
 <1% 1%-10% 11%-50% >50%
 - If "Yes" what percentage of your practice (% of patient care) was devoted to performing weight control surgery?
 <1% 1%-10% 11%-50% >50%
 - Do you have ownership interests in a weight control clinic? Yes No
 - If "Yes" what is the name of the weight control clinic with which you are affiliated _____
36. If you use silicone gel/saline breast implants, do you use the manufacturer's informed consent forms in addition to your normal informed consent procedure? Yes No
37. Do you use x-ray equipment on your premises? Yes No
If yes, are your x-rays overread by a radiologist? Yes No
38. Do you perform any surgical procedures in your professional office or similar non-hospital facility? Yes No
If yes, list procedures _____
39. Do you perform laparoscopic surgery? Yes No If yes, number of annual procedures performed? _____
40. If you administer anesthetics, is there a pre-anesthesia examination and conference with the patient? Yes No
41. Do you use pulse oximetry and capnography with general anesthesia Yes No
42. Do you assist in surgery? On your own patients _____ On the patients of others _____
43. 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 _____

Education and Training

44. Indicate your educational background (attach a copy of your Curriculum Vitae)
- | | | | |
|--|----------------|----------------|-------|
| 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 | _____ |
| f. Fellowship or advanced trng | Location _____ | Year Completed | _____ |
| g. Please explain any gaps in above chronological sequence _____ | | | |
45. 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 | _____ |
46. Are you a foreign medical school graduate? Yes No
47. If yes, are you certified by the Educational Council for Foreign Medical School Graduates? Yes No

Insurance

Please list your professional liability policies for the past ten years

Company	Policy No.	Policy Limits	Deductible	Claims Made <input type="checkbox"/>	Occurrence <input type="checkbox"/>	Policy Period
_____	_____	_____	_____	Claims Made <input type="checkbox"/>	Occurrence <input type="checkbox"/>	_____
_____	_____	_____	_____	Claims Made <input type="checkbox"/>	Occurrence <input type="checkbox"/>	_____
_____	_____	_____	_____	Claims Made <input type="checkbox"/>	Occurrence <input type="checkbox"/>	_____
_____	_____	_____	_____	Claims Made <input type="checkbox"/>	Occurrence <input type="checkbox"/>	_____

If at any time you were without insurance, please indicate on a separate sheet of paper.

Claims

48. Complete and attach a Claim Information Form for each claim, potential claim, or suite
- a. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim or suit arising out of the Rendering or failing to render professional services? Yes No
 If "Yes" how many? _____
 If "Yes" have these been reported to your insurer? Yes No
 - b. Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? Yes No
 If "Yes" how many? _____
 If "Yes" have these been reported to your insurer? Yes No

If reported to your insurer, please provide a copy of the report(s).

49. 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? | <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. Have you or do you presently have any chronic or life-threatening physical illness or defects? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Have you had any judgment made against you or any out-of-court settlements made on your behalf? | <input type="checkbox"/> | <input type="checkbox"/> |

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

Signing this application does not bind **Yellowstone Insurance Exchange, RRG** 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 **Yellowstone Insurance Exchange, RRG** about any matter contained in this application, then coverage provided by virtue of this application is void.

Date: _____

(X) _____
(Applicant)

(X) _____
(Witness)

**Additional Required Information:
Please include with application**

- **CV**
- **Copy of State License**
- **Copies of all certificates, to include DEA, ACLS, PALS, ATLS.**
- **Loss Runs/Claims Histories from each carrier for every employer during the last 5 consecutive years. (Please include copies of Certificates of Insurance as well.)**
- **Three (3) written professional references.**

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.



Yellowstone Insurance Exchange, RRG
SUPPLEMENTAL CLAIM INFORMATION

INSTRUCTIONS TO THE APPLICANT

- A. This form should be completed by the applicant whose signature appears on the Yellowstone Insurance Exchange, RRG Professional Liability Insurance Application.
B. One of these forms should be completed for each claim or incident in which the applicant has been involved.
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.

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 claim was made
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 any 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 complaint?
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)

Yellowstone Insurance Exchange, RRG

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, have provided *Yellowstone Insurance Exchange, RRG* information in their insurance application in order for *Yellowstone Insurance Exchange, RRG* 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 *Yellowstone Insurance Exchange, RRG* with any information, whether written or otherwise, which may be material to evaluating my application for insurance with *Yellowstone Insurance Exchange, RRG*. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to *Yellowstone Insurance Exchange, RRG*.

I consent for *Yellowstone Insurance Exchange, RRG* 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)